DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficient Care of a Patient Who Died by Suicide and Facility Leaders' Response at the Charlie Norwood VA Medical Center in Augusta, Georgia

HEALTHCARE INSPECTION | REPORT #22-01116-110 | MAY 10, 2023

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review allegations that providers at the Charlie Norwood VA Medical Center in Augusta, Georgia, (facility) (1) failed to "provide services," and delayed care for a patient who died by suicide on the grounds of the Aiken Community Based Outpatient Clinic in Aiken, South Carolina; and (2) the facility director ". . . covered it up." Further, the OIG identified concerns related to Veterans Crisis Line (VCL) referrals and Emergency Department communication, suicide prevention documentation, completed suicides on VA campuses, and quality management reviews.[1]

The OIG substantiated that the patient received deficient clinical care. The OIG identified six deficiencies that hindered the patient's referral for further mental health evaluation and timely pain management services. Specifically, primary care providers failed to follow-up on the patient's positive mental health screenings and a discontinued mental health consult and order recommended testing; facility staff failed to ensure the patient received a timely pain management appointment; pain management clinic providers failed to perform the patient's required mental health screenings; a nurse failed to communicate the patient's urgent VCL referral prior to the Emergency Department encounter; and suicide prevention staff failed to act after the patient's urgent VCL referral.

The patient was in their sixties at the time of death in fall 2021.[2] In the spring of 2021, the patient presented to the Aiken Community Based Outpatient Clinic for an initial primary care visit and reported difficulty with bowel movements, urinary problems, and "tolerable" pain "all over." A primary care nurse completed a (1) pain assessment, and (2) alcohol use and depression screens. The alcohol use and depression screens were positive, indicating the need for further assessment. The nurse also administered a Columbia Suicide Severity Rating Scale (C-SSRS), during which the patient endorsed suicidal ideation, but denied suicidal intent.[3]

Primary care provider (PCP) 1 placed relevant consults including for pain management and documented a plan to "discuss [alcohol use] again at next visit." PCP 1 reviewed the positive

[1] VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. The directive was amended by VHA Directive 1503(1), *Operations of the Veterans Crisis Line Center*, February 23, 2022. The two policies contain the same or similar language related to the purpose and background of VCL, except for the change in referral terminology from *VCL consult* to *VCL request*. VCL was established by VHA in 2007 and is a toll-free hotline staffed by trained mental health personnel who provide "mental health services to Veterans 24 hours per day, 7 days per week."

[2] The OIG uses the singular form of they (their) in this instance to maintain patient privacy.

[3] VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," November 1, 2020. A C-SSRS is a screening tool used to identify a patient's risk of suicide. VA/DoD, *Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*, 2019. Suicidal ideation occurs when one has "thoughts of engaging in suicide-related behavior." Suicidal intent occurs when one has "past or present evidence (implicit or explicit) that an individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions." The patient's C-SSRS was not positive.

depression screen and noted that the patient declined further mental health intervention and evaluation.[4] The patient returned for a second primary care visit and saw a different primary care provider (PCP 2). During that encounter, the patient reported "full body" pain and PCP 2 prescribed a muscle relaxant medication and noted the patient was anticipating an upcoming pain management appointment. PCP 2 did not discuss the previously positive alcohol and depression screens with the patient.

The patient saw a urology clinic physician assistant in early summer 2021, for further evaluation of urinary frequency and an elevated prostate-specific antigen level result from a few months earlier.[5] A cystoscopy showed "no significantly obstructive prostate" and a normal bladder. A laboratory test for prostate-specific antigen levels was repeated and indicated a normal level.[6]

The patient presented for initial consultation in the pain management clinic during late summer 2021, where a physician fellow ordered imaging of the patient's spine and documented a plan to follow-up after the imaging was complete.[7] The fellow did not document the required C-SSRS. The imaging showed narrowing and degenerative changes in the spine.

Two weeks later, the patient saw a urology clinic physician assistant for a follow-up on urinary issues. The physician assistant documented the patient may have "psychogenic diabetes insipidus," (as the patient consumed large volumes of liquid daily) and recommended a mental health evaluation and follow-up with primary care.[8] Two days later, a primary care nurse practitioner (PCP 3) ordered a neuropsychology consult "to [rule out] psychogenic diabetes insipidus." A neuropsychologist discontinued the consult noting, "this is outside the scope of practice of neuropsychology," and recommended a referral to the Mental Health Behavioral

[4] PCP 1 also recorded that the "[patient] is actively suicidal on questioning." PCP 1 told the OIG that this was an erroneous entry, and the patient was not actively suicidal during the initial encounter.

[5] National Institutes of Health National Cancer Institute, "prostate-specific antigen," accessed April 29, 2022, https://www.cancer.gov/types/prostate/psa-fact-sheet. A prostate-specific antigen is a "protein produced by normal, as well as malignant, cells of the prostate gland." Elevated levels may indicate prostate cancer but may also indicate conditions such as inflammation or enlargement of the prostate.

[6] Mayo Clinic, "cystoscopy," accessed April 29, 2022, https://www.mayoclinic.org/tests-procedures/cystoscopy/about/pac-20393694. "A procedure that allows [a] doctor to examine the lining of [the] bladder and the tube that carries urine out of [the] body (urethra)."

[7] VHA Handbook 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019. For this report, fellows are physicians in an approved subspecialty graduate medical education program.

[8] The physician assistant appears to be using a term, *psychogenic diabetes insipidus*, that condenses the medical diagnoses psychogenic polydipsia and dipsogenic diabetes insipidus. Psychogenic polydipsia is increased fluid intake without an identifiable medical cause. Dipsogenic diabetes insipidus refers to increased urination that results from drinking more liquids and may reflect a problem with the brain centers controlling thirst or be caused by mental health problems. *Merriam-Webster.com Dictionary*, "psychogenic," accessed April 29, 2022, https://www.merriam-webster.com/dictionary/psychogenic. "Originating in the mind: attributable to psychological or emotional factors;" National Institutes of Health National Institute of Diabetes and Digestive and Kidney Diseases, "diabetes insipidus," accessed March 1, 2022, https://www.niddk.nih.gov/health-information/kidney-disease/diabetes-insipidus, a "disorder that causes the body to make too much urine."

Health Interdisciplinary Program (BHIP). PCP 3 then ordered a BHIP consult and documented urological symptoms as the "reason for mental health referral." A BHIP psychiatrist discontinued the consult, documenting a recommendation to PCP 3 to obtain a water deprivation test to rule out urological problems, and to reconsult if no urological cause was identified.[9] PCP 3 ordered several tests to evaluate the patient's frequent urination.

The following week, the patient called VCL reporting suicidal ideation without a plan or intent and agreed to go to the facility's Emergency Department for further evaluation. The VCL responder created a consult to the facility suicide prevention team and called the facility's Emergency Department and spoke with an Emergency Department nurse (Nurse 1). About one hour after calling VCL, the patient arrived at the facility's Emergency Department complaining of pain and requested imaging and pain medication. A C-SSRS screen was negative. A physician attempted to obtain more information and documented (1) the patient refused to answer additional questions, and (2) the patient was "tired of waiting," and left without further care or discharge instructions. The physician did not document knowledge of the VCL referral.

Three days later, a suicide prevention case manager documented a follow-up to the patient's VCL call noting that the patient presented to the Emergency Department "Veteran reached," and "[Suicide Prevention] staff and/or other clinical staff connected with Veteran. Risk assessed, and needs addressed as indicated."

Two weeks later, the patient called a pain management clinic nurse practitioner and expressed suicidal ideation. The nurse practitioner advised the patient to go to the Emergency Department; the patient refused but agreed to not harm themself. The next day, the patient met with the chief of the pain management clinic who assessed the patient's pain and created a plan for future pain treatment but did not complete a clinically indicated C-SSRS.

Over the next month, pain management clinic providers treated the patient with multiple interventions, including an epidural steroid injection, tramadol, and a narcotic pain patch.[10] Less

[9] VHA Deputy Under Secretary for Health for Operations and Management memorandum, "General Mental Health Staffing Model Team Development: Behavioral Health Interdisciplinary Program (BHIP) Team-Based Care," August 5, 2013. BHIP is a general mental health outpatient team that provides interdisciplinary care for an assigned panel of veterans; National Institutes of Health National Institute of Diabetes and Digestive and Kidney Diseases, "diabetes insipidus," accessed March 1, 2022, https://www.niddk.nih.gov/health-information/kidney-disease/diabetes-insipidus. A water deprivation test assists medical providers with diagnosing the underlying cause of diabetes insipidus. "The test involves not drinking any liquids for several hours. A health care professional will [then] measure how much urine [is] pass[ed], check. . . weight, and monitor changes in. . . blood and urine."

[10] The patient had four encounters with Pain Management Clinic staff between October 6 and November 9. Cleveland Clinic, "Cervical Epidural Steroid Injection," accessed March 21, 2022, https://my.clevelandclinic.org/health/treatments/22293-cervical-epidural-steroid-injection#:~:text=A%20cervical%20epidural%20steroid%20injection%. Cervical epidural steroid injections are used for temporary pain relief. Medline Plus, "tramadol," accessed on May 2, 2022, https://medlineplus.gov/druginfo/meds/a695011.html. A narcotic used "to relieve moderate to moderately severe pain."

than two weeks later, a facility neurosurgeon recommended a full neurological and mechanical exam to evaluate for any signs of nerve or spinal cord damage.

The pain management clinic nurse practitioner reported receiving a request the following week to return a phone call to the patient. Two days later, the nurse practitioner called the patient twice and left a message to return the call. The same day a security guard found the patient deceased via a self-inflicted gunshot wound in the parking lot of the Aiken Community Based Outpatient Clinic.

Inspection Results

PCP 2 Failed to Follow-Up on the Patient's Positive Mental Health Screenings

During the patient's return visit to primary care in early summer 2021, PCP 2 did not document follow-up related to the spring 2021 positive screens for depression and alcohol misuse. VA clinical guidelines recommend further assessment of depression symptoms and assessment of risk, following a positive depression screen.[11] PCP 2 told the OIG of seeing the patient's positive mental health screens, but the focus of the visit was on the patient's pain. The OIG found PCP 2 did not offer further intervention or evaluation of the patient's positive depression screen, failed to follow-up on the patient's positive alcohol misuse screen, and failed to further assess the patient's suicidal ideation. The OIG found these clinical deficiencies precluded referral for further mental health evaluation.

PCP 3 Failed to Follow-Up on a Discontinued Mental Health Consult and Order Recommended Testing

Following the discontinuation of a BHIP consult, PCP 3 ordered additional tests to evaluate a physiological cause of the patient's polydipsia; however, PCP 3 did not follow the BHIP psychiatrist's recommended action to order a water deprivation test. Additionally, PCP 3 took no further action to resubmit the BHIP consult. PCP 3 told the OIG of being unfamiliar with water deprivation tests and having "no idea," why the test was not ordered, and acknowledged resubmitting the BHIP consult was their responsibility. The OIG found that PCP 3 failed to order recommended testing and resubmit the discontinued BHIP consult to ensure further mental health evaluation.

[11] VA/DoD, *Clinical Practice Guidelines for the Management of Major Depressive Disorder*, April 2016. Clinical practice guidelines recommend patients who test positive for depression on the Patient Health Questionnaire-2 have "further assessment of symptoms and assessment of risk."

Facility Staff Failed to Ensure the Patient Received a Timely Pain Management Appointment

The OIG found the patient waited 139 days from the clinically indicated date for an intake appointment in the pain management clinic, far exceeding the facility's mean wait times and not consistent with the Veterans Health Administration's requirement for "a timely and appropriate" pain assessment.[12]

Veterans Health Administration (VHA) policy requires the service who enters a consult must review the "status of ordered consults to make sure that the patient receives timely care."[13] The acting chief of primary care and Chief of Staff noted that primary care providers can facilitate timelier appointments; however, PCPs 1 and 2 did not intervene or address the patient's extended wait time. PCP 1 told the OIG they preferred an in-house appointment for this patient. PCP 2 reported not being aware of the patient's pain management clinic appointment date and the delay, and erroneously believed primary care was not involved in following up to ensure a timely pain management appointment.

