DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in the Management of a Patient's Reported Intimate Partner Violence at the Ralph H. Johnson VA Medical Center, in Charleston, South Carolina

HEALTHCARE INSPECTION | REPORT #20-03763-207 | AUGUST 3, 2021

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate OIG-identified concerns related to Ralph H. Johnson VA Medical Center (facility) staff's management of a patient's reported perpetration of intimate partner violence (IPV), including inpatient discharge planning, timeliness of clinical documentation, determination of reporting responsibilities, and outpatient providers' response to the patient's reported IPV.[1] Additionally, the OIG evaluated concerns related to implementation of the IPV Assistance Program (IPVAP).

Synopsis of Patient's Care

The patient was in their 20's at the time of death by suicide in fall 2019.[2] The patient initiated treatment with a facility primary care physician in early spring (day 1) 2019, and reported a history of anxiety disorder, major depressive disorder, and insomnia and treatment with an antidepressant and a mood stabilizer.[3] In late spring (day 49), the patient presented to the Emergency Department. A social worker documented the patient "had thoughts of…killing [the spouse], and [themselves]," and a resident physician admitted the patient to the facility's Inpatient Mental Health Unit. The next day, the Inpatient Mental Health Unit attending psychiatrist (attending psychiatrist) documented that the patient reported "being abusive towards [the spouse]," and two days later the inpatient psychiatry resident documented that a medical student contacted the patient's spouse, who reported that the patient was emotionally abusive, "forced sex on" the spouse, and tracked the spouse's location using telephone tracking services. The spouse also indicated having "no safe place to go" and being "afraid that [the patient] will continue to abuse [the spouse]" after the hospital discharge. On Day 56, the patient was discharged with an outpatient appointment for the following week.

On day 77, the patient's mental health treatment coordinator documented that the patient reported, "I verbally abused my [spouse] in the past," and on day 91, an outpatient social worker noted the patient's "[history] of IPV." On day 141, the outpatient social worker also documented the patient's "IPV behavior including stalking and controlling behaviors."

The IPVAP

In 2013, a Department of Veterans Affairs Domestic Violence Task Force published a national IPV policy implementation plan that included recommendations for standardized IPV screening,

[1] For purposes of this report and based on consultation with non-VA violence prevention subject matter experts, the OIG uses the term perpetrator to describe a current or former intimate partner who engages in IPV.

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

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

provision of evidence-based IPV treatment, adherence to state abuse and neglect reporting laws, and consultation with VA Legal Counsel if unsure of state reporting requirements.[4] In 2018, the Senate Appropriations Committee directed VA to fund a full-time IPVAP coordinator at each VA medical center. The Veterans Health Administration (VHA) subsequently published an IPVAP directive and considered a medical center "out of compliance" if a designated IPVAP coordinator or implementation of "the full scope of services" was not in place starting January 24, 2019, and the National IPVAP Office required a plan to achieve compliance be submitted.[5] In an interview with the OIG, IPVAP national leaders stated that prior to April 2018, when funding was allocated for the hiring of IPVAP coordinators, many medical centers had a designated point of contact (POC) who served in the role as collateral duty.

OIG Findings

The OIG found that despite both the patient's and spouse's reports of IPV, Inpatient Mental Health Unit staff did not consult with the IPVAP POC or speak with the spouse to ensure the spouse felt safe with the patient returning home following the patient's discharge. The attending psychiatrist speculated that because the facility's IPV POC was an Inpatient Mental Health Unit social worker, other Inpatient Mental Health Unit treatment team members likely discussed the reports of IPV with the IPVAP POC.[6] However, the patient's electronic health record (EHR) did not include evidence that the treatment team discussed the reported IPV with the IPVAP POC. The OIG determined that Inpatient Mental Health Unit staff's failure to consult with the IPVAP POC and to address the spouse's safety resulted in missed opportunities to obtain additional IPV resources, provide treatment resources to both the patient and spouse, and ensure the safety of the spouse prior to the patient's discharge.

The inpatient psychiatry resident completed a progress note addendum that included critical information related to reports of IPV 34 days after contact with the patient's spouse and not within 24 hours, as required by facility policy.[7] In an interview with the OIG, the attending psychiatrist speculated that signature was delayed due to the residency rotation schedule and that the inpatient psychiatry resident ended the Inpatient Mental Health Unit rotation prior to signing the note, and signed it upon returning for another rotation in spring 2019. Failure to timely complete the progress note addendum resulted in other treating clinicians not having prompt

[4] VHA Directive 1198. VHA Directive 1198 supports the execution of critical recommendations as delineated in the VHA Plan for Implementation of the Domestic Violence/Intimate Partner Violence Assistance Program (2013).

[5] VA, VHA Directive 1198*, Intimate Partner Violence Assistance Program (January 24, 2019) Frequently Asked Questions (FAQ),* February 2019.

[6] The patient's Inpatient Mental Health Unit social worker and former IPVAP POC no longer worked for VHA during this inspection and therefore, the OIG did not interview them.

[7] Facility Center Policy Memorandum No. 136-16-14, *Electronic Medical Records,* December 6, 2016, rescinded May 2020.

access to critical information related to the patient's reported IPV and may have contributed to inadequate provision of IPV-related resources and interventions for the patient and the spouse.

The OIG found that facility staff failed to consider consultation with the Office of Chief Counsel about the patient's IPV although VHA advises employees to "work with your Office of Chief Counsel" regarding state reporting requirements for victims of IPV.[8] In an interview with the OIG, the attending psychiatrist speculated that the spouse was aware of potential risks and that given the inpatient psychiatry resident's detailed documentation of the spouse's report of IPV, the inpatient staff likely discussed the patient's homicidal ideation with the spouse. However, the patient's EHR did not contain documentation that the treatment team spoke with the spouse prior to the patient's discharge to ensure that the spouse felt safe with the patient returning home.

Given the patient's homicidal ideation, patient and spouse reports of IPV, and severity of the reported IPV, the OIG would have expected staff consideration of consultation with the Office of Chief Counsel to definitively identify reporting responsibilities. The OIG was unable to determine whether consultation with the Office of Chief Counsel would have resulted in staff reporting IPV to the state. However, failure to determine reporting responsibilities may contribute to state agencies not having information necessary to provide advocacy and protection for IPV victims and result in individuals remaining in a dangerous situation.

Outpatient mental health staff did not consult with the IPVAP POC to provide the patient and spouse IPV resources and intervention or document discussion of resources or treatment options in response to the patient's reported IPV, as the OIG would have expected. During an interview with the OIG, the outpatient social worker reported awareness of the IPVAP POC at the time of the patient's care; however, the outpatient social worker thought that referrals were most effective for IPV victims rather than perpetrators. The mental health treatment coordinator told the OIG that as a substance use disorder clinic social worker, treatment with the patient focused on substance use and that an IPVAP referral was not considered, in part, because the patient denied any IPV. The OIG would have expected that the mental health treatment coordinator, to ensure continuity in transitions across levels of care, would have reviewed the patient's Inpatient Mental Health Unit documentation. The OIG was unable to determine whether staff's failure to address reports of IPV contributed to the patient's death by suicide because of multiple causal factors.[9] However, failure to consult with the IPVAP POC or discuss resources or treatment options may contribute to a lack of access to IPV services and, thus, prevent perpetrators' access to resources that may reduce the likelihood of future IPV behaviors.

[8] VHA Directive 1199, *Reporting Cases of Abuse and Neglect*, November 28, 2017.
[9] The circumstances of the patient's death are discussed in a companion report, VA OIG, *Deficiencies in Mental Health Care Coordination and Administrative Processes for a Patient Who Died by Suicide*, Report No.20-02368-202, August 3, 2021.