According to VHA policy, when scheduling staff are unable to schedule a routine specialty clinic appointment within 28 days of the clinically indicated date, the patient must be offered an option for care in the community and this offer must be documented in the electronic health record.[14] The OIG found no evidence that the medical support assistant told the patient of the eligibility for community care. The medical support assistant's failure to offer community care may have contributed to the patient's delayed pain care.[15]

Pain Management Clinic Providers Failed to Perform the Patient's Required Mental Health Screenings

Although required by VHA policy, a fellow failed to perform a C-SSRS during the patient's pain management clinic intake appointment, and the chief of the pain management clinic did not

[12] VHA Directive 1232(3), *Consult Processes and Procedures,* August 24, 2016, amended April 5, 2021, was replaced by VHA Directive 1232(4), *Consult Processes and Procedures*, August 24, 2016, amended December 14, 2021.VHA Directive 2009-053, *Pain Management,* October 28, 2009. Unless otherwise specified, the amended policies contain similar language about timely care.

[13] VHA Directive 1232(3); VHA Directive 1232(4).

[14] VA, "Community Care Overview," accessed May 16, 2022, https://www.va.gov/communitycare/. "VHA Office of Community Care Field Guidebook, "Chapter 2: Eligibility, Referral, and Scheduling," accessed February 2, 2022.

[15] The OIG found that scheduling auditors noted errors in the medical support assistant's documentation in the audit cycles prior to and following the scheduling of the patient's pain management consult. The OIG learned that no administrative actions had been initiated due to cases pending with the Office of Workers' Compensation Programs and Equal Employment Opportunity. The OIG could not determine why the medical support assistant did not document the offer of community care.

perform a C-SSRS when clinically indicated.[16] The fellow acknowledged the screening "was not done effectively," and said the focus of the appointment was on pain management. The chief of the pain management clinic believed the patient was connected to mental health although the OIG found the patient had never met with mental health staff. The OIG concluded that if the required C-SSRS screenings were completed, there may have been an opportunity to discuss engagement in mental health care with the patient.

A Nurse Failed to Communicate the Patient's Urgent VCL Referral Prior to the Emergency Department Encounter

During fall 2021, a VCL responder placed an urgent referral for the patient to present to the facility's Emergency Department and created a Facility Transport Plan.[17] The VCL responder then contacted the Emergency Department to advise of the patient's referral and spoke with Nurse 1. The patient arrived about an hour after the VCL call. A VCL support services assistant then contacted the Emergency Department to confirm the patient's arrival; however, the OIG found Nurse 1 did not inform the physician of the patient's urgent VCL referral. The OIG found no documentation in the patient's electronic health record (EHR) that reflected communication to the Emergency Department provider of the patient's call to, and referral from, VCL. Nurse 1 told the OIG there was no formal process for communicating VCL calls to physicians in the Emergency Department and while some Emergency Department nurses enter notes into the EHR when they receive a call from VCL staff, it is not a requirement. The Emergency Department physician who assessed the patient told the OIG of being unaware of the patient's VCL call and would have connected the patient to mental health if aware. The OIG determined that the Emergency Department physician's unawareness of the patient's call to VCL limited the ability to evaluate the patient and possibly engage the patient in further mental health care.

Suicide Prevention Staff Failed to Act After the Patient's Urgent VCL Referral

The OIG found that, although required by VHA policy, facility suicide prevention staff failed to contact the patient and accurately document resolution of the VCL referral, including facilitation of primary care and mental health appointments. The suicide prevention case manager documented contact with the patient, however, the OIG learned there was no contact. The OIG interviewed the VA Executive Director for Suicide Prevention who stated that following a prior

[16] VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memorandum, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy), Attachment," November 10, 2020.

[17] VHA Directive 1503; VHA Directive 1503(1). A Facility Transport Plan is a plan developed with a patient, "to present to a treatment facility without the assistance of emergency services." VCL responders place an urgent referral when the patient agrees to treatment at a "medical facility via a Facility Transport Plan (FTP) without an appointment and without the assistance of emergency services."

OIG inspection, they learned that suicide prevention staff at VA medical centers misinterpreted VHA policy and incorrectly believed that contact with other clinical staff replaced the requirement for suicide prevention staff to contact patients following a VCL referral.[18] The OIG concluded if the patient had been contacted as required, there would have been an opportunity to discuss engaging in mental health care.

Facility Leaders' Response Following the Patient's Death

The OIG did not substantiate that facility leaders "covered up" the patient's death by suicide. The OIG received this allegation from an anonymous complainant and could not determine why the complainant concluded facility leaders attempted to "cover up" the patient's death.[19] The OIG found that facility leaders immediately responded per VHA guidance, including notification of Veterans Integrated Service Network and VA central office personnel, mobilization of resources, and documentation of the suicide in the EHR. However, facility leaders failed to initiate a timely investigation of the death as a sentinel event.

A sentinel event is a type of adverse event defined by The Joint Commission as "a patient safety event…that reaches an individual served and results in any of the following: death, permanent harm, [and] severe temporary harm."[20] VHA guidance and policy clearly assert a "death by suicide on a VA campus is considered a sentinel event," and signals "the need for immediate investigation and response," which may include a root cause analysis (RCA).[21]

The OIG learned through interviews of the executive director, high reliability organization/quality and patient safety (quality management chief) and patient safety manager that an immediate investigation did not occur because they lacked awareness of VHA guidance identifying suicide on a VA campus as a sentinel event. The Facility Director chartered an initial RCA investigation in early 2022, which identified suicide prevention as an "involved" service and appointed the facility's suicide prevention program manager as the RCA leader. Thus, the

[18] VA OIG, *Suicide Prevention Coordinators Need Improved Training, Guidance, and Oversight*, Report No. 20-02186-78, June 6, 2022.

[19] The anonymous complainant provided no details as to facility leaders' actions that would constitute a "cover up."

[20] The Joint Commission, E-dition, SE-1, July 1, 2021, "Sentinel Events (SE)." VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. The Joint Commission is an organization that accredits medical facilities, including VHA facilities, to ensure they provide "safe, high quality of care," and comply with standards.

[21] VHA Deputy Under Secretary for Health for Operations and Management memorandum, "Guidance for Action Following a Suicide on a Department of Veterans (VA) Campus," November 13, 2019. VA property includes "owned, leased, or otherwise contracted spaces." VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. RCA is a process for identifying contributing causal factors and changes to "improve performance and reduce the risk." This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language regarding RCAs and sentinel events as the rescinded 2011 handbook.

RCA team's composition did not align with VHA policy to exclude involved individuals, and could impact the credibility of the RCA. After being notified by the OIG of this concern, the Facility Director chartered a second RCA appointing a facility suicide prevention coordinator as the RCA leader. Again, the OIG expressed conflict of interest concerns to the Facility Director. The Facility Director then chartered a third RCA, which the OIG reviewed and found the RCA team composition was in accordance with VHA policy; therefore, the OIG did not make a recommendation.

The OIG examined information about quality management reviews, which included a Behavioral Health Autopsy (BHA), a Family Interview Tool Contact (FIT-C), and peer reviews.[22] A suicide prevention case manager reported timely completion of the patient's BHA; however, the BHA contained multiple errors pertaining to mental health screenings, and the OIG learned in an interview, the patient's family was not contacted to complete the FIT-C form as VHA requires. The suicide prevention case manager told the OIG of being unable to locate family contact information; however, the OIG reviewed the patient's EHR, the VCL web-based application, and police reports, and was able to identify names and contact information for two family members. The failure to accurately document in the patient's BHA prevented the identification of "contributory factors (e.g., psychosocial stressors, diagnoses, service utilization) relevant to Veterans' suicides and VA suicide prevention efforts."[23]

The OIG found that a facility leader initiated an issue brief the same date the patient was found deceased, indicating that the patient's death by suicide would require a peer review; however, according to the quality management chief, a miscommunication regarding deadlines and role responsibility within the facility's Quality Management Department resulted in delayed peer reviews.[24] The OIG learned that, in early 2022, the quality management chief initiated a process change to receive all issue briefs in order to identify items that require Quality Management Department follow-up.

Following the OIG notification of the hotline inspection in early 2022, the Facility Director initiated a clinical review of the patient's care at the facility to gather more information from each clinical leader and to determine if the "standard of care was met." This review resulted in

[22] VHA Deputy Under Secretary for Health for Operations and Management memorandum, *Behavioral Autopsy Program Implementation*, December 11, 2012. VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," November 1, 2020. Suicide prevention staff complete FIT-C forms after conducting interviews with family members to "understand the circumstances impacting the Veteran's life in the time before the death." VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.The peer review process is an evaluation of "care provided by individual clinicians within a selected episode of care."

[23] VA, Behavioral Health Autopsy Program Data Definitions, May 11, 2017.

[24] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. The peer review process is an evaluation of "care provided by individual clinicians within a selected episode of care," and opportunities for improvement in clinical practice or healthcare systems are identified. The OIG learned that facility leaders initiated five peer reviews in February 2022.

10 action items. The quality management chief told the OIG of being responsible for tracking the follow-up actions. The OIG noted that the clinical review failed to identify and address multiple deficiencies in care.[25] The quality management chief told the OIG that peer reviews were the only items requiring any further action believing that relevant services were managing the other action items. However, the OIG found no evidence of completion for all 10 action items identified within the clinical review. The OIG concluded that although the Facility Director initiated a clinical review of the patient's care, the review failed to identify and address multiple deficiencies in care.

The OIG made nine recommendations to the Facility Director related to mental health screenings, consult management, referral to community care, mandatory suicide risk assessments, communication of VCL referral information to Emergency Department providers, staff documentation and closure of VCL referrals, completed suicides on VA campuses, accurate completion of BHA and FIT-C forms, peer reviews, and clinical review.

VA Comments and OIG Response

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

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[25] The OIG identified the clinical review did not include input from quality management leaders, did not identify delays in pain management, missed mental health screenings, and did not address deficiencies in Suicide Prevention staff response and failures in Emergency Department processes.

Contents

Abbreviations

BHA	behavioral health autopsy
BHIP	Behavioral Health Interdisciplinary Program
CBOC	community-based outpatient clinic
C-SSRS	Columbia Suicide Severity Rating Scale
EHR	electronic health record
FIT-C	Family Interview Tool Contact
MRI	magnetic resonance imaging
OIG	Office of Inspector General
RCA	root cause analysis
VCL	Veterans Crisis Line
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review allegations and assess clinical and administrative concerns at the Charlie Norwood VA Medical Center in Augusta, Georgia (facility), involving a patient who died by suicide on the grounds of the Aiken Community Based Outpatient Clinic (Aiken CBOC) in Aiken, South Carolina.

Background

The facility, part of Veterans Integrated Service Network (VISN) 7, is composed of two medical centers located in Uptown and Downtown Augusta, Georgia, and three CBOCs in Athens and Statesboro, Georgia; and in Aiken, South Carolina. Designated as level 1b, high complexity, the facility has 204 hospital beds and 132 community living center beds.[1] The facility provides comprehensive health care including emergency care, primary care, mental health, and specialty care. The Aiken CBOC provides primary care and mental health services.

Prior OIG Reports

In a July 2019 review of quality of care and leadership failures at the facility, the OIG found the assessment of a sentinel event was not consistent with Veterans Health Administration (VHA) policy, a root cause analysis (RCA) was not conducted, "and as a result, the facility may have missed opportunities to improve patient care and safety."[2] The OIG made 27 recommendations, with one recommendation related to evaluation of sentinel events and RCAs. As of September 2021, all recommendations have been closed.

In September 2020, the OIG published a report that reviewed concerns related to facility leaders' insufficient review and response to a patient's death that resulted in 18 recommendations; all were closed as of November 2021.[3]

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[1] VHA Office of Productivity, Efficiency and Staffing, "Facility Complexity Level Model Fact Sheet," January 28, 2021. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex and level 3 facilities are the least complex.

[2] VA OIG, *Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No. 19-00497-161, July 11, 2019. The Joint Commission, E-dition, SE-1, July 1, 2021, "Sentinel Events (SE)." A sentinel event is a patient safety event that results in death, permanent, or severe temporary harm. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. An RCA is an interdisciplinary process for "identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls." This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language regarding RCAs and sentinel events as the rescinded 2011 handbook.

[3] VA OIG, *Deficiencies in Care and Excessive Use of Restraints for a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia*, Report No. 19-08106-273, September 30, 2020.

In a December 2020 report, the OIG found deficiencies with RCA completion. The OIG made 20 recommendations, with two recommendations related to the RCA process. As of October 2021, all recommendations have been closed.[4]

In June 2022, the OIG found nationwide deficiencies with VA Medical Center Suicide Prevention staff closing Veterans Crisis Line (VCL) referrals without performing required follow-up and found that some Suicide Prevention coordinators marked codes in error that made it appear they had reached patients and assisted them, when they had not. The OIG made five recommendations to the Under Secretary for Health including a recommendation related to reviews of complete and correct crisis line referral information in the electronic health record (EHR). As of October 2022, all recommendations remained open.[5]

Allegations and Related Concerns

During a late fall morning in 2021, a building security guard discovered the patient on the grounds of the Aiken CBOC. The Aiken County coroner pronounced the patient's death on the scene. The patient's family provided a note, written by the patient, that described severe pain, physical and mental suffering, and allegations that the facility delayed care.[6]

VA police initially referred the matter to the OIG Office of Investigations, who then referred the case to the OIG Office of Healthcare Inspections a week later to review the allegations described in the patient's note. Approximately two weeks later, an anonymous complaint to the OIG alleged the facility failed to "provide services to a Veteran with suicide ideation, which led to the Veteran committing suicide," and the Facility Director "has covered it up." As the complaint was anonymous, the OIG was unable to ask for clarification and defined failure to provide services as deficient clinical care. The OIG opened a hotline on January 3, 2022, to review the allegations and the patient's clinical care and facility leaders' response to the patient's death.[7] During the inspection, the OIG identified additional concerns related to VCL referrals, Emergency Department communication, suicide prevention documentation, completed suicides on VA campuses, and quality management reviews.

[4] VA OIG, *Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center in Augusta, Georgia*, Report No. 20-00132-28, December 16, 2020.

[5] VA OIG, *Suicide Prevention Coordinators Need Improved Training, Guidance, and Oversight*, Report No. 20-02186-78, June 6, 2022. VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. The directive was amended by VHA Directive 1503(1), *Operations of the Veterans Crisis Line Center*, February 23, 2022. The two policies contain the same or similar language related to the purpose and background of VCL, except for the change in referral terminology from VCL consult to VCL request. VCL was established by VHA in 2007 and is a toll-free hotline staffed by trained mental health personnel who provides "mental health services to Veterans 24 hours per day, 7 days per week."

[6] The patient's family provided a note, found in the patient's residence, to the local police department.

[7] For the purposes of this report, *facility leaders* include senior executive leaders and program managers.

Scope and Methodology

The OIG conducted a virtual site visit from February 14 through March 1, 2022.

The OIG interviewed VHA and facility leaders, primary care providers, a psychiatrist, an Emergency Department physician, a pain management clinic nurse practitioner, an addiction and pain management clinic fellow, the acting Aiken CBOC nurse manager, an Emergency Department nurse manager, a VCL crisis responder, a suicide prevention case manager, and a patient safety manager.[8]

The OIG reviewed VHA directives and handbooks, external standards, guidelines, and facility policies related to pain management, suicide prevention, and actions following death by suicide on VA property. The OIG reviewed quality management reviews, a patient safety report, a facility issue brief, and police reports.[9] The OIG conducted an independent EHR review and analysis related to the patient's provision of care from March 1, 2021, through their death.[10] The OIG also used a software application to analyze relevant individuals' emails related to the suicide prevention team's awareness and response to the patient's contact with VCL.

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 (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–24. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to

[8] VHA leaders included the VCL Executive Director, the Executive Director of Suicide Prevention, and a National Center for Patient Safety psychologist and pharmacy executive. Facility leaders included the Facility Director; the Chief of Staff; the acting chief of primary care; the chief of the pain management clinic; the suicide prevention program manager; and the executive director of high reliability organization, quality and patient safety. The facility pain management division is organized under Surgery Service. EHR notes use the terms *pain management clinic* and *pain medicine*. This report will use the term *pain management clinic* for clarity and consistency. VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019. For this report, fellows are physicians in an approved subspecialty graduate medical education program.

[9] Deputy Secretary for Health for Operations and Management (10N) Guide to VHA Issue Briefs, March 29, 2018. "Issue Briefs are drafted to provide specific information to leadership within the organization, working through the appropriate chain of command, regarding a situation/event/issue. Issue Briefs are designed to provide clear, concise, and factual information about unusual incidents, deaths, disasters, or anything else that might generate media interest or impact care." Issue briefs are reviewed by "senior leaders within [VA]– up to the Secretary."

[10] The patient began care at the facility in March 2021.

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.

Patient Case Summary

The patient was in their 60s at the time of the death by suicide in fall 2021.[11] The patient had a past medical history significant for chronic neck and back pain, and gastrointestinal and urinary issues.

The patient's initial appointment at the Aiken CBOC occurred in early spring 2021 with a primary care provider (PCP 1).[12] On intake, a primary care nurse documented the patient's responses to a pain assessment and three mental health screenings—an alcohol use screen, depression screen, and the Columbia Suicide Severity Rating Scale (C-SSRS) screen.[13] Specifically, the patient reported a pain level of 3 out of 10, located "all over" and tolerable at the current level.[14] Both the alcohol use and depression screening tests were positive. In addition, the patient reported on the C-SSRS having suicidal ideation, including thoughts of wishing they were dead, wishing they could go to sleep and not wake up, and thoughts of suicide. The patient denied any suicidal intent.[15]

PCP 1 recorded that the patient was complaining of difficulty having bowel movements; urinary problems including urgency, hesitancy, and incomplete voiding; as well as chronic pain in multiple joints including neck, lower back, and right shoulder. PCP 1 also recorded that the

[11] The OIG uses the singular form of they (their) in this instance to maintain patient privacy.

[12] The patient was new to VHA, and this was the first healthcare encounter.

[13] VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," November 1, 2020. A C-SSRS is a screening tool used to identify a patient's risk of suicide. The C-SSRS is considered positive when patients say *yes* to specific questions. VA, *RISK ID: Suicide Risk Identification*, October 14, 2020. A positive C-SSRS requires completion of a secondary screen, the Comprehensive Suicide Risk Evaluation.

[14] VA/Department of Defense (DoD), *Clinical Practice Guideline for Opioid Therapy for Chronic Pain*, February 2017. "Intensity of pain should be measured in the following manner using a Numeric Rating Scale (NRS) (0 to 10)." Defense & Veterans Center for Integrative Pain Management, Defense and Veterans Pain Rating Scale, v2.0, accessed November 28, 2022, http://www.dvpmi.org/clinical-resources/defense-veterans-pain-rating-scale-dvprs/. Zero is a report of "no pain" and 10 is the report of "as bad as it could be, nothing else matters."

[15] VA/DoD, *Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*, 2019. Suicidal intent occurs when one has "past or present evidence (implicit or explicit) that an individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions." Suicidal ideation occurs when one has "thoughts of engaging in suicide-related behavior." Although the patient endorsed suicidal ideation, the C-SSRS was not positive, as the patient did not answer yes to any of the questions that would have prompted a secondary screen.

"[patient] is actively suicidal on questioning."[16] The patient's laboratory results indicated an elevated prostate-specific antigen.[17] PCP 1 assessed the patient for alcohol use disorder, recorded "cut back on [alcohol] discussed," and documented a plan to "discuss [alcohol use] again at next visit." PCP 1 provided patient education on unsafe drinking levels and documented the "[Patient] does not want to see [mental health] for [alcohol help]." PCP 1 reviewed the positive depression screen, completed an evaluation, and documented that the patient "declines further intervention [and] evaluation." PCP 1 provided the patient with instructions for accessing emergency services. PCP 1 placed consults for gastroenterology, urology, physical therapy, occupational therapy, and pain management.[18]

In spring 2021, physical and occupational therapists recommended home exercise programs and follow-up.

In late spring 2021, the patient returned for a second primary care visit and met with a different primary care provider (PCP 2). On intake, a second primary care nurse recorded the patient's "full body" pain as 7 out of 10. PCP 2 saw the patient for complaints of chronic pain and prescribed a muscle relaxant medication and documented [the patient] "is awaiting pending consult, most anticipated is pain manag[e]ment." PCP 2 recorded a normal mood and affect and recommended a six-month follow-up visit. PCP 2 did not discuss the previously positive alcohol and depression screens with the patient.

Approximately two weeks later, a physician assistant saw the patient in the urology clinic for further evaluation of urinary symptoms (increased frequency and urgency) and the elevated prostate-specific antigen level. A laboratory test for prostate-specific antigen level was repeated and indicated a normal level. In mid-summer 2021, a cystoscopy was performed and showed "no significantly obstructive prostate" and a normal bladder.[19]

During late summer 2021, the patient presented for an initial consultation in the pain management clinic. An addiction and pain management clinic fellow documented the patient's pain history, including neck, and upper, mid, and lower back pain. The fellow identified that the

[16] PCP 1 told the OIG that this was an erroneous entry, and the patient was not actively suicidal during the initial encounter.

[17] National Institutes of Health National Cancer Institute, "prostate-specific antigen," accessed April 29, 2022, https://www.cancer.gov/types/prostate/psa-fact-sheet. A prostate-specific antigen is a "protein produced by normal, as well as malignant, cells of the prostate gland." Elevated levels may indicate prostate cancer but may also indicate conditions such as inflammation or enlargement of the prostate.

[18] *Merriam-Webster.com Dictionary*, "gastroenterology," accessed April 29, 2022, https://www.merriam-webster.com/dictionary/gastroenterology. "A branch of medicine concerned with the structure, functions, diseases, and pathology of the stomach and intestines." *Merriam-Webster.com Medical Dictionary*, "urology," accessed April 29, 2022, https://www.merriam-webster.com/medical/urology. "A branch of medicine dealing with the urinary or urogenital organs."

[19] Mayo Clinic, "cystoscopy," accessed April 29, 2022, https://www.mayoclinic.org/tests-procedures/cystoscopy/about/pac-20393694. "A procedure that allows [a] doctor to examine the lining of [the] bladder and the tube that carries urine out of [the] body (urethra)."

pain in these areas had been present for years and the patient had failed medical management. The fellow did not record a C-SSRS screen during the visit. The chief of the pain management clinic acknowledged receipt of the fellow's encounter note. The fellow ordered magnetic resonance imaging (MRI) studies of the lumbar and cervical spine, with a plan to follow-up after the imaging was complete for further discussion of pain management options.[20] The MRI was completed three weeks later and showed moderately severe narrowing of spinal canal nerve passages in several areas of the cervical spine, and the lumbar spine revealed degenerative changes.

A week prior to the MRI, a urology clinic physician assistant saw the patient for a follow-up on the urinary issues and noted that the patient consumed large volumes of liquid, more than five liters a day, with a similar large volume of urine output. The physician assistant recommended a mental health evaluation and follow-up with primary care as the patient may have "psychogenic diabetes insipidus" and it was "Not likely that [urology] follow-up would benefit this patient at this time."[21]

Two days after the urology clinic visit, a primary care nurse practitioner (PCP 3) ordered a neuropsychology consult with a provisional diagnosis of polydipsia and "to [rule out] psychogenic diabetes insipidus."[22] A neuropsychologist discontinued the consult one-half hour later noting that polydipsia was "outside the scope of practice of neuropsychology," and recommended a referral to the Mental Health Behavioral Health Interdisciplinary Program (BHIP). PCP 3 next ordered a BHIP consult, which was discontinued by a BHIP psychiatrist

[20] *Merriam-Webster.com Dictionary*, "magnetic resonance imaging," accessed April 29, 2022, https://www.merriam-webster.com/dictionary/magnetic%20resonance%20imaging. "A noninvasive diagnostic technique that produces computerized images of internal body tissues." Cleveland Clinic, "Spine Structure and Function," accessed July 5, 2022, https://my.clevelandclinic.org/health/articles/10040-spine-structure-and-function. Lumbar refers to the lower part of the spine that "bears most of [the] body's weight, as well as the stress of lifting and carrying items." Cervical refers to the part of the spine encompassing the neck, allowing one to move their head.