The OIG found that the Facility Director did not ensure development of an IPVAP protocol, as required.[10] Further, although the Facility Director appointed a licensed independent provider as the IPVAP Coordinator in 2016, at the time of the patient's care in 2019, facility staff and leaders did not identify the assigned IPVAP coordinator as a resource. Delayed development of a protocol, and ineffective communication regarding the staff assignment of the IPVAP Coordinator may have contributed to inadequate procedural guidance, and staff's lack of access to IPVAP consultation and resources.

The OIG also found that VHA guidance was unclear about IPV training responsibilities. Although medical center directors are identified as responsible to ensure training for all staff involved in IPV screening, IPVAP coordinators are responsible for other aspects of staff training.[11] Further, the 2019 IPVAP directive stated that there was no requirement for formal, national, mandatory IPV training.[12] The absence of clear expectations regarding staff IPV training may result in inadequate staff training and deficient actions related to IPV screening, reporting requirements, and resources offered to IPV perpetrators and victims.

The OIG made one recommendation to the Under Secretary for Health related to IPV training guidance and three recommendations to the Facility Director related to staff consultation with the IPVAP coordinator, timely clinical documentation, and consultation with the Office of General Counsel to determine reporting requirements.

Comments

The Under Secretary for Health and Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided acceptable action plans (see appendixes A, B, and C). Based on information provided, the OIG considers recommendations 1 and 3 closed. For the remaining open recommendations, the OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained. The OIG provided comments regarding disagreement with the Facility Director's responses to recommendations 2 and 3 (see appendix C).

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[10] VHA Directive 1198.
[11] VHA Directive 1198.
[12] VHA Directive 1198.

Contents

Abbreviations

EHR	electronic health record
IPVAP	Intimate Partner Violence Assistance Program
IPV	intimate partner violence
MHTC	Mental Health Treatment Coordinator
OIG	Office of Inspector General
POC	point of contact
REACH VET	Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate OIG-identified concerns related to staff's management of a patient's reported perpetration of intimate partner violence (IPV) at the Ralph H. Johnson VA Medical Center (facility).[1]

Background

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

Veterans Health Administration's Intimate Partner Violence Policy

In 2013, a Department of Veterans Affairs Domestic Violence Task Force published a national IPV policy implementation plan that included recommendations for standardized IPV screening, provision of evidence-based IPV treatment, adherence to state abuse and neglect reporting laws, and consultation with VA Legal Counsel if unsure of state reporting requirements.[2] In January 2014, the National IPV Assistance Program (IPVAP) Manager was appointed and initiated "enterprise-wide awareness and implementation."[3] From June 2015 to June 30, 2017, six Veterans Health Administration (VHA) medical centers participated in a "rapid implementation cycle" that identified best practices for expanding the IPVAP nationally.[4] In 2016, VHA conducted the first IPVAP evaluation to establish baseline data regarding implementation at VHA medical centers.[5]

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[1] For purposes of this report and based on consultation with non-VA violence prevention subject matter experts, the OIG uses the term perpetrator to describe a current or former intimate partner who engages in IPV.

[2] VHA Directive 1198. VHA Directive 1198 supports the execution of critical recommendations as delineated in the VHA Plan for Implementation of the Domestic Violence/Intimate Partner Violence Assistance Program (2013).

[3] VA Care Management and Social Work, "Intimate Partner Violence Assistance Program 2018 Program Summary," January 2019.

[4] Deputy Under Secretary for Health for Operations and Management (10N), *Veterans Health Administration (VHA) Intimate Partner Violence Assistance Program (IPVAP) Evaluation and Needs Assessment*, June 29, 2018.

[5] Deputy Under Secretary for Health for Operations and Management (10N), Veterans Health Administration (VHA) *Intimate Partner Violence Assistance Program (IPVAP) Evaluation and Needs Assessment,* June 29, 2018; VA Care Management and Social Work, "Intimate Partner Violence Assistance Program 2018 Program Summary," January 2019.

In 2018, the Senate Appropriations Committee directed VA to fund a full-time IPVAP coordinator at each VA medical center. VHA required each medical center to complete a Point in Time Evaluation and Needs Assessment by July 31, 2018.[6] VHA subsequently published an IPVAP directive and considered a medical facility "out of compliance" if a designated IPVAP coordinator or implementation of "the full scope of services" was not in place starting January 24, 2019, and the National IPVAP Office required a plan to achieve compliance be submitted.[7]

The January 2019 IPVAP directive requires that veterans, their intimate partners, and VA employees affected by IPV are offered services including IPV assessment and intervention.[8] The Office of Care Management and Social Work is responsible to ensure the implementation of the IPVAP nationally.[9] The National Director of Social Work has oversight of the "development and implementation of national directives, program initiatives and VHA guidance related to the delivery of IPV assistance."[10] The National IPVAP Manager is responsible for supporting the implementation of the IPVAP nationally.[11] The VISN IPVAP champion is responsible for supporting medical center IPVAP coordinators and providing implementation reports to the Deputy Under Secretary for Health for Operations and Management.[12] The medical center director must ensure that IPVAP implementation includes (1) appointment of an IPVAP coordinator who is a licensed independent provider, (2) development of a facility IPVAP protocol, and (3) provision of specialty training for staff who screen patients for IPV.[13] In an interview with the OIG, IPVAP national leaders stated that prior to April 2018, when funding was allocated for the hiring of IPVAP coordinators, many medical centers had a designated POC who served in the role as collateral duty.

[6] Deputy Under Secretary for Health for Operations and Management (10N), Veterans Health Administration (VHA) Intimate Partner Violence Assistance Program (IPVAP) Evaluation and Needs Assessment, June 29, 2018; VA Care Management and Social Work, "Intimate Partner Violence Assistance Program 2018 Program Summary," January 2019. Subsequent annual program evaluations included staffing of the IPVAP Coordinator, public awareness, employee training, community partnerships, screenings, documentation, intervention, and IPV treatment and were titled, "Program Implementation and Evaluation Needs Assessments."

[7] Department of Veterans Affairs, VHA Directive 1198, *Intimate Partner Violence Assistance Program (January 24, 2019) Frequently Asked Questions (FAQ),* February 2019.

[8] VHA Directive 1198, *Intimate Partner Violence Assistance Program,* January 24, 2019.

[9] VHA Directive 1198.

[10] VHA Directive 1198.

[11] VHA Directive 1198.

[12] VHA Directive 1198. National Social Work Program VA Care Management and Social Work Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*, October 2020, designated the role of IPVAP VISN point of contact as IPVAP VISN champion.

[13] VHA Directive 1198.

In October 2020, VHA disseminated an operating guide to facilitate the implementation of the IPVAP at medical centers.[14] The operating guide further delineated the IPVAP structure to include a VISN lead coordinator to serve as a liaison between the national manager and medical center IPVAP coordinators within the VISN, and medical center champions who are licensed independent providers trained to provide IPVAP responses within a VA clinic or a specialty department.[15]

VHA required that staff determine, in consultation with the Office of Chief Counsel if necessary, state reporting requirements for victims of IPV and "whether VA has legal authority to disclose the pertinent information to the state."[16] VHA "covered professionals" must comply with VA, federal, and state abuse and neglect reporting laws, including state requirements to report IPV, complete state reporting forms, and document the report promptly in the patient's electronic health record (EHR).[17]

Facility staff have a duty to "suspend confidentiality" and "take all reasonable measures to protect the intended, identified victim" upon becoming aware of a patient's "intent to inflict serious or fatal injury on another individual."[18] Measures may include notifying the victim and appropriate authorities. Mental health providers should seek consultation and document consultation in the patient's EHR.[19]

IPVAP Coordinator

Although a full-time employee equivalent position "is optimal," the IPVAP coordinator may be assigned as a collateral duty if provided "adequate protected time" to satisfy the role responsibilities.[20] The IPVAP coordinator is responsible to provide

[14] VA National Social Work Program VA Care Management and Social Work Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*, October 2020.

[15] VHA Directive 1198; National Social Work Program VA Care Management and Social Work Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*, October 2020. The VISN IPVAP Lead Coordinator role may be filled by the IPVAP Champion, medical center IPVAP Coordinator, or medical center IPVAP Champion.

[16] VHA Directive 1199, *Reporting Cases of Abuse and Neglect*, November 28, 2017.

[17] VHA Directive 1199. VHA defines a covered professional as VHA employees or contractors "performing a healing role or practicing the healing arts."

[18] Facility Policy 116-19-16, *Management of Mental Health Patient Disclosure of Intent to Inflict Serious or Fatal Injury - Duty to Warn & Protect,* January 17, 2019.

[19] Facility Policy 116-19-16.

[20] VHA Directive 1406, *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017. A full-time equivalent represents the hours worked by an employee in a normal 80-hour pay period. The value ranges from 0.0 to 1.0, with 1.0 representing 80 hours worked in a pay period.

- Staff guidance on IPV interventions,
- New employee orientation,
- Annual training for all staff,
- Specialized training for providers engaged in IPV screening and intervention, and
- IPV referral response.[21]

For patients who screen positive for IPV, the IPVAP coordinator is responsible to

- Offer safety planning,
- Provide treatment referrals,
- Implement evidence-based services, and
- Provide patients and their partners with community resources and interventions.[22]

Concerns

During another hotline inspection at the facility, the OIG team identified the following concerns:[23]

- Deficiencies in management of the patient's reported IPV
    - Inadequate inpatient discharge planning
    - Delayed documentation
    - Failure to determine IPV-related reporting responsibilities
    - Inadequate outpatient providers' response to the patient's reported IPV
- Inadequate IPVAP implementation
- Inconsistent VHA IPVAP training guidance

[21] VHA Directive 1198.

[22] VHA Directive 1198.

23 VA OIG, *Deficiencies in Mental Health Care Coordination and Administrative Processes for a Patient Who Died by Suicide*, Report No.20-02368-202, August 3, 2021; VHA Directive 1198. IPV is a type of domestic violence that occurs between intimate partners, and can include stalking, and sexual or physical violence.

Scope and Methodology

The OIG conducted a virtual site visit from August 17–20, 2020.[24]

The OIG interviewed facility leaders and staff familiar with the patient's care and relevant processes, the VISN 7 IPVAP Champion, the VISN 7 IPVAP Lead Coordinator, the National IPVAP Manager, and the Acting National Director of Social Work.[25] The OIG also interviewed two non-VA violence prevention subject matter experts.[26]

The OIG reviewed the patient's EHR, VHA directives, handbooks, and memoranda, facility policies and a protocol, state reporting laws, The Joint Commission standards, facility medical bylaws, and organizational charts. The OIG also reviewed the facility's annual 2018–2020 Program Implementation and Evaluation Needs Assessments submitted to VHA Patient Care Services.

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

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

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

[24] The site visit was conducted virtually due to the Coronavirus (COVID-19) pandemic. The World Health Organization, 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. COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), a newly discovered coronavirus.

[25] Facility leaders included the Facility Director, Associate Director, Chiefs of Mental Health and Social Work Service, and Section Chief of Mental Health.

[26] The two non-VA subject matter experts were behavioral scientists specializing in public health and violence prevention.

Patient Case Summary

The patient was in their 20's at the time of death by suicide in the fall 2019. The patient initiated treatment with a facility primary care physician on a day in 2019 (day 1) and reported a history of anxiety disorder, major depressive disorder, and insomnia and treatment with an antidepressant and a mood stabilizer.[27] The patient also reported cannabis use for chronic musculoskeletal pain. The physician noted a plan for the patient to "establish care with mental health for further evaluation and treatment."

On the same day, a primary care mental health integration psychologist documented that the patient reported a history of sexual and physical abuse as a child.[28] The patient reported "feeling empty," denied current suicidal and homicidal ideation, and the psychologist documented symptoms of loss of interest, poor focus, fatigue, purposeless, and sleep disturbances. The psychologist provisionally diagnosed recurrent major depressive disorder and anxiety disorder, and placed a consult to the outpatient mental health clinic for medication management.

On day 33, an outpatient mental health clinic psychiatrist documented that the patient reported worsening anxiety since 2016 with daily recurring thoughts of childhood abuse and combat experiences, continued cannabis use, and difficulty maintaining employment due to problems with anger. The patient screened negative on the secondary suicide risk screen. The psychiatrist increased the mood stabilizer medication dosage and planned for the patient to return in four weeks.[29]

On day 48, the patient contacted the Veterans Crisis Line and reported suicidal ideation, a plan to either overdose on medications or use a knife, thoughts of killing family pets, and having written "a suicide letter."[30] The patient developed a safety plan with the Veterans Crisis Line responder and agreed to a consult with the facility's Suicide Prevention Coordinator.[31]

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

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

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

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

[31] VHA Directive 1503. Responders are staff who interact with individuals who contact the Veterans Crisis Line through chats, calls, and texts.

On day 49, the Suicide Prevention Case Manager telephoned the patient who reported suicidal ideation with a plan to overdose on medications that were available in the home.[32] The Suicide Prevention Coordinator contacted the patient's spouse at work and the spouse agreed to transport the patient to the facility.

The patient arrived at the facility's Emergency Department and a social worker documented that the patient's "obsessing and paranoia have been so bad that [the patient] has had thoughts of destroying all of their pictures, killing their animals, killing [the spouse], and [themselves]." The patient acknowledged "daily marijuana use to help with [the patient's] symptoms."

That day, a resident physician admitted the patient to the facility's Inpatient Mental Health Unit and documented that the patient was "currently at high risk for suicide as [spouse] recently asked for a separation." On day 50, the Inpatient Mental Health Unit attending psychiatrist (attending psychiatrist) documented that the patient reported "being abusive towards [the spouse], first in the context of while [the patient] is sleeping but later [the patient] said this has also happened during sex. [The patient's] become obsessive about [the spouse]."

In an addendum started on day 51, an inpatient psychiatry resident documented that an Inpatient Mental Health Unit medical student spoke to the patient's spouse, and that the spouse reported that "[the spouse] is afraid that [the patient] will continue to abuse [the spouse]" after the hospital discharge.[33] Additionally, the spouse reported to the medical student that the patient "hits [the spouse] at night when having bad dreams but also other times when [the patient] goes into blind rage…emotionally abuses [the spouse] with derogatory statements…has forced sex on [the spouse] many times…tracks [the spouse's] every move with phone location services. [The spouse] wants to leave patient." The inpatient psychiatry resident documented that a social worker and the medical student contacted the patient's spouse to offer information on a domestic abuse shelter and to "speak to [the spouse] about options for [the spouse's] safety."

On day 56, the Inpatient Mental Health Unit social worker (inpatient social worker), inpatient psychiatry resident, a medical student, and the Suicide Prevention Coordinator met with the patient for a discharge and safety planning meeting. The inpatient social worker completed a suicide prevention safety plan with the patient. The inpatient psychiatry resident documented discharge diagnostic impressions including major depressive disorder, recurrent, severe, posttraumatic stress disorder, cannabis use disorder, and alcohol use disorder. The patient was discharged with an outpatient appointment for the following week.