[21] The physician assistant appears to be using a term, *psychogenic diabetes insipidus*, that condenses the medical diagnoses psychogenic polydipsia and dipsogenic diabetes insipidus. Psychogenic polydipsia is increased fluid intake without an identifiable medical cause. Dipsogenic diabetes insipidus refers to increased urination that results from drinking more liquids and may reflect a problem with the brain centers controlling thirst or be caused by mental health problems. *Merriam-Webster.com Dictionary*, "psychogenic," accessed April 29, 2022, https://www.merriam-webster.com/dictionary/psychogenic. "Originating in the mind: attributable to psychological or emotional factors." National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, "diabetes insipidus," accessed March 1, 2022, https://www.niddk.nih.gov/health-information/kidney-disease/diabetes-insipidus, a "disorder that causes the body to make too much urine."

[22] *Merriam-Webster.com Dictionary*, "polydipsia," accessed April 29, 2022, https://www.merriam-webster.com/dictionary/polydipsia, "excessive or abnormal thirst." PCP 2 told the OIG that the patient was assigned initially to a primary care provider who retired and then saw PCP 1 and PCP 2 in the interim, until being ultimately assigned to PCP 3 at the Aiken CBOC in the summer of 2021.

about one hour later.[23] PCP 3 responded to the discontinued BHIP consult by writing "Why was this discontinued? [the patient] needs to have [mental health] causes for... symptoms ruled in or ruled out." In reply, a BHIP psychologist pasted a copy of the psychiatrist's addendum into the consult note that discussed obtaining a water deprivation test.[24]

The psychiatrist who discontinued the BHIP consult request also wrote an addendum to the urology clinic note, discussed the role of a water deprivation test in making a diagnosis of psychogenic polydipsia, and suggested that "if no identifiable cause for polyuria from a urological source, then a consult may be placed again." PCP 3 ordered several tests, including a brain MRI, to evaluate a physiological cause of the frequent urination but did not order a water deprivation test.[25] The brain MRI was scheduled for two weeks later and was ordered to "[rule out] diabetes insipidus, [and] pituitary gland tumors."

A week prior to the brain MRI, the patient called VCL reporting suicidal ideation without a plan or intent, and stated, "I want it to end. I'd really rather just wake up dead one morning." The patient agreed to go to the facility's Emergency Department for further evaluation.

Later that morning, the patient presented to the Emergency Department with complaints of "pain all over [the patient's] body 10/10 [for] 'a while.'" A triage nurse performed a C-SSRS screen and the patient denied suicidal ideation and intent. An Emergency Department physician documented that the patient complained of worsening pain, "was hoping to just get a lidocaine injection in his neck to help [the patient's] headache," and the patient requested an emergent brain MRI. The Emergency Department physician attempted to obtain more information regarding the patient's symptoms and documented that the patient refused to answer additional questions. The patient left the Emergency Department without further care or discharge instructions. The Emergency Department physician documented the patient "did not want anything else done…was tired of waiting…and would just go home and continue to wait." The Emergency Department physician deemed the patient's disposition as "eloped."[26]

On September 20, 2021, a suicide prevention case manager documented a follow-up note to the VCL call noting that the patient presented to the Emergency Department and that the "needs

[23] VHA Deputy Under Secretary for Health for Operations and Management memorandum, "General Mental Health Staffing Model Team Development: Behavioral Health Interdisciplinary Program (BHIP) Team-Based Care," August 5, 2013. BHIP is a general mental health outpatient team that provides interdisciplinary care for an assigned panel of veterans.

[24] National Institutes of Health National Institute of Diabetes and Digestive and Kidney Diseases, "diabetes insipidus," accessed March 1, 2022, https://www.niddk.nih.gov/health-information/kidney-disease/diabetes-insipidus. A water deprivation test assists medical providers with diagnosing the underlying cause of diabetes insipidus. "The test involves not drinking any liquids for several hours. A health care professional will [then] measure how much urine [is] pass[ed], check…weight, and monitor changes in…blood and urine."

[25] PCP 3 ordered urine and blood laboratory tests.

[26] The Emergency Department physician documented that the patient did not leave against medical advice as, "there does not appear to be any emergent medical or emergent surgical conditions at this time."

[were] addressed as indicated." The note further stated, "Veteran reached" and "[suicide prevention] staff and/or other clinical staff connected with Veteran. Risk assessed, and needs addressed as indicated."

The patient's brain MRI did not show a tumor. Approximately two weeks later, the patient spoke with the pain management clinic nurse practitioner and reported that imaging had been completed. In this call, the patient reported continued severe neck and back pain and, per the nurse practitioner's documentation, stated that "something needed to be done or [the patient] would do something about it," and that "the pain is so bad I could take my own life." The nurse practitioner did not perform a C-SSRS screen and advised Emergency Department follow-up. The patient refused to go to the Emergency Department but agreed to come to the pain management clinic the following morning. The nurse practitioner documented "Pt [patient] agreed and reported [the patient] would not harm [themself]."

The next day, the patient met with the chief of the pain management clinic who reviewed the brain MRI findings of multilevel cervical disc disease and spinal canal stenosis, noted the patient's pain was severe, prescribed a narcotic medication for pain, and scheduled the patient for an epidural steroid injection.[27] The chief of the pain management clinic did not complete a C-SSRS.

Two days later, the patient underwent an epidural steroid injection into his neck without any immediate complications. The following week, the patient spoke with the pain management clinic nurse practitioner reporting that the injection helped for a few days, but the pain returned. The patient reported relief with tramadol, and the nurse practitioner refilled the medication.[28]

Four weeks later, the fellow saw the patient and documented that the tramadol was no longer helping. The fellow added a narcotic pain patch and ordered a lower back epidural steroid injection, which was scheduled for a month later. The fellow documented a mental status exam at this visit of a normal mood and affect and no suicidal ideation. In addition, the fellow placed a neurosurgical consultation for input regarding any possible surgical options for the patient's pain.

Three weeks prior to the steroid injection appointment, a facility neurosurgeon completed an electronic consult, which consisted of a review of the patient's chart and imaging studies and noted "MENTAL HEALTH [*sic*] issues with suicidal ideation at times." The neurosurgeon recommended a full neurological and mechanical exam to evaluate for any signs of nerve or

[27] Cleveland Clinic, "Cervical Epidural Steroid Injection," accessed March 21, 2022, https://my.clevelandclinic.org/health/treatments/22293-cervical-epidural-steroid-injection#:~:text=A%20cervical%20epidural%20steroid%20injection%. Cervical epidural steroid injections are used as a "temporary pain relief option for certain causes of chronic neck pain." Anti-inflammatory medication is injected "into the epidural space around [the] spinal nerves" to relieve the pain.

[28] Medline Plus, "tramadol," accessed on May 2, 2022, https://medlineplus.gov/druginfo/meds/a695011.html. A narcotic used "to relieve moderate to moderately severe pain."

spinal cord damage. The neurosurgeon stated if surgery was indicated, the patient would first need a "mental health evaluation and management" due to the neurosurgeon's concern about performing surgery on the patient due to "pain alone."

The pain management clinic nurse practitioner reported receiving a request to return a phone call to the patient, and, two days later, on the day the patient was found deceased, calling the patient twice and leaving a message to return the call. Three days later, a social worker entered a Suicide Behavior and Overdose Report into the patient's EHR stating that a security guard found the patient deceased via a self-inflicted gunshot wound in the parking lot of the Aiken CBOC.[29]

Inspection Results

1. Deficiencies in Clinical Care Prior to the Patient's Death

The OIG substantiated that the patient received deficient clinical care. The OIG reviewed the patient's care and determined the following failures precluded referral for further mental health evaluation and timely pain management services:

- PCP 2 failed to follow-up on the patient's positive mental health screenings.
- PCP 3 failed to follow-up on a discontinued mental health consult and order recommended testing.
- Facility staff failed to ensure the patient received a timely pain management appointment.
- Pain management clinic providers failed to perform the patient's required mental health screenings.
- A nurse failed to communicate the patient's urgent VCL referral prior to the Emergency Department encounter.
- Suicide prevention staff failed to follow-up after the patient's urgent VCL referral.

PCP 2 Failed to Follow-up on the Patient's Positive Mental Health Screenings

In early spring 2021, the patient presented for an initial primary care appointment with PCP 1, screened positive for depression and alcohol misuse, and endorsed suicidal ideation with no plan. In late spring, the patient saw PCP 2 for routine follow-up. The OIG found PCP 2 failed to

[29] VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," November 2020. The Suicide Behavior and Overdose Report is a national progress note within the EHR and "is the primary documentation source of suicide and suicide-related events."

follow-up on the patient's positive mental health screenings per VHA requirements and as recommended by clinical guidelines.[30]

Primary care teams perform "nationally required preventive mental health screenings" and provide brief alcohol counseling and treatment for depression and other uncomplicated mental health disorders.[31] VHA policy encourages primary care teams to engage mental health providers when caring for patients with mental health disorders.[32] Primary care staff are required to perform annual depression screening for patients using the Patient Health Questionnaire-2.[33] Clinical practice guidelines recommend patients who test positive for depression on the Patient Health Questionnaire-2 have "further assessment of symptoms and assessment of risk."[34] VHA policy also requires staff to perform an alcohol misuse screening for new patients and annual screening for established patients in primary care.[35] Primary care physicians or other medical providers must conduct further assessment on patients who screen positive for alcohol misuse to determine the severity of misuse and to establish a diagnosis.[36] VHA policy requires primary care physicians to provide, "education and counseling regarding drinking limits and the adverse consequences of heavy drinking," to patients identified with "alcohol use in excess" of clinical guidelines.[37]

[30] VA/DoD, *Clinical Practice Guideline for the Management of Major Depressive Disorder*, April 2016; VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015; VA Deputy Under Secretary for Health for Operations and Management memorandum, "Screening and Counseling for Alcohol Misuse in Outpatient Clinics," January 12, 2017.

[31] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook,* February 5, 2014, amended May 26, 2017. Patients are assigned to a Patient Aligned Care Team, which consists of a PCP, nurses, and other clinical staff. Primary Care staff provide, "routine mental health care, consistent with team members' clinical privileges, skills, scope of practice or functional statements. In addition to screening, clinical evaluation of patients during routine primary care may also lead to recognition of symptoms of mental disorder." VistA Clinical Reminders, "Mental Health Reminder Updates 7.0 Install Guide," October 2020. Mental health screenings are conducted through the clinical reminder system.

[32] VHA Handbook 1101.10(1).

[33] VA Suicide Risk Identification Strategy, "Minimum Requirements by Setting," updated June 18, 2020. VA/DoD, *Clinical Practice Guideline for the Management of Major Depressive Disorder*, April 2016. The Patient Health Questionnaire-2 includes two questions, "Over the past two weeks, how often have you been bothered by the following problems? 1.Little interest or pleasure in doing things 2. Feeling down, depressed, or hopeless."

[34] VA/DoD, *Clinical Practice Guideline for the Management of Major Depressive Disorder*, April 2016.

[35] VHA Handbook 1160.01. VA Deputy Under Secretary for Health for Operations and Management memorandum, "Screening and Counseling for Alcohol Misuse in Outpatient Clinics," January 12, 2017. "VA requires annual screening for alcohol misuse using the AUDIT-C instrument." VHA Handbook 1160.01 does not delineate which staff members should perform screening and states, "During new patient encounters and at least annually, patients in primary care, appropriate medical specialty care settings, and mental health care services need to be screened for alcohol misuse."

[36] VHA Handbook 1160.01.

[37] VHA Handbook 1160.01.