On day 57, the attending psychiatrist telephoned the patient and documented that the patient denied suicidal or homicidal ideation, planned to attend appointments the following week, and

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

[33] VA Handbook 1400.01, *Resident Supervision*, December 19, 2012. Resident physicians function under the supervision of an attending physician at all times.

that the patient and spouse were "getting along much better." On day 58, an outpatient psychiatrist returned the patient's telephone call and documented that the patient accidentally took too much medication and denied suicidal ideation.

On day 61, the patient was admitted to another, non-VA hospital for a suicide attempt. The patient was discharged on day 69. As scheduled by the Suicide Prevention Coordinator, a substance use disorder clinic psychiatry resident physician assessed the patient on day 70.

On day 71, a substance use disorder clinic social worker was assigned as the patient's mental health treatment coordinator (MHTC).[34] On day 72, an outpatient psychologist met with the patient and documented that the patient reported residing in the same home but not sleeping in the same room as the spouse. The patient reported that the spouse "was/is scared of [the patient]" due to the patient's possible bipolar disorder diagnosis and history of "attacking [the spouse] in [the patient's] sleep."

On day 77, the MHTC completed a psychosocial assessment with the patient and documented that the patient reported living with the spouse, being "very impulsive," and that "I verbally abused my [spouse] in the past." On day 84, the MHTC met with the patient for an individual appointment. The MHTC documented that the patient reported recent spousal separation and that the spouse had a restraining order against the patient. The MHTC documented that the patient made a request for contact with a Department of Defense Family Advocate; however, the MHTC "expressed concern for sharing information with individuals connected with [the patient's] active duty military record" and "encouraged Veteran to obtain what may be needed directly from Medical Records."[35]

The same day, the Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET) Coordinator documented that the patient may benefit from enhanced

[34] Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012; VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. The MHTC's role is to ensure communication with both the patient and the patient's designated family members or friends about the patient's treatment and any issues related to their care, and serves as a point of contact during transitions across levels of care.

[35] Department of Defense Family Advocacy Program, *Addressing Domestic Abuse, Briefing to the Defense Advisory Committee on Women in the Services,* September 17, 2019, accessed September 1, 2020, https://dacowits.defense.gov/Portals/48/Documents/General%20Documents/RFI%20Docs/Sept2019/FAP%20RFI%208.pdf. The Family Advocacy Program provides clinical and case management services related to domestic abuse to individuals eligible for care in military medical facility.

treatment and assigned the MHTC as the REACH VET Provider.[36] On day 86, the MHTC documented, in a REACH VET Provider Note, that changes in the patient's care were not indicated.

On day 91, an outpatient social worker completed a diagnostic assessment with the patient and noted that the patient's symptoms were consistent with borderline personality disorder. The outpatient social worker documented that the patient had a "[history] of IPV." The patient stated there was an "active protection/separation order with the military police.".

On day 141, the outpatient social worker documented the patient's "IPV behavior including stalking and controlling behaviors," and added an addendum to the note the next day that the patient endorsed passive homicidal ideation towards the estranged spouse's significant other. On day 145, the patient told an outpatient psychiatry resident physician about cannabis use, continued difficulty coping with upcoming divorce, depressed mood, and taking sleep medication in the morning and at night. The patient denied suicidal thoughts. On day 148, the outpatient social worker documented that the patient reported continued "surveillance behavior" including using a tracking device. The outpatient social worker documented supervisory consultation and that although the patient reported passive thoughts of harming the spouse's significant other, "the veteran did not articulate a threat, plan, or intent that would rise to the level of Tarasoff."[37]

Between day 159 and day 210, the outpatient social worker spoke to the patient by phone three times and made six additional outreach attempts. The patient died by suicide on day 214.[38]

[36] Acting Deputy Under Secretary for Health for Operations and Management, *REACH VET: Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment,* August 10, 2016. VHA implemented the REACH VET program in 2016 using a statistical model to identify patients at increased risk for suicide behavior and other adverse outcomes. The REACH VET Coordinator identifies the appropriate REACH VET provider and reviews the REACH VET provider responsibilities. REACH VET providers are responsible for reviewing the patient's clinical information, enhancing treatment as appropriate, outreaching the patient, documenting patient outreach within one week of notification.

[37] National Conference of State Legislatures (website), "Mental Health Professionals' Duty to Warn," accessed June 17, 2020, https://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx. In 1976, *Tarasoff v Regents of the University of California* imposed a ruling that mental health professionals have a duty to warn third parties when aware of a patient's threat made to the third party's safety. Since then, almost all states have enacted similar laws to protect third parties from a patient's threat on their safety.

[38] For additional patient case summary details, see VA OIG, *Deficiencies in Mental Health Care Coordination and Administrative Processes for a Patient Who Died by Suicide*, Report No. 20-02368-202, August 3, 2021.

Inspection Results

Deficiencies in Management of the Patient's Reported IPV

The OIG found deficiencies in staff's management of the patient's reported IPV, specifically related to inadequate inpatient discharge planning, delayed documentation, failure to determine IPV-related reporting responsibilities, inadequate outpatient provider response to the patient's reported IPV.

Inadequate Inpatient Discharge Planning

The OIG found that Inpatient Mental Health Unit staff did not adequately complete discharge planning including failure to consult with the IPVAP POC and address the spouse's safety prior to the patient's discharge.[39]

Inpatient mental health services provide safety and clinical intervention to treat patients who present "a safety risk to self or others."[40] Inpatient mental health unit staff must be sufficiently trained to recognize risk of suicide or violence including warning signs of dangerous behaviors. When staff identify warning signs, the treatment team "must act immediately to optimize safety."[41] "Discharge planning provides for continuity of care to meet identified needs" of the patient.[42] VHA requires inpatient staff to initiate discharge planning "promptly" after a patient's admission and coordinate "appropriate follow-up care."[43] Facility Medical Staff Bylaws require that "discharge planning is initiated as early as a determination of need is made," provides for continuity of care, and is documented in patients' EHRs.[44] VHA requires that, with patient consent, inpatient staff include outpatient clinicians and family members in discharge planning.[45]

On day 49, a resident physician admitted the patient to the facility's Inpatient Mental Health Unit, and documented that the patient agreed to the treatment team calling the spouse "for collateral" information. The following day, the attending psychiatrist documented that the patient reported "being abusive" towards the spouse although denied current homicidal ideation. On

[39] National Social Work Program VA Care Management and Social Work Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*, October 2020. The OIG was informed that from 2017 through August 5, 2020, an Inpatient Mental Health Unit social worker, who was not a licensed independent provider, served as the IPVAP POC.

[40] Facility Medical Staff Bylaws, December 31, 2018.

[41] Facility Medical Staff Bylaws, December 31, 2018.

[42] Facility Medical Staff Bylaws, December 31, 2018.

[43] VHA Handbook 1160.06, *Inpatient Mental Health Services,* September 16, 2013.

[44] Facility Medical Staff Bylaws, December 31, 2018.

[45] VHA Handbook 1160.06.; Deputy Under Secretary for Health for Operations and Management Memorandum, *Eliminating Veteran Suicide: Enhancing Acute Inpatient Mental Health and Residential Rehabilitation Treatment Program (RRTP) Discharge Planning and Follow-up,* June 12, 2017.

day 51, the inpatient psychiatry resident documented that a medical student contacted the patient's spouse, who reported that the patient was emotionally abusive, "forced sex on" the spouse, and tracked the spouse's location using telephone tracking services. The spouse also indicated having "no safe place to go." The inpatient social worker and medical student documented providing the spouse with resources to a shelter "for [the spouse's] safety." Additionally, the inpatient psychiatry resident documented that "we have spoken to [the patient's spouse] and currently have concerns about [the spouse's] safety as well. [The spouse] discussed separating from [the patient] for reasons related to safety."

In an interview with the OIG, the attending psychiatrist acknowledged being concerned about the patient's reported IPV, and did not remember consulting with the IPVAP POC. The attending psychiatrist speculated that because the facility's IPVAP POC was an Inpatient Mental Health Unit social worker, other Inpatient Mental Health Unit treatment team members likely discussed the reports of IPV with the IPVAP POC.[46] The patient's EHR did not include evidence that any Inpatient Mental Health Unit treatment team members discussed the reported IPV with the IPVAP POC.

The OIG determined that Inpatient Mental Health Unit staff's failure to consult with the IPVAP POC resulted in missed opportunities to obtain additional IPV resources, provide treatment resources to both the patient and spouse, and ensure the safety of the spouse prior to the patient's discharge.

Delayed Documentation

The OIG determined that an inpatient psychiatry resident completed a progress note addendum 34 days after contact with the patient's spouse and not within 24 hours as required by facility policy.[47] VHA requires staff to complete timely EHR entries in accordance with medical center policy and that Health Information Management staff implement a process for ongoing monitoring of unsigned progress notes.[48] Facility policy requires inpatient staff to complete documentation within 24 hours of beginning a progress note.[49] To prevent clinical decision-making based on information that may later be revised or removed, progress notes are not viewable to other providers until signed.[50]

[46] The patient's Inpatient Mental Health Unit social worker and former IPVAP POC no longer worked for VHA during this inspection and therefore, the OIG did not interview them.

[47] Facility Center Policy Memorandum No. 136-16-14, *Electronic Medical Records,* December 6, 2016, rescinded May 29, 2020.

[48] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[49] Facility Center Policy Memorandum No. 136-16-14; Facility Medical Staff Bylaws, December 4, 2018.

[50] VHA Handbook 1907.01.

On day 51, the inpatient psychiatry resident began a progress note addendum that included the spouse's report of IPV and on day 85, 34 days later, the inpatient psychiatry resident signed the addendum. In the progress note addendum, the inpatient psychiatry resident documented that a medical student called the patient's spouse, who reported that the "[the spouse] is afraid that [the patient] will continue to abuse [the spouse]" after the hospital discharge. Additionally, the spouse reported to the medical student that the patient "hits [the spouse] at night when having bad dreams but also other times when [the patient] goes into blind rages…emotionally abuses [the spouse] with derogatory statements…has forced sex on [the spouse] many times…tracks [the spouse's] every move with phone location services. [The spouse] wants to leave patient." The inpatient psychiatry resident documented that a social worker and the medical student contacted the patient's spouse to offer information on a domestic abuse shelter and to "speak to [the spouse] about options for [the spouse's] safety."

In an interview with the OIG, the attending psychiatrist speculated that signature was delayed due to the residency rotation schedule and that the inpatient psychiatry resident ended the Inpatient Mental Health Unit rotation prior to signing the note, and signed it upon returning for another rotation in spring 2019. In an interview with the OIG, the Chief, Health Information Management Services confirmed monitoring of unsigned notes. However, the inpatient psychiatry resident's unsigned addendum did not appear in the unsigned notes reports and the Chief, Health Information Management Services was unable to provide an explanation for the exclusion.

The OIG found that the inpatient psychiatry resident failed to complete a progress note addendum within 24 hours, as required by facility policy.[51] Failure to complete the progress note addendum timely resulted in other treating clinicians not having prompt access to critical information related to the patient's reported IPV and may have contributed to inadequate provision of IPV-related resources and interventions for the patient and the spouse.

Failure to Determine IPV-Related Reporting Responsibilities

The OIG found that facility staff failed to consider consultation with the Office of Chief Counsel about the patient's IPV although VHA advises employees to "work with your Office of Chief Counsel" regarding state reporting requirements for victims of IPV.[52] Reporting abuse "as soon as possible," ensures that agencies responsible for advocacy and protection of vulnerable populations are notified.[53]

On day 49, when the patient presented to the Emergency Department, a registered nurse documented that the patient reported "intentional infliction of harm" towards the spouse. The

[51] Facility Center Policy Memorandum No. 136-16-14.

[52] VHA Directive 1199, *Reporting Cases of Abuse and Neglect*, November 28, 2017.

[53] VHA Directive 1199.

patient reported having "grabbed [the spouse] by the hair slamming [the spouse's] head into the bed." An Emergency Department social worker documented that the patient "has had thoughts of destroying all of their pictures, killing their animals, killing [the spouse] and [patient's] self" and an inpatient psychiatry resident admitted the patient to the facility's Inpatient Mental Health Unit.

The OIG found that facility staff did not consider consultation with the Office of General Counsel regarding reporting responsibilities related to the patient's reported IPV.[54] Outpatient Mental Health Clinic providers told the OIG that they did not consult with the Office of Chief Counsel and in an interview with the OIG, the attending psychiatrist speculated that Inpatient Mental Health Unit staff did not consult the Office of Chief Counsel and staff believed that the spouse was aware of potential risks. The attending psychiatrist further speculated that, given the inpatient psychiatry resident's detailed documentation of the spouse's report of IPV, inpatient staff likely discussed the patient's homicidal ideation with the spouse. In an interview with the OIG, the inpatient psychiatry resident did not recall the patient's case, was unsure of mandatory reporting requirements for IPV, and reported that in a situation where there was uncertainty about reporting requirements, deferring to the attending psychiatrist. However, the OIG did not find documentation in the patient's EHR that the inpatient psychiatry resident discussed the patient's homicidal ideation with the spouse or consulted with the attending psychiatrist.

The outpatient social worker and the outpatient social worker's supervisor told the OIG that during their clinical consultation about the patient, it was mutually determined that because the patient did not make an imminent threat, the outpatient social worker could not breach the patient's confidentiality and contact the spouse. Additionally, in an interview with the OIG, the outpatient social worker expressed openness to consulting with VA legal counsel; however, reported being unaware of the consultation procedures. The outpatient social worker's supervisor told the OIG that they did not consider consultation with the Office of Chief Counsel.

Given the patient's homicidal ideation, patient and spouse reports of IPV, and severity of the reported IPV, the OIG would have expected staff consideration of consultation with the Office of Chief Counsel to definitively identify reporting responsibilities. The OIG was unable to determine whether consultation with the Office of Chief Counsel would have resulted in staff reporting IPV to the state. However, failure to determine reporting responsibilities may contribute to state agencies not having information necessary to provide advocacy and protection for IPV victims and result in individuals remaining in dangerous situations.

[54] VHA Directive 1199; VHA Directive 1198.

Inadequate Outpatient Providers' Response to the Patient's Reported IPV

The OIG found that staff did not consult with the IPVAP POC to provide the patient and spouse IPV resources and intervention or document discussion of resources or treatment options in response to the patient's reported IPV, as the OIG would have expected. Following the patient's inpatient discharge, the patient was seen for outpatient mental health treatment and reported IPV to both the MHTC and outpatient social worker several times in spring and summer 2019 (see table 1).