In November 2020, VHA implemented a suicide risk screening and evaluation process for all patients performed by providers, nurses, or other associated health staff.[38] The initial suicide risk screening, the C-SSRS, is positive when a patient acknowledges thoughts of planning or intention to complete suicide over the past month. A positive C-SSRS screening prompts completion of a secondary suicide risk screen, the Comprehensive Suicide Risk Evaluation.[39]

Per VHA, care coordination processes must ensure no lapses of care, communication between involved providers with necessary information for healthcare decision-making, and integration of clinically recommended care to minimize inefficiencies and avoid missed opportunities.[40]

The OIG reviewed the patient's EHR and found that a primary care nurse administered the depression, alcohol misuse, and C-SSRS screens during the patient's first primary care visit in early spring 2021. The nurse also documented notifying PCP 1 of the patient's positive depression and alcohol misuse screens in the EHR. The C-SSRS screen was not positive because the patient did not answer "yes" to specific questions on the C-SSRS, which did not prompt further assessment using the Comprehensive Suicide Risk Evaluation.[41]

Following the nurse's assessment, PCP 1 met with the patient and documented a "brief alcohol intervention is indicated." PCP 1 informed the patient of risks associated with alcohol misuse and indicated a plan to discuss the patient's alcohol use, "at [the] next visit." PCP 1 also documented that the patient was "actively suicidal [upon] questioning" and "declines further intervention."[42]

The OIG found that in response to the patient's positive depression screen, PCP 1 documented,

> I have reviewed the results of the Mental Health screens and have evaluated the patient. Based on the evaluation, the following disposition plan will be implemented: Patient declines further intervention or evaluation at this time. Contact information and instructions for accessing emergency services provided.

PCP 1 told the OIG of speaking with the patient about alcohol misuse and depression, but the patient declined mental health assistance. When asked whether PCP 1 considered referring the

[38] VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memorandum, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation, (Risk ID Strategy)," November 13, 2020.

[39] VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memorandum, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation, (Risk ID Strategy)," November 13, 2020. VA Suicide Risk Identification Strategy, "Staff Specific Guidance," May 6, 2021.

[40] VHA Handbook 1101.10(1).

[41] A C-SSRS is positive when patients answer yes to specific questions.

[42] PCP 1 told the OIG of erroneously documenting in the EHR that the patient was "actively suicidal on further questioning," and intended to write that the patient was "not actively suicidal on further questioning." However, PCP 1 did not correct the error in the EHR.

patient to same day mental health services, PCP 1 stated the patient's concerns were primarily chronic pain,

> I thought about it but after further questioning with [the patient] I didn't think that [the patient] needed to be seen. [The patient's] more issue is. . . [the] chronic pain issues as far as things that was that reason, [the patient] said "yeah I could go to sleep or kill myself as far as the pain," and that's the thing.

The OIG found that although PCP 1 offered the patient further mental health intervention and evaluation and provided instructions for accessing emergency services, the patient refused. PCP 1 also told the OIG that, after discussions with the patient, same day mental health services were unnecessary.

The patient returned for a primary care visit with PCP 2 in late spring for complaints of chronic pain. The OIG reviewed the EHR and found PCP 2 did not document follow-up related to the patient's primary care appointment that had taken place earlier in the spring, that noted positive screens for depression and alcohol misuse. Although VA clinical guidelines suggest further assessment of depression symptoms and risk following a positive depression screen, PCP 2 failed to assess the patient's risk, and did not discuss this concern with the patient.[43] Additionally, PCP 1 documented that alcohol misuse would be addressed at the next appointment; however, PCP 2 failed to discuss this concern with the patient.

During an interview with the OIG, PCP 2 remembered seeing the patient's positive depression and alcohol misuse screens from the prior primary care appointment but reported focusing on the patient's chronic pain. When asked why PCP 2 did not follow-up on the patient's positive mental health screenings and past suicidal ideation, PCP 2 said,

> The visit was. . . focused on. . . pain and. . . making sure [the patient] has those referrals to. . . specialist[s]. . . [the patient] didn't seem. . . upset but I didn't conduct any further. . . testing on that. . . [the patient] seemed very fine at the visit. It was about making sure [the] referrals are in place.

Although VA clinical guidelines indicated an assessment of depression symptoms and risk following a positive depression screen was recommended, PCP 2 did not offer further intervention or evaluation. The OIG also found that although PCP 1 documented a plan to follow-up on the patient's positive alcohol misuse screen at the next visit, PCP 2 failed to ensure the follow-up was completed. Additionally, PCP 2 failed to further assess the patient's suicidal ideation. The OIG found these clinical deficiencies precluded referral for further mental health evaluation.

[43] VA/DoD, *Clinical Practice Guideline for the Management of Major Depressive Disorder*, April 2016. Clinical practice guidelines recommend patients who test positive for depression on the Patient Health Questionnaire-2 have "further assessment of symptoms and assessment of risk."

PCP 3 Failed to Follow-up on a Discontinued Mental Health Consult and Order Recommended Testing

The OIG determined that the patient's BHIP consult was discontinued so that further testing could be conducted; however, PCP 3 failed to follow-up on the recommended test. Per VHA policy, the provider who places the consult is responsible for, "reviewing discontinued or canceled consults to determine if additional clinical measures are necessary."[44]

The OIG reviewed the patient's EHR and found that in late summer 2021, PCP 3 entered a consult to request mental health "BHIP assistance" to rule out a mental health cause for the patient's "psychogenic diabetes insipidus."[45] The BHIP psychiatrist discontinued the consult, recommended a water deprivation test, and wrote "if no identifiable cause for polyuria from a urological source, then a consult may be placed again." During an interview, the BHIP psychiatrist denied awareness of the patient's previously positive depression screen and told the OIG, "psychogenic polydipsia is a diagnosis of exclusion and I felt like [it would] be better to work it up instead of. . . going on a fishing expedition."

The OIG found that although PCP 3 ordered additional tests to evaluate a physiological cause of the patient's polydipsia, a water deprivation test was not ordered, and no further action was taken to resubmit the BHIP consult.

When asked why the water deprivation test was not ordered, PCP 3 told the OIG of being unfamiliar with water deprivation tests and having "no idea" why it was not ordered. The OIG then asked who was responsible for ordering the water deprivation test, PCP 3 stated, "Yeah, it's our responsibility. . . So, it's like I may have missed resending [the BHIP consult] I fully admit that, but also. . . [the patient] was also seen by urology. . . why did they not close the loop as well?"

The OIG determined that PCP 3 initially sent the BHIP consult; however, did not follow the BHIP psychiatrist's recommended actions upon its discontinuation. The OIG found that PCP 3 failed to order recommended testing and resubmit the discontinued BHIP consult to ensure further mental health evaluation.

[44] VHA Directive 1232(3), *Consult Processes and Procedures,* August 24, 2016, amended April 5, 2021, was replaced by VHA Directive 1232(4), *Consult Processes and Procedures*, August 24, 2016, amended December 14, 2021.VHA Directive 2009-053, *Pain Management,* October 28, 2009. Unless otherwise specified, the amended policies contain similar language about the sending service's requirements to review discontinued consults.

[45] PCP 3 placed the BHIP consult at the recommendation of the patient's urology provider and documented urological symptoms as the "reason for mental health referral."

Facility Staff Failed to Ensure the Patient Received a Timely Pain Management Appointment

The OIG determined the patient waited 139 days from the clinically indicated date for an intake appointment in the pain management clinic.[46] PCP 1 and PCP 2 did not intervene when the patient had an extended wait time for the pain management appointment.

In 1998, VHA identified pain management as a national priority with an objective to "develop a comprehensive, multicultural, integrated, system-wide approach to pain management that reduces pain and suffering and improves quality of life for Veterans experiencing acute and chronic pain."[47] VHA policy further states, "Chronic pain can be a complex, biopsychosocial condition involving cognitive, psychosocial, and substance abuse issues as well as medical and mental health co-morbidities."[48] Primary care providers must have timely access to "pain consultative and treatment sources."[49] Per VHA, once pain is identified, "a timely and appropriate" assessment must occur and an individualized plan of care documented.[50]

According to facility policy, when a patient is referred to specialty care, the sending provider enters a consult in the EHR and determines the date the care is clinically indicated. Once the consult is entered, the receiving service must review the consult and schedule the appointment within two business days. The receiving service completes a clinical review of the consult to determine whether the consult is appropriate and if services are available within the facility.[51] The service who sends the consult must review the "status of ordered consults to make sure that the patient receives timely care."[52]

The OIG reviewed the patient's EHR and determined that during the patient's initial primary care appointment, PCP 1 placed a pain management consult with a clinically indicated date in the spring of 2021. PCP 1 documented a preference for the patient to be seen at the facility pain management clinic and that the patient had tried, "multiple modalities [to treat pain] without success." Later that day, the chief of the pain management clinic received and accepted the consult. Three days later, a medical support assistant scheduled the patient's appointment with

[46] VHA Directive 1232(3); VHA Directive 1232(4). Both amended policies contain the same definition for clinically indicated dates. The clinically indicated date is the earliest date that the requesting provider determines care is clinically appropriate.

[47] VHA Directive 2009-053, *Pain Management,* October 28, 2009.

[48] VHA Directive 2009-053.

[49] VHA Directive 2009-053. Pain consultative and treatment sources include, "Pain Medicine specialists, interdisciplinary pain clinics and centers, Hospice and Palliative Care Services, Mental Health services, Social Work services, and Clinical Chaplaincy services, among others," or non-VA community resources as indicated.

[50] VHA Directive 2009-053.

[51] Medical Center Policy No. 6011, *Consultation and Consults Scheduling Processes,* July 8, 2019.

[52] VHA Directive 1232(3); VHA Directive 1232(4). The amended policies contain similar language about timely care.

the facility's pain management clinic for late summer 2021, 139 days after the clinically indicated date.[53]

In late spring 2021, the patient returned to primary care with complaints of chronic pain and saw PCP 2. PCP 2 prescribed muscle relaxers, documented the patient was anticipating an appointment with the pain management clinic, and advised the patient to return to primary care in six months.

The OIG found PCP 1 and PCP 2 did not intervene or address the patient's extended wait time for the pain management appointment at the facility. The OIG asked PCP 1 and PCP 2 about the patient's extended wait time for an appointment in the pain management clinic for an initial consult. PCP 1 told the OIG of delays with initial pain management consults, stating "it can take a while to get somebody into Pain Management." However, PCP 1 preferred the patient to be seen, "in-house" at the facility pain management clinic noting the clinic has "more modalities and helps [*sic*] than some of the outside pain management clinics have." PCP 2 told the OIG that the patient was waiting for an initial pain management consult. However, "the actual date of the visit sometimes you know, is not, not available for me to see," therefore, PCP 2 was not aware of the patient's pain management appointment date and the delay. Additionally, PCP 2 stated that primary care was not involved in following up to ensure a timely pain management clinic appointment.

The OIG asked facility leaders about the timeliness of the patient's initial pain management consult appointment:

- The acting chief of primary care stated that primary care providers are responsible for the initial pain management evaluation, placing consults for specialized pain management care, and can facilitate more timely appointments for patients.
- The Chief of Staff reported finding no evidence primary care providers advocated for an earlier appointment.
- The chief of the pain management clinic stated that the patient "wasn't booked for about four months" and that the patient should have been offered a community care appointment if there was an "abnormal wait period."

[53] The patient's wait time of 139 days from the clinically indicated date from the spring of 2021 to the date the appointment was scheduled during late summer 2021 far exceeded the facility's mean wait times. During the time the patient was receiving services, the mean wait time for community care was 36 days from the clinically indicated date to the date the appointment was scheduled. For those referred to a VA pain clinic, the mean wait time was 89 days from the clinically indicated date to the scheduled appointment.

The OIG found facility providers failed to ensure the patient received timely pain management, which, per VHA policy, "reduces pain and suffering and improves quality of life for Veterans experiencing acute and chronic pain."[54]

Medical Support Assistant Failed to Document Community Care Eligibility

The OIG found no evidence that the medical support assistant, who scheduled the patient's appointment in the pain management clinic, told the patient of the eligibility for community care. The medical support assistant also did not document the patient's decision to opt in or out of community care, as per VHA requirements.