The MHTC's goal is to ensure continuity of care during transitions in levels of care, communicate with both the patient and, when appropriate, the patient's designated family members or friends about the patient's treatment and any issues related to their care, assist a patient's engagement in treatment, and serve as a point of contact during transitions in care.[55]

Table 1: Timeline of the Patient's Reported IPV

Date	Reported IPV
Day 77	The patient reported to the MHTC, "I verbally abused my [spouse] in the past."
Day 83	The MHTC documented that the patient and spouse "have separated and there are restraining orders involved."
Day 86	The patient was identified as at high risk for adverse outcomes through the REACH VET program. The MHTC did not document the patient's history of engaging in IPV, documented that the patient was "receiving appropriate care," and "no changes are indicated."
Day 91	The outpatient social worker reported a history of "IPV" as a safety concern.
Day 105	The outpatient social worker documented the patient's treatment plan that included a goal "to build a life that feels more worth living" and did not include addressing IPV.
Day 141	The outpatient social worker documented that the patient "reported engaging in IPV behavior including stalking and controlling behaviors."
Day 142	The outpatient social worker documented "having the urge to contact or follow my [spouse]" as a risk factor in the patient's safety plan.

[55] Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator,* March 26, 2012; VHA Handbook 1160.01, "VA mental health services," U.S. Department of Veterans Affairs, accessed January 28, 2021, https://www.va.gov/health-care/health-needs-conditions/mental-health/. VA provides various levels of mental health care including inpatient, outpatient, and residential treatment.

Date	Reported IPV
Day 148	The outpatient social worker documented that the patient reported continuing to participate in "surveillance behaviors" including accessing the spouse's email account and using a tracking device to track the spouse's activities.

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

During an interview with the OIG, the outpatient social worker reported awareness of the IPVAP POC at the time of the patient's care; however, determined that referrals were most effective for IPV victims rather than perpetrators. Additionally, the outpatient social worker told the OIG that the patient was not a candidate for an available treatment due to the patient's unwillingness to discontinue the behavior. The outpatient social worker told the OIG about consulting with an outpatient mental health supervisor, who corroborated that they concluded that the patient did not make an imminent threat towards the spouse and therefore could not breach the patient's confidentiality and speak to the spouse.

In interviews with the OIG, the MHTC reported not having reviewed the EHR documentation from the patient's Inpatient Mental Health Unit admission and provided contradictory reports regarding knowledge of IPV behaviors. During an initial interview with the OIG, the MHTC acknowledged that the patient reported that the spouse made accusations that they both engaged in physical violence. In a subsequent interview, however, the MHTC denied knowledge of any reported IPV behavior. The MHTC told the OIG that as a substance use disorder clinic social worker, treatment with the patient focused on substance use and that an IPVAP referral was not considered, in part, because the patient denied any IPV. The OIG would have expected that the MHTC, to ensure continuity in transitions across levels of care, would have reviewed the patient's Inpatient Mental Health Unit documentation.

The OIG determined that outpatient mental health providers did not consult with the IPVAP POC to ensure resources and access to IPV treatment or engage the patient in a discussion of resources and treatment options. The OIG was unable to determine whether staff's failure to address reports of IPV contributed to the patient's death by suicide because of multiple causal factors. However, failure to consult with the IPVAP POC or discuss resources or treatment options may contribute to lack of access to IPV services and, thus, prevent perpetrators' access to resources that may reduce the likelihood of future IPV behaviors.

Inadequate IPVAP Implementation

The OIG found that the Facility Director did not ensure development of an IPVAP protocol, as required.[56] Further, although the Facility Director appointed a licensed independent provider as

[56] VHA Directive 1198.

the IPVAP Coordinator in 2016, at the time of the patient's care in 2019, facility staff and leaders identified a non-licensed independent provider as a resource for IPVAP information.

In January 2019, VHA required medical center directors to ensure development of a facility IPVAP protocol, and appointment of an IPVAP coordinator who is a licensed independent provider. The Chief, Social Work Service established an IPVAP protocol on September 4, 2020, approximately 19 months after the established requirement.[57]

Documentation from March 3, 2016, Domestic Violence/Intimate Partner Violence Task Committee Minutes indicate assignment of a licensed independent social worker as the IPVAP Coordinator.[58] Although the assigned IPVAP Coordinator told the OIG of being an IPVAP point of contact and "we do not have an Intimate Partner Violence Coordinator." Additionally, of 15 interviews the OIG conducted with facility staff and leaders, none accurately identified the assigned IPVAP Coordinator and only the Inpatient Social Work Supervisor identified the assigned IPVAP Coordinator as a consultant. However, on August 10, 2020, facility leaders assigned another social worker, who was a licensed independent provider, as the Interim IPVAP Coordinator and sent facility-wide notification including the Interim IPVAP Coordinator's contact information on August 17.[59]

Inconsistent VHA IPVAP Training Guidance

The OIG also found that VHA guidance was unclear about IPV training responsibilities. The January 2019 IPVAP directive identifies medical center directors as responsible to ensure that "All staff engaged in screening for IPV are provided with skills-based training and support." The IPVAP coordinator responsibilities include, but are not limited to

> Providing/coordinating general local training for all staff on IPVAP services at new employee orientation and at least annually thereafter;
>
> Offering staff training for all providers and key personnel that addresses the dynamics of IPV…;
>
> Arranging specialized in-depth training in assessment, screening, and treatment intervention for staff or providers who are directly engaged in these activities; and
>
> Providing training to facility staff on the IPVAP documentation guidelines.[60]

[57] VHA Directive 1198.

[58] The unsigned meeting minutes did not include information about attendees.

[59] The OIG notified the Facility Director of this hotline inspection on August 3, 2020.

[60] VHA Directive 1198.

However, the IPVAP directive also states, "there are no formal national mandatory training requirements associated with this directive."[61] Further, the October 2020 IPVAP Operating Guide delineates that the IPVAP coordinator will provide the following three levels of staff training:

- Level 1 ensures all medical center staff are aware of how to identify IPV and how to obtain assistance and is recommended to be provided at new employee orientation and "annually thereafter."

- Level 2 is additional training required of all clinic staff in areas where IPV screening occurs and can be provided "during staff meetings, during scheduled trainings, by handout or in paper read-ahead forms."

- Level 3 is advanced training on IPV assessment, safety planning, intervention, and resources for IPVAP champions.[62]

Inconsistent VHA guidance may have contributed to lack of clarity regarding IPVAP training. The absence of clear expectations regarding staff IPV training may result in inadequate staff training and deficient actions related to IPV screening, reporting requirements, and resources offered to IPV perpetrators and victims.

Conclusion

The OIG found that despite both the patient's and spouse's reports of IPV, Inpatient Mental Health Unit staff did not consult with the IPVAP POC or speak with the spouse to ensure the spouse felt safe with the patient returning home. Failure to consult with the IPVAP POC and to address the spouse's safety resulted in missed opportunities to obtain additional IPV resources, provide treatment resources to both the patient and spouse, and ensure the safety of the spouse prior to the patient's discharge.

The inpatient psychiatry resident completed a progress note addendum, that included critical information related to reports of IPV, 34 days after contact with the patient's spouse and not within 24 hours as required by facility policy.[63] Failure to complete timely documentation resulted in other treating clinicians not having prompt access to critical information related to the

[61] VHA Directive 1198.

[62] Department of Veterans Affairs (VA) National Social Work Program VA Care Management and Social Work Intimate Partner Violence Assistance Program, *Operating Guide National Intimate Partner Violence Assistance Program*, October 2020.

[63] Facility Center Policy Memorandum No. 136-16-14, *Electronic Medical Records,* December 6, 2016, rescinded May 2020.

patient's reported IPV and may have contributed to inadequate provision of IPV-related resources and interventions for the patient and the spouse.

The OIG found that facility staff did not consider consultation with the Office of Chief Counsel about the patient's IPV although VHA advises employees to "work with your Office of Chief Counsel" regarding state reporting requirements for victims of IPV.[64] The OIG was unable to determine whether consultation with the Office of Chief Counsel would have resulted in staff reporting IPV to the state. However, failure to determine reporting responsibilities may contribute to state agencies not having information necessary to provide advocacy and protection for IPV victims and result in individuals remaining in dangerous situations.

Outpatient mental health staff did not consult with the IPVAP POC to provide the patient and spouse IPV resources and intervention or document discussion of resources or treatment options in response to the patient's reported IPV. The OIG was unable to determine whether staff's failure to address reports of IPV contributed to the patient's death by suicide because of multiple causal factors. However, failure to consult with the IPVAP POC or discuss resources or treatment options may contribute to lack of access to IPV services and, thus, prevent perpetrators' access to resources that may reduce the likelihood of future IPV behaviors.

The Facility Director did not ensure development of an IPVAP protocol, as required and facility staff and leaders did not identify the assigned IPVAP Coordinator as a resource.[65] Delayed development of a protocol, and ineffective communication regarding the staff assignment of the IPVAP Coordinator may have contributed to inadequate procedural guidance, and staff's lack of access to IPVAP consultation and resources.

Additionally, VHA guidance was unclear about IPV training responsibilities. The absence of clear expectations regarding staff IPV training may result in inadequate staff training and deficient actions related to IPV screening, reporting requirements, and resources offered to IPV perpetrators and victims.

Recommendations 1–4

1. The Ralph H. Johnson VA Medical Center Director ensures mental health staff consult with the Intimate Partner Violence Assistance Program and safety plan, as warranted to address Intimate Partner Violence.
2. The Ralph H. Johnson VA Medical Center Director ensures Inpatient Mental Health Unit resident physicians complete timely clinical documentation in accordance with Ralph H. Johnson VA Medical Center Policy.

[64] VHA Directive 1199, *Reporting Cases of Abuse and Neglect*, November 28, 2017.
[65] VHA Directive 1198.

3. The Ralph H. Johnson VA Medical Center Director makes certain staff consult with the Office of General Counsel to determine reporting requirements of Intimate Partner Violence, as appropriate.
4. The Under Secretary for Health establishes clear guidance related to Intimate Partner Violence training requirements.

Glossary

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

alcohol use disorder. Habitual use of alcohol that can cause impairments in an individual's day to day functioning.[66]

anxiety disorder. Worry or fear that is persistent, gets worse over time, and can interfere with employment, school, and relationships.[67]

borderline personality disorder. A pattern of unstable behaviors based on an individual's perception of their experiences, usually negative and inflexible, that can impact their emotions and cause impairment in social relationships.[68]

cannabis. The cannabis plant is the source for the psychoactive substance in marijuana.[69]

cannabis use disorder. A habitual use of cannabis that can cause impairments in an individual's day to day functioning.[70]

insomnia. A sleep disorder that can make it hard to fall asleep, hard to stay asleep, or cause an individual to wake up too early and not be able to get back to sleep.[71]

major depressive disorder. An episode of at least two weeks characterized by depressed mood or loss of interest/pleasure in activities, changes in sleeping patterns and appetite, changes in energy, feelings of worthlessness or guilt, and thoughts of death.[72]

posttraumatic stress disorder. A trauma-related disorder that evolves after a person is exposed to serious injury, potential death, or sexual violence. Diagnosed after experiencing symptoms for more than one month including recurrent intrusive symptoms associated with the event,

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

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

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

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

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

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

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

avoidance of any potential reminders of the event, negative changes in mood and thought processes, and increased reactivity.[73]

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

Appendix A: Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: June 11, 2021

From: Acting Under Secretary for Health (10)

Subj: Healthcare Inspection—Deficiencies in the Management of a Patient's Reported Intimate Partner Violence at the Ralph H. Johnson VA Medical Center in Charleston, South Carolina

To: Assistant Inspector General for of Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report regarding the Intimate Partner Violence Assistance Program (IPVAP) at Charleston VA Medical Center. We note that this is a companion report to another yet unpublished OIG draft report on the same incident.[1] We appreciate OIGs recommendations and acknowledge there are improvements to be made. We are committed to ensuring a safe environment for all Veterans.
2. The National IPVAP offers comprehensive services for Veterans, their partners and VA staff impacted by intimate partner violence (IPV). This Veterans Health Administration program has become a national model for application of trauma-informed, evidence-based programs for those who experience and those who use IPV.
3. IPVAP is committed to promoting awareness, education, and training for IPVAP Coordinators, VA staff and community partners. In fiscal year 2020, 81 training events were held and reached over 7,125 attendees. The IPVAP Fact Sheet Library includes over 20 topics relevant to IPV. There are over 15 topic specific IPV awareness campaigns available on the internal IPVAP SharePoint site for IPVAP Coordinator use.
4. The IPVAP Website provides an interactive space for Veterans, their partners and staff to access resources, connect with the facility IPVAP Coordinator, and obtain information on healthy, unhealthy and at risk relationships. This link is available to the public https://www.socialwork.va.gov/IPV/Index.asp.
5. IPVAP has a Memorandum of Agreement with the National Domestic Violence Hotline to provide supportive services 24 hours per day, 365 days per year. This link is available to the publichttps://www.socialwork.va.gov/IPV/Index.asp.
6. The Strength at Home therapeutic intervention has been validated as effective for reducing severity and frequency of IPV, Post Traumatic Stress Disorder and substance use specifically in the Veteran population. Strength at Home is now offered at over 120 VA facilities.
7. Collaborations and partnerships
    a. The National IPVAP partnered with VA Connecticut Healthcare System to establish the first IPVAP Innovation Hub – a center of excellence charged with exploring the feasibility of screening, assessment and intervention for bi-directional intimate partner violence and safety planning.
    b. The National IPVAP collaborated on establishing a Human Trafficking Tiger Team to explore impact of human trafficking as it relates to Veterans and IPV, homelessness, substance use and poverty.

c. The National IPVAP actively supports the White Ribbon-VA initiative to end IPV, Sexual Assault and Harassment in the VA Community.

8. VHA notes that some of the language in the report regarding IPVAP Coordinator responsibilities for training could be more consistent with policy. Specifically, VHA asks OIG to replace the clause "other aspects of staff training" with "providing/coordinating general local training for all staff on IPVAP services" (see Page iv, paragraph 2, line 2). Additionally, VHA notes that the Medical Center Director has a significant role in ensuring IPVAP Coordinators fully implement the program.
9. I concur with the OIG's recommendation to the Office of the Under Secretary for Health and provide the attached action plan. Comments and action plans for recommendations 1, 2 and 3 are provided by the Medical Center Director.
10. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office.

(Original signed by:)

Richard A. Stone, M.D.

Under Secretary for Health Response

Recommendation 4

The Under Secretary for Health establishes clear guidance related to Intimate Partner Violence training requirements.

Concur.

Target date for completion: October 2021

Comments

The National Intimate Partner Violence Assistance Program (IPVAP) asserts that all VA staff should have awareness of the impact of intimate partner violence (IPV) on Veterans, their intimate partners and VA staff. It is imperative that all VA staff have awareness about available IPVAP resources and how to access IPVAP programs and support. Since 2014, the Intimate Partner Violence Assistance program supported this effort through the provision of training to VA health care facilities and sharing of resources. Training resources are provided to IPVAP Coordinators on recorded calls and saved on the IPVAP SharePoint for VA staff access. An on-boarding process for new IPVAP Coordinators has been in place for several years to ensure that all coordinators receive training on their roles and responsibilities and have support to effectively carry out their duties at the facility level.