VA provides care to veterans through community providers when VA cannot provide the care needed. Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual veterans. When scheduling staff are unable to schedule a patient for a routine specialty clinic appointment within 28 days of the clinically indicated date, a patient is eligible for care in the community and must be offered the option. Per VHA guidance, the scheduler must document whether a patient agrees with community care or not. If a patient chooses to opt-out of community care, the scheduler must specifically document the decision in the consult.[55]

As noted previously, the medical support assistant scheduled the patient's appointment with the facility's pain management clinic 139 days after the clinically indicated date. The Chief of Staff told the OIG the scheduler should have offered the patient a community care option if unable to schedule the patient for specialty care within a timely manner.[56]

The OIG found the medical support assistant did not document the patient's community care eligibility and did not document the patient's decision to receive community care, or not, as VHA requires. The OIG found the medical support assistant's failure to offer community care consistent with VHA policy may have contributed to the patient's delayed pain care.

[54] VHA Directive 2009-053.

[55] VA, "Community Care Overview," accessed May 16, 2022, https://www.va.gov/communitycare/. "VHA Office of Community Care Field Guidebook, "Chapter 2: Eligibility, Referral, and Scheduling," accessed February 2, 2022. This documentation would include the medical support assistant's discussion with the patient regarding the late summer 2021 appointment date or that a community care appointment was offered. The OIG also determined the patient did not "no show" or cancel any appointments with the facility's Pain Management Clinic that would have extended the appointment further.

[56] The Chief of Staff described timely as 30 days or less.

Facility Leaders Failed to Conduct Required Scheduling Audits

The OIG found that scheduling auditors noted errors in the medical support assistant's documentation in the audit cycles prior to and following the medical support assistant's scheduling of the patient's pain management consult in early spring 2021.[57]

In 2017, VHA standardized auditing of the scheduling process to "improve the reliability of outpatient appointment wait times." The auditing process includes reviewing scheduled appointments for accuracy and providing "just in time constructive feedback to staff." Audit cycles are bi-annual, and a minimum of 10 scheduled appointments for each scheduling staff member must be reviewed for each cycle. If a staff member schedules less than 10 appointments during the audit cycle, all appointments must be reviewed.[58]

The OIG reviewed the scheduling audits for the medical support assistant who scheduled the patient's appointment for the cycles prior to, during, and following the patient's care at the facility (see table 1).

Table 1. OIG Analysis of a Scheduling Audit of a Facility Medical Support Assistant

Cycle	Facility Audit Results*	OIG Summary of Facility Audit Results
October 1, 2020 – March 31, 2021	23 audits performed; 12 appointments contained scheduling errors.	Errors included identification that "PID not used by scheduler, incorrect PID used;" the failure to indicate that the patient opted out of community care; and "Scheduler comments do not match documentation or do not identify how they decided entered [*sic*] wait time (PID)."†
April 1, 2021 – September 30, 2021	No audits performed.	No audits to review.
October 1, 2021 – March 31, 2022	20 audits performed; 5 appointments contained scheduling errors.	Errors included the failure to document the patient's decision to opt out of community care and "Scheduler comments do not match documentation or do not identify how they decided entered [*sic*] wait time (PID)."

Source: Medical support assistant audit scheduling records provided by a facility leader.
**The OIG did not independently verify the scheduling records reviewed by scheduling supervisors.*
†A PID, or patient indicated date, is the date a patient requests an appointment to be scheduled.

The OIG learned the scheduling auditors did not conduct audits of the medical support assistant's work from April through September 2021. The executive director, high reliability

[57] The OIG was informed that scheduling supervisors conducted the audits.

[58] VHA Scheduling Auditor Guidebook, "Level 1 Audits, Groupings, and Reports." Audit cycles run from October 1 through March 31, and April 1 through September 30.

organization/quality and patient safety (quality management chief) told the OIG no audits were performed as the medical support assistant was detailed out of the service, "on or about," June 23, 2021. However, the OIG found no audits were performed of the review period prior to the detail.[59]

VHA guidance states, "Feedback is critical to clear any misinterpretation of scheduling policy and/or to provide staff with the necessary knowledge and skills to adjust scheduling practice and eliminate future errors."[60] The OIG requested, "any administrative actions and/or follow-up/feedback provided to [the medical support assistant] that resulted from the auditing." The quality management chief responded that "feedback is verbal" and no administrative actions have been initiated due to cases pending with the Office of Workers' Compensation Programs and Equal Employment Opportunity.[61]

The OIG concluded that facility staff failed to ensure the patient received a timely pain management appointment. The OIG also found that although required by VHA policy, there was no documentation or evidence that the medical support assistant offered community care to the patient. The OIG found deficiencies in audits of the medical support assistant's appointment scheduling. The OIG concluded that if the patient had been advised of, and opted for community care, the patient may have received more timely pain management.

Pain Management Clinic Providers Failed to Perform the Patient's Required Mental Health Screenings

The OIG found that during the patient's pain management clinic intake appointment during late summer 2021, the fellow did not perform the C-SSRS per VHA policy.[62] Additionally, the OIG found that the chief of the pain management clinic did not perform a C-SSRS when clinically indicated.

VHA requires C-SSRS screening in the pain management clinic

- during referral or intake appointments,
- when the appointment is greater than 30 days from referral, or

[59] The medical support assistant acted on the patient's pain management consult during early spring 2021. The OIG did not evaluate how many additional appointments the medical support assistant scheduled from this period through approximately the next two and a half months.

[60] VHA Scheduling Auditor Guidebook, Level 1 Audits, Groupings, and Reports.

[61] The OIG could not determine why the medical support assistant did not document the offer of community care.

[62] VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memorandum, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy), Attachment," November 10, 2020.

- when clinically indicated.[63]

During the pain management clinic intake appointment in late summer, the fellow evaluated the patient for upper and lower back pain and ordered an MRI. The OIG found that although the fellow documented the patient had, "no anxiety, no depression," the required C-SSRS was not completed.

The fellow told the OIG that the C-SSRS screening was not performed during the patient's intake appointment. The fellow stated that the screening "was not done effectively" and the focus of the appointment was pain management. When asked whether an opportunity was missed to refer the patient to mental health, the fellow said,

> I could have dug a little deeper. I could have had a lower threshold for sending [the patient] out given [the patient's] history of chronic pain, and maybe had a little bit longer conversation to try to get past any unwillingness to discuss it with me.

In early fall 2021, the patient spoke with a pain management clinic nurse practitioner by telephone and endorsed severe pain and suicidal thoughts, "the pain is so bad I could take my own life." The nurse practitioner urged the patient to go to an emergency department and the patient refused.[64] The nurse practitioner made an appointment for the patient in the pain management clinic the following day.

The next day, the patient met with the chief of the pain management clinic who prescribed pain medication and noted the patient's pain as severe. The chief of the pain management clinic did not document any discussion or assessment for suicide with the C-SSRS, although an evaluation was clinically indicated as the patient endorsed suicidal thoughts to the pain management clinic nurse practitioner the previous day.

During an interview, the OIG asked the chief of the pain management clinic if there was consideration to refer the patient to mental health. The chief reported believing the patient was already connected to a mental health provider. When asked if the chief considered repeating a suicide risk screen, the chief said,

> When [the patient] came in, and [the patient] was in. . . real pain, and [the patient] needs pain treatment. So, we proceeded to provide that. . . [The patient] continued to see [the] primary mental health provider. I don't know if [the patient] saw [the primary mental health provider] in the interim or not. . . . So, from my point of

[63] VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memorandum, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy), Attachment," November 10, 2020.

[64] The nurse practitioner documented that the patient agreed not to self-harm and go to the emergency room or nearest healthcare facility if further thoughts of self-harm occurred.

> view, pain point of view. We acted timely, got [the patient] in incredibly quickly. . . [the patient] did not express any suicidality or any of that in the clinic.

The OIG reviewed the patient's EHR and found that the patient was not connected to mental health services and there was no documentation that the patient met with mental health staff.

The OIG concluded that although required, the fellow failed to conduct a C-SSRS during the patient's pain management clinic intake appointment. Additionally, the OIG determined that the chief of the pain management clinic failed to complete a clinically indicated C-SSRS and erroneously believed the patient was connected to mental health care. The OIG concluded that if the required C-SSRS screenings were completed, there may have been an opportunity to discuss engagement in mental health care with the patient.

A Nurse Failed to Communicate the Patient's Urgent VCL Referral Prior to the Emergency Department Encounter.

The OIG found that an Emergency Department nurse (Nurse 1) received the patient's urgent VCL referral but did not communicate the referral to the Emergency Department physician who assessed the patient.

VCL, established in 2007, is a toll-free hotline, available to veterans, 24 hours a day, 7 days a week and staffed by trained mental health staff. VCL provides crisis intervention services, and "referrals to local VHA mental health and medical programs as well as other VA and community-based services as appropriate."[65]

Per VHA policy, following a patient's call to VCL, a referral is made to the local facility suicide prevention team as "appropriate," or if the patient "requests and accepts." VCL responders place an urgent referral when a patient agrees to treatment at a "medical facility via a Facility Transport Plan (FTP) without an appointment and without the assistance of emergency services."[66] VCL staff are then required to notify designated facility staff which includes

- contacting and notifying the VA medical facility of a patient's plan to arrive,
- creation of an email referral via a web-based application to the facility suicide prevention coordinator,

[65] VHA Directive 1503; VHA Directive 1503(1).

[66] VHA Directive 1503; VHA Directive 1503(1). A Facility Transport Plan is a plan developed with a patient, "to present to a treatment facility without the assistance of emergency services." The OIG recognizes VCL referral terminology changed from a *consult* in VHA Directive 1503, (which was current at the time of the inspection) to a *request* in VHA Directive 1503(1). For the purposes of this report, the OIG refers to VCL consults and VCL requests as VCL referrals. The three categories of VCL referrals are urgent, emergent, and routine. An emergent referral is placed when a patient is an imminent threat to themselves or others, or when emergency medical services are dispatched. A routine referral is placed when a patient requires follow-up for depression, mental health issues, or other concerns.

- alerting the facility suicide prevention coordinator via voicemail about the urgent referral, and
- confirmation with facility staff that the patient arrived for treatment as planned.[67]

VHA policy states that the redundancy of the VCL referral notification "is to ensure that high-priority referrals are received."[68]

In late summer 2021, the patient contacted VCL and endorsed severe chronic pain and suicidal thoughts but denied a plan to complete suicide. The VCL responder assessed the patient as "moderate to low risk," for suicide, and determined the call required an urgent referral. The patient made a Facility Transport Plan with the VCL responder and agreed to go to the facility's Emergency Department.

The OIG reviewed VCL call recordings, web-based application referral, and electronic communication, and found that following the patient's VCL call, the VCL responder

- called the facility Emergency Department and spoke with Nurse 1,
- told Nurse 1 the patient was a VCL caller who endorsed chronic pain and suicidal thoughts with no plan or intent, provided patient demographics, and stated the patient was in transport to the facility,
- created a referral via the web-based application and sent the referral to the facility suicide prevention team via email,
- requested mental health and primary care consults for the patient, and
- alerted the facility suicide prevention team of the urgent referral, via voicemail.

In addition, a VCL support services assistant contacted a facility Emergency Department staff member to confirm the patient's arrival.

The OIG reviewed the patient's EHR and found the patient presented to the facility's Emergency Department about an hour after the VCL call. An Emergency Department nurse (Nurse 2) evaluated the patient, whose chief complaint was "pain all over [the] body," and performed a C-SSRS screen. The patient answered, "no" to all applicable C-SSRS questions, denying suicidal thoughts. Although Nurse 1 received a verbal handoff from the VCL responder, the OIG found no documentation in the patient's EHR that reflected communication to the Emergency Department provider of the patient's call to, and referral from, VCL. The patient complained of

[67] VHA Directive 1503; VHA Directive 1503(1). VCL staff use a web-based application to record their contact with patients. The OIG learned in an interview this application is not part of a patient's EHR and is only viewable to VHA providers once Suicide Prevention staff receive the VCL referral and enter the information into the patient's EHR.

[68] VHA Directive 1503; VHA Directive 1503(1).

severe pain and according to the EHR, was "tired of waiting," wanted to go home, and left the Emergency Department with a disposition of "elopement."[69]

The OIG interviewed the Emergency Department nurse manager and learned there was no specific facility policy or process for communicating VCL referrals to Emergency Department staff. However, the informal process was for a nurse to take the VCL call and inform the charge nurse to look for the patient.

The OIG confirmed through VCL call recordings that Nurse 1 spoke with the VCL responder; however, Nurse 1 did not recall the conversation and did not enter call information in the patient's EHR. When asked why the patient was not identified as a VCL referral in the EHR, Nurse 1 told the OIG there was no standard operating procedure or formal process for communicating VCL calls to physicians. Nurse 1 told the OIG the facility process to communicate VCL referrals was to tell the nearest provider about a potentially incoming patient. Nurse 1 further stated that while some Emergency Department nurses enter notes into the EHR when they receive a call from VCL, it is not a requirement.

The Emergency Department physician who assessed the patient told the OIG of being unaware of the patient's VCL call. The physician would have connected the patient to mental health if the physician had known the patient was a VCL referral that had endorsed thoughts of suicide. When asked about the elopement, the Emergency Department physician said,

> [The patient] had a capacity to make the decision to leave so I didn't feel that [the patient] needed to leave against medical advice and I wasn't able to fully finish my evaluation so the designation was that [the patient] left, so the question was did [the patient] leave prior to a complete medical screening, I thought my medical screening was adequate enough to make the assessment that [the patient] didn't need to go against medical advice. [The patient] just didn't allow us to finish our evaluation.

The OIG concluded that Nurse 1 received a handoff from the VCL responder but failed to ensure the treating Emergency Department physician was aware of the patient's call to, and referral from, VCL. The OIG determined that the Emergency Department physician's unawareness of the patient's call to VCL limited the ability to evaluate the patient and possibly engage the patient in further mental health care.

[69] The following Monday, a nurse (Nurse 3) contacted the patient and documented, "Patient states that [the patient] left because the ED [Emergency Department] was not treating [the patient's] pain. Patient states that [the patient] is going to follow-up with [the patient's] PCP and will not be coming back to the ED [Emergency Department]."

Suicide Prevention Staff Failed to Act After the Patient's Urgent VCL Referral

The OIG found that following the patient's VCL call during late summer 2021, facility suicide prevention staff failed to contact the patient and did not provide follow-up per VHA requirements. Additionally, the OIG found a suicide prevention case manager documented contact with the patient, although no actual contact occurred.

Per VHA policy, following an urgent VCL referral a facility suicide prevention case manager or coordinator must

- "view and act" on the referral in the web-based application, within one business day of receipt,
- update the referral status "as soon as possible and no later than 1 business day from the time submitted via the VCL web-based application,"
- document follow-up in the EHR,
- attempt a minimum of three phone calls to reach the patient,
- document all attempts in the patient's EHR and in the web-based application, and
- provide detailed information about actions taken to resolve issues identified in the referral, prior to closure.[70]

Additionally, a facility suicide prevention case manager or coordinator is responsible for "[f]acilitating the resolution of the Customer's needs identified."[71]

The OIG reviewed the patient's EHR and found that three days later, the suicide prevention case manager

- viewed and updated the patient's VCL referral in the web-based application;
- documented that the patient presented to the facility's Emergency Department, connected with "[suicide prevention] and/or other clinical staff," and the patient's "needs [were] addressed;"
- indicated that an initial phone call was made to the patient within 24 business hours, the patient "reached," and the patient was "aware and in agreement with plan;" and
- requested a VCL referral closure.

[70] VHA Directive 1503; VHA Directive 1503(1). A referral from VCL is a "referral for follow-up submitted by a VCL Responder to a VA medical facility Suicide Prevention Coordinator . . . via the VCL Web-Based application." "Referrals generated over the weekend or on a federal holiday must be responded to by the [Suicide Prevention coordinator] the following business day."

[71] VHA Directive 1503; VHA Directive 1503(1).

However, during an interview with the suicide prevention case manager, the OIG learned that the patient was not contacted, contrary to documentation. When asked about this contradiction, the suicide prevention case manager confirmed not having contacted the patient because the patient was seen in the Emergency Department where the needs were met. The suicide prevention case manager further stated that because mental health providers did not assess the patient in the Emergency Department, the suicide prevention case manager surmised that the patient was "not actively experiencing suicidal ideation or intention." The OIG found the facility suicide prevention case manager failed to follow VHA policy after the patient's urgent VCL referral by

- not contacting the patient,
- documenting contact with the patient, although contact did not occur, and
- failing to respond to the VCL responder's identification that mental health and primary care appointments were indicated for the patient.[72]

When asked about the discrepancy in the suicide prevention case manager's documentation and actions regarding patient contact, both the suicide prevention case manager and suicide prevention program manager told the OIG that facility suicide prevention staff previously believed contact with "other clinical staff," including Emergency Department staff, met the contact requirement with patients following a VCL urgent referral. The suicide prevention case manager told the OIG that following a January 2022 "Suicide Prevention national meeting" where guidance was clarified, the practice changed "that we need to follow up with [patients] even if like in this case, they're in the emergency room" following a VCL referral.

The OIG found that the VA Office of Mental Health and Suicide Prevention distributed an email on January 6, 2022, clarifying that suicide prevention coordinators are responsible to facilitate resolution of the needs identified in VCL referrals, and to reassess patients for any potential risks. The email also clarified that referrals should be closed only after the suicide prevention coordinator makes contact with the patient, or after three unsuccessful attempts to make contact.

The OIG interviewed the VA Executive Director for Suicide Prevention who recalled that, as a result of an OIG inspection, learning that suicide prevention staff at VA medical centers misinterpreted VHA policy and incorrectly believed that contact with other clinical staff replaced the requirement for suicide prevention staff to contact patients following a VCL referral. The OIG also interviewed the VCL Executive Director who stated in response to the OIG inspection, the national VCL EHR template was changed to remove the option for suicide prevention staff to select "other contact."[73]

[72] VHA Directive 1503; VHA Directive 1503(1).

[73] VA OIG, Suicide Prevention Coordinators Need Improved Training, Guidance, and Oversight.

The OIG determined that although VHA policy requires suicide prevention staff to facilitate resolution of a patient's identified needs and document "detailed information about what actions have been taken to resolve issues identified," the suicide prevention case manager failed to address the patient's needs for mental health and primary care referrals as identified by the VCL responder, or document why referrals were unnecessary.[74]

Suicide prevention staff failed to contact the patient and accurately document resolution of the VCL referral, including responding to requests for primary care and mental health consults. The OIG further concluded if the patient was contacted as required, this would have been an opportunity to discuss engaging in mental health care. Although suicide prevention staff failed to contact the patient, the OIG is not making a recommendation as it is addressed in the VA OIG, *Suicide Prevention Coordinators Need Improved Training, Guidance, and Oversight* report.

2. Facility Leaders' Response Following the Patient's Death

The OIG did not substantiate that facility leaders "covered up" the patient's death by suicide. The OIG received this allegation from an anonymous complainant and could not determine why the complainant concluded facility leaders attempted to "cover up" the patient's death.[75]

The OIG found that following the patient's death, facility leaders initiated an immediate response per VHA guidelines including notification of VISN and VA central office personnel, mobilization of resources, and documentation of the suicide in the EHR. However, they did not initiate a timely investigation into the factors that led to the patient's death. Additionally, once the investigation was initiated, it did not align with VHA policy regarding the investigation team's composition.

The OIG further found that the completed quality management reviews did not follow VHA policy and guidance as

- the Behavioral Health Autopsy (BHA) contained multiple errors,[76]
- the patient's family was not contacted to complete the Family Interview Tool Contact (FIT-C) form, and[77]

[74] VHA Directive 1503; VHA Directive 1503(1).

[75] The anonymous complainant provided no details as to facility leaders' actions that would constitute a "cover up."

[76] VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," November 1, 2020. The Behavioral Health Autopsy Program collects information from all veteran deaths by suicide reported to VA facilities to increase VA's knowledge of suicide on a national level using EHR review, family interviews, and reviews by Suicide Prevention coordinators.

[77] VHA Deputy Under Secretary for Health for Operations and Management memorandum, *Behavioral Autopsy Program Implementation*, December 11, 2012. VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," November 1, 2020. Suicide prevention staff complete Family Interview Tool-Contact Forms after conducting interviews with family members to "understand the circumstances impacting the Veteran's life in the time before the death."

- facility leaders did not initiate timely peer reviews.

Immediate Response Following the Patient's Death

Per VHA memorandum, facility leaders should ensure specific immediate actions occur following a death by suicide on a VA campus. VHA guidance states, "leaders responses following a suicide are crucial to suicide prevention" and "leaders must take prompt action to provide a supportive and informed response to mitigate risk and promote healing for Veterans, employees, and the community."[78] The OIG found facility leaders took immediate action consistent with VHA guidance (see table 2).

Table 2. OIG Analysis of Guidance for Action Immediately Following a Suicide on a VA Campus Compared to Facility Leaders' Actions

Actions	OIG Analysis
Should Occur Immediately Following the Patient's Death	
Alert Emergency Services	In late fall 2021, an Aiken CBOC security guard discovered the patient and contacted facility police at 6:14 a.m.
Notify Leadership and Secure the Area	Facility police notified facility leaders and the suicide prevention program manager the same day. The local police department, the Aiken Department of Public Safety, initiated a crime scene upon arrival and secured the location.
Mobilize Facility and Patient Support and Family Notification	Facility leaders told the OIG that Mental Health and Chaplain Services engaged with Aiken CBOC staff that day. The Aiken Department of Public Safety contacted the patient's family the same day.
Should Occur Within Two Hours Following the Patient's Death	
Heads Up Message	The Facility Director notified the VISN 7 Network Director the same day.
Notification of the Event	A public affairs officer drafted a media release the same day.*
Should Occur Within 24 Hours Following the Patient's Death	
Complete Suicide Behavior and Overdose Report	The suicide prevention program manager completed the Suicide Behavior and Overdose Report three days later.†
Complete Issue Brief	A facility leader completed an issue brief on the day the patient was found deceased.
Provide Employee Support	The acting Aiken CBOC nurse manager emailed Aiken CBOC staff on the day the patient was found deceased, with Employee Assistance Program resources.‡

[78] VHA Deputy Under Secretary for Health for Operations and Management memorandum, "Guidance for Action Following a Suicide on a Department of Veterans Affairs (VA) Campus," November 13, 2019. Although VA guidance identifies actions to be taken by the facility during the year after the patient's death; for the purposes of this report, the OIG identified an immediate response as occurring within 72 hours of the patient's death.

Actions	OIG Analysis
Should Occur Within 48-72 Hours Following the Patient's Death	
Provide Further Employee Support – Recommended Services	Facility leaders reported that a facility chaplain and mental health staff provided support to the Aiken CBOC staff the day the patient was found deceased, and a chaplain provided additional support four days later.

Source: "Guidance for Action Following a Suicide on a VA Campus" and OIG analysis of actions taken by facility leaders and staff.
**The Facility Director told the OIG that the press release was not distributed as no media outlets inquired about the patient's death.*
†VHA guidance does not indicate whether requirements are within 24 hours or 24 business hours. The OIG identified that three days later was the first business day following a weekend.
‡According to the U.S. Office of Personnel Management, the Employee Assistance Program is "a voluntary, confidential program that helps employees (including management) work through various life challenges that may adversely affect job performance, health, and personal well-being."

Facility Leaders Did Not Initiate a Timely Investigation

The OIG found that although facility leaders immediately responded per VHA guidance, including notification of VISN and VA central office personnel, mobilization of resources, and documentation of the suicide in the EHR, they did not initiate a timely investigation.[79] Additionally, once the Facility Director initiated an RCA investigation, the composition of the RCA team was not in alignment with VHA policy.