The National IPVAP will conduct the following actions to address the recommendation listed above: provide clarification of program requirements and expectations for IPVAP Coordinators to provide training for staff at the facility level; and educate IPVAP Coordinators of available education opportunities and resources.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 1, 2021

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

Subj: Healthcare Inspection—Deficiencies in the Management of a Patient's Reported Intimate Partner Violence at the Ralph H. Johnson VA Medical Center in Charleston, South Carolina

To: Office of the Under Secretary for Health (10)

1. I have had the opportunity to review the Draft Report, Healthcare Inspection – Deficiencies in the Management of a Patient's Reported Intimate Partner Violence.
2. VISN 7 and Ralph H. Johnson VA Medical Center submits concurrence to recommendations 1-3 and request closure. The draft report response demonstrates Ralph H. Johnson VA Medical Center's compliance with VHA Directives and policy.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(*Original signed by*:)

Maureen F. McCarthy, MD
Interim Director

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 28, 2021

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

Subj: Healthcare Inspection—Deficiencies in the Management of a Patient's Reported Intimate Partner Violence at the Ralph H. Johnson VA Medical Center in Charleston, South Carolina

To: Interim Director, VA Southeast Network (10N7)

1. We are deeply saddened by the loss of this Veteran. The loss of any Veteran by suicide is a tragedy.
2. Thank you for the opportunity to review the second of two Inspector General draft reports involving this patient.
3. In this case, the Intimate Partner Violence Program was in place and appropriate resources were utilized in the care provided to this patient in alignment with VA policy. The veteran received extensive care and was involved in several programs and the spouse was provided resources. While we agree that there are opportunities for improvement, Ralph H. Johnson provided quality care for this veteran utilizing appropriate resources.
4. I reviewed recommendations 1-3. I concur with the recommendations and request closure for recommendations 1-3 based on the evidence provided.

(*Original signed by*:)

Scott R. Isaacks, FACHE

Facility Director Response

Recommendation 1

The Ralph H. Johnson VA Medical Center Director ensures mental health staff consult with the Intimate Partner Violence Assistance Program and safety plan, as warranted to address Intimate Partner Violence.

Concur.

Target date for completion: April 30, 2021

Director Comments

While the treatment team utilized appropriate resources in the care of this patient and the patient had a safety plan, we concur with the recommendation. The Ralph H. Johnson VAMC [VA Medical Center] implemented the Intimate Partner Violence Assistance Program (IPVAP) in May 2016. All program requirements were met with the exception of the local [standard operating procedure] to mirror the national policy. As required under VA policy, the facility assigned a [licensed independent provider] IPVAP coordinator well before there was a directive to do so. The IPV coordinator was given appropriate time to complete the functions of the program and has maintained the position without interruption. This is evidenced by 16 cases being referred to the IPVAP between March 2019 and June 2020 and managed appropriately. While we agree mental health staff should consult with the IPVAP coordinator as warranted, the clinical team determined a referral to this program was not warranted in the case. The IPVAP Champion worked on the inpatient Mental Health unit and was available for consultation. There is no mandate that a case be referred to the IPVAP as this program is intended to be a resource to VA clinicians. In this case, based upon the assessment of the patient to include discussions with the spouse along with the extensive care that was already being provided, the treating clinicians determined that, based upon their clinical judgement, referral to the IPVAP was not warranted or necessary as appropriate treatment and referrals were provided. The patient was referred to the Substance Use Disorder Treatment and Recovery (STAR) program upon discharge, which was the most appropriate initial referral to address the IPV, as sobriety is critical to managing impulsive aggressive behavior. The patient's spouse was advised of safety options on day 51. There were no missed opportunities to obtain additional IPV resources or referrals as those services were already being provided as part of this patient's extensive treatment plan. Mental Health and other staff do consult with the IPVAP coordinator as evidenced by the 16 referrals noted above and the use of the clinical reminder activated in September 2020 which triggers a consult when appropriate. Of the consults offered, 26 were accepted by veterans and spouses from November 2020 through April 2021 and 100% compliance is evident by consult disposition. Based on the evidence provided we request closure of this recommendation.

OIG Comment

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

Recommendation 2

The Ralph H. Johnson VA Medical Center Director ensures Inpatient Mental Health Unit resident physicians complete timely clinical documentation in accordance with Ralph H. Johnson VA Medical Center Policy.

Concur.

Target date for completion: Completed April 30, 2021

Director Comments

The Ralph H. Johnson VAMC concurs timely clinical documentation for the resident note was not in accordance with our policy, however, all information in the note was available and documented in medical record. All critical information contained in the day 51 addendum to the MH [Mental Health] Inpatient Attending Note was also documented in other inpatient notes, including the day 50 Mental Health Inpatient Attending Note, the attending physician's addendum to the day 50 Mental Health Inpatient Resident note, and the attending physician's addendum to the day 55 Mental Health Inpatient Resident note. A review of Mental Health resident physicians' notes completed from November 1, 2020 through April 30, 2021 revealed 100% compliance with timely documentation, therefore we request closure.

OIG Comment

The OIG strongly disagrees with the Director's comments. Documentation of "forced sex" of a spouse is critical information that should be immediately available to providers. The OIG identified the concern that this information was only included in the inpatient psychiatry resident's addendum and therefore inaccessible to other providers for 34 days. The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 3

The Ralph H. Johnson VA Medical Center Director makes certain staff consult with the Office of General Counsel to determine reporting requirements of Intimate Partner Violence, as appropriate.

Concur.

Target date for completion: Completed April 30, 2021

Director Comments

Though the Ralph H. Johnson VAMC treatment team met the reporting IPV requirements, we concur with the recommendation. We do agree that, when there are questions regarding reporting requirements, the staff should consult with the Office of General counsel. The provider did not determine imminent danger for "duty to warn" for the Veterans spouse at the time of treatment. South Carolina does not mandate reporting of known or suspected intimate partner violence unless the IPV involves gunshot wound treatment. The veteran's spouse did not appear to be at risk and was provided with safety resources. Interviewees may have been confused by OIG referencing "duty to warn," which is a notification standard based in case law ("Tarasoff") which expects a provider to warn an intended victim of serious imminent harm. Facility Policy 116-19-16 referenced by the OIG addresses this "duty to warn," which is different from a mandatory IPV reporting requirement. "Tarasoff" or "duty to warn" did not apply in this case because the patient consistently denied homicidal ideation throughout his hospital stay after initially endorsing homicidal ideation without intent on the day of admission. Providers would not consult the Office of General Counsel when there is no question regarding the reporting requirements. We request closure of this recommendation as the IPVAP coordinator is aware of the state laws and will consult with Office of General Counsel for any questionable cases and staff have received training regarding IPVAP and consultation is addressed in the education didactic.

OIG Comment

The OIG disagrees with the Ralph H. Johnson VA Medical Center Director's determination that there was no question regarding reporting requirements. Given the mandatory reporting of abuse of a vulnerable adult with criminal enforcement, the immunity from civil suit for reports of IPV in good faith, and ambiguity about whether the patient's spouse was a vulnerable adult, the OIG would expect facility staff to have consulted with Office of General Counsel about whether to report.[1] However, the Facility Director provided sufficient supporting documentation that the IPVAP coordinator and staff have been educated about the consultative role of the Office of General Counsel, and the OIG considers this recommendation closed.

[1] South Carolina Code of Laws, Title 43 – Social Services, Chapter 35 - Adult Protection, Article 1, Sections 42-35-25 (A), 45-35-10 (8), 45-35-10 (11); 45-35-85 (A), https://www.scstatehouse.gov/code/t43c035.php; South Carolina Code of Laws, Title 20 – Domestic Relations, Chapter 4 – Protection from Domestic Abuse, Article 1, Sections20-4-110, https://www.scstatehouse.gov/code/t20c004.php.

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