Per VHA policy, patient safety managers are responsible for reviewing patient safety events and determining follow-up actions.[80] The policy further identifies sentinel events as a type of adverse event defined by The Joint Commission as "a patient safety event…that reaches an individual served and results in any of the following: death, permanent harm, [and] severe temporary harm."[81] VHA guidance expands on VHA policy and asserts, a "death by suicide on a VA

[79] VHA Deputy Under Secretary for Health for Operations and Management memorandum, "Guidance for Action Following a Suicide on a Department of Veterans Affairs (VA) Campus," November 13, 2019. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. "To be timely, an RCA must be completed, signed by the facility Director and submitted to the [National Center for Patient Safety] within 45 days of the facility becoming aware that an RCA is required."

[80] VHA Handbook 1050.01. VHA National Center for Patient Safety, "Guidebook for JPSR Business Rules and Guidance," November 2021. VHA uses a patient safety event reporting system and database called The Joint Patient Safety Reporting System. Each Joint Patient Safety Report is scored with a Safety Assessment Code that evaluates frequency and severity of an event to determine a score. The score may also be used to determine if "further investigation is needed or if an issue needs to be elevated to leadership or national levels."

[81] The Joint Commission, E-dition, SE-1, July 1, 2021, "Sentinel Events (SE)." VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. The Joint Commission is an organization that accredits medical facilities, including VHA facilities, to ensure they are providing "safe, high quality of care," and comply with standards.

campus is considered a sentinel event."[82] VHA policy states sentinel events signal "the need for immediate investigation and response," which may be an RCA.[83] VHA defines an RCA as "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."[84]

The OIG learned that following the patient's death by suicide, a patient safety manager entered a Joint Patient Safety Report to initiate a patient safety review. When asked why a timely investigation such as an RCA was not completed following the patient safety review, the quality management chief and the patient safety manager told the OIG that they believed the patient's death did not meet the VHA policy definition of a sentinel event and were unaware of VHA guidance stating otherwise.[85]

The OIG concluded that facility leaders did not conduct an immediate investigation after the patient's death due to the quality management chief and patient safety manager's lack of awareness of VHA guidance identifying suicide on a VA campus as a sentinel event.

RCA Team Composition

The OIG found the Facility Director chartered an initial RCA on February 16, 2022, which identified Suicide Prevention as an "involved" service and appointed the facility suicide prevention program manager as the RCA leader.

Per VHA, for an RCA to be credible, the RCA team must "exclude individuals directly involved in the adverse event."[86] As VHA policy excludes persons directly involved with the event from serving on the RCA team, the OIG identified that appointing the facility suicide prevention program manager as the RCA leader could impact the RCA's credibility. The OIG notified the Facility Director of this concern on February 25, 2022.

The Facility Director chartered a second RCA on February 25, 2022, and appointed a facility suicide prevention coordinator as the RCA leader. Again, the OIG was concerned that appointing a facility suicide prevention coordinator as the RCA leader could impact the RCA's credibility. The OIG notified the Facility Director of this concern on February 28, 2022.

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[82] VHA Deputy Under Secretary for Health for Operations and Management memorandum, "Guidance for Action Following a Suicide on a Department of Veterans Affairs (VA) Campus," November 13, 2019. VA property includes "owned, leased, or otherwise contracted spaces."

[83] VHA Handbook 1050.01.

[84] VHA Handbook 1050.01. RCAs are interdisciplinary in nature, focus primarily on systems and processes, ask "what" and "why" until contributing factors are considered and identify changes that could be made in systems and processes that "would improve performance and reduce the risk of the adverse event or close call" recurring.

[85] The quality management chief stated the death was not a sentinel event "according to Joint Commission" and the patient safety manager stated the death was not a sentinel event as "sentinel events are typically ones that happen inpatient."

[86] VHA Handbook 1050.01.

The Facility Director chartered a third RCA, completed on March 29, 2022. The OIG reviewed the RCA and found the RCA team composition was in accordance with VHA policy and did not include facility suicide prevention staff as leaders or team members. Due to the correction made by the Facility Director, the OIG determined this issue did not warrant a recommendation.

Deficient Quality Management Reviews

The OIG found a suicide prevention case manager completed the patient's BHA timely; however, the BHA contained multiple errors and the patient's family was not contacted to complete the FIT-C form.[87] The OIG also found that facility leaders did not initiate peer reviews until after the OIG inspection was initiated.

Per VHA policy and guidance, specific quality management reviews should occur following a death by suicide on a VA campus.[88] These quality reviews include completion of a BHA and peer reviews.[89]

Failure to Complete an Accurate BHA and FIT-C Form

In December 2012, VHA implemented the BHA Program, a quality improvement program that seeks to "identify contributory factors (e.g., psychosocial stressors, diagnoses, service utilization) relevant to Veterans' suicides and VA suicide prevention efforts."[90] Per VHA, facility suicide prevention staff must complete a BHA and the FIT-C form within 30 days of awareness of a patient's death by suicide.[91] A VHA resource guide provides suicide prevention staff instructions on how to complete the BHA and FIT-C form.

The BHA is completed through use of an EHR analysis template, which includes "demographic characteristics, risk & protective factors, use of mental health and crisis services, diagnoses and symptoms, and clinical impressions."[92] VA policy also identifies how facility suicide prevention staff complete the FIT-C form, through a conversation with the deceased's family members explaining "the formal interview program and request their participation to understand the

[87] VHA Deputy Under Secretary for Health for Operations and Management memorandum, "Behavioral Autopsy Program Implementation, "December 11, 2012. VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021.

[88] VHA Deputy Under Secretary for Health for Operations and Management memorandum, "Guidance for Action Following a Suicide on a Department of Veterans Affairs (VA) Campus," November 13, 2019. VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. VHA Handbook 1050.01.

[89] For purposes of this review, the OIG considers the BHA and peer reviews as quality management reviews.

[90] VHA Deputy Under Secretary for Health for Operations and Management memorandum, "Behavioral Autopsy Program Implementation, "December 11, 2012. VA, Behavioral Health Autopsy Program Data Definitions, May 11, 2017.

[91] VHA Directive, 1160.07.

[92] VA, Behavioral Health Autopsy Program Data Definitions, May 11, 2017.

circumstances impacting the Veteran's life in the time before the death."[93] After the BHA and FIT-C are completed, "statistical staff and program analysts. . . collect, process, and evaluate the information provided to uncover larger statistical trends and improve VA's [suicide prevention program]."[94]

A suicide prevention case manager reported completion of the BHA within 30 days, and the OIG found the form contained multiple errors pertaining to mental health screenings. Additionally, the OIG learned in an interview, the suicide prevention case manager did not contact the patient's family to complete the FIT-C form.

The BHA resource guide instructs suicide prevention staff to search the EHR for mental health screens under "All Evaluated" when looking for previous screens, not only those completed by mental health providers.[95]

The suicide prevention case manager told the OIG that the patient's positive depression screen was omitted from the BHA because the BHA is "looking for [a depression screen] specifically done in the mental health program. So since [the patient] wasn't screened by anyone in mental health, [the patient] was screened in Primary Care by the primary care provider that would not count for that."

The suicide prevention case manager told the OIG of being unable to complete the FIT-C form because the patient's family's contact information could not be obtained:

> So, there is absolutely no contact information in the chart for a family member, there's no next of kin listed, there's none of that. So I had no ability to reach family, I did ask [the suicide prevention program manager] what we needed. I let [the suicide prevention case manager] know there was no family to contact. [The suicide prevention case manager] told me that apparently there's a cousin that was referenced at one point in time in the note or something I'm not sure. Like I've said, I've never seen the note but that we didn't have contact information for this individual at least in our program, someone else might have it but it was never given to us. So, if we don't have contact information for someone and there's no one listed as next of kin, then we just have to put in there that we weren't able to reach anyone.

The OIG reviewed the patient's EHR, the VCL web-based application, and police reports, and was able to identify names and contact information for two family members.

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[93] VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," November 1, 2020.

[94] VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," November 1, 2020. The BHA program is managed by VA's VISN 2 Center for Excellence for Suicide Prevention.

[95] VA Behavioral Health Autopsy Program Resource Guide: Instructions for Completing the BHAP Chart Review & Family Interview Contact (FIT-C) Form, March 11, 2017.

When asked if there were instructions for completing a BHA, the suicide prevention case manager told the OIG, "I don't know if there's any written guidance on [BHA]." The OIG asked the same of the suicide prevention case manager's supervisor, the suicide prevention program manager. The suicide prevention program manager provided the OIG with the BHA resource guide that outlined instructions on how to complete a BHA. The suicide prevention program manager told the OIG of being unaware if BHAs are reviewed prior to submission to the national data center and that there is no facility process to ensure quality.

The OIG concluded the suicide prevention case manager's failure to accurately document in the patient's BHA prevented the identification of "contributory factors (e.g., psychosocial stressors, diagnoses, service utilization) relevant to Veterans' suicides and VA suicide prevention efforts."[96] Additionally, the suicide prevention case manager did not capture factors contributing to the patient's death on the FIT-C and did not attempt to locate and speak with the patient's family.

Failure to Complete Timely Peer Reviews

The OIG found that a facility leader initiated an issue brief that indicated the patient's death by suicide would require a peer review. The OIG requested the completed peer reviews on January 28, 2022, and learned that facility leaders did not initiate the peer reviews as the issue brief indicated. Subsequently, facility leaders notified the OIG that five peer reviews were initiated in February 2022.

Per VHA, as part of a comprehensive quality management program, facility leaders may initiate a peer review. The peer review process is an evaluation of "care provided by individual clinicians within a selected episode of care," and opportunities for improvement in clinical practice or healthcare systems are identified.[97]

The quality management chief told the OIG that facility leaders had not initiated peer reviews due to a miscommunication regarding "who's going to do what by when, and who is going to relay that information." During the inspection, the quality management chief told the OIG of a process change after recognizing that peer reviews were not initially completed. As of February 14, 2022, the quality management chief receives all issue briefs and reported "that will give me visibility to follow-up on items that I feel that the quality department needs to be looking into."

The OIG concluded facility leaders identified the need for peer review immediately after the patient's death; however, a miscommunication within the facility's Quality Management Department resulted in delayed peer reviews.

[96] VA, Behavioral Health Autopsy Program Data Definitions, May 11, 2017.
[97] VHA Directive 1190.

3. Deficient Clinical Review of the Patient's Care

The OIG learned that following the January 28, 2022, notification of the OIG hotline inspection, the Facility Director initiated a clinical review of the patient's care at the facility. The OIG noted that the clinical review did not identify certain deficiencies in care nor address the deficiencies in the subsequent action plan.

VHA policy defines a look-back or EHR review as "an organized process for identifying patients or staff with exposure to potential risk incurred through past clinical activities, with the explicit intent to notify them and offer care and recourse, as appropriate."[98]

The Facility Director told the OIG that the clinical review's purpose was to gather a "more in-depth review from each clinical leader" and to determine if the "standard of care" was met.

The quality management chief described the clinical review performed on the patient as

> This type of clinical review is conducted at the will of the Director to hear from the disciplines who cared for the Veteran, to ask questions and to see what can be gleaned both positively and negatively regarding the care delivery to the patient. What is learned from the clinical review determines what follow up actions will be taken: further deep dive into a process, review of a policy, peer review, etc.

The OIG determined that the chief of the pain management clinic, the suicide prevention program manager, the chief of mental health, and the acting chief of primary care provided their perspectives regarding the patient's clinical care. These perspectives were presented to facility leaders on February 2, 2022, and follow-up actions were identified.[99] The quality management chief told the OIG of being responsible for tracking the follow-up actions.

The OIG examined the clinical review and learned the following:

- The chief of the pain management clinic, the suicide prevention program manager, and the chief of mental health stated the standard of care was met.
- The acting chief of primary care indicated the standard of care was not met due to the positive depression screen, "We have M[ental] H[ealth] services at the Aiken CBOC, and they should had been involved for guidance and care of this veteran. The information related to his new M[ental] H[ealth] diagnosis needed better documentation by provider."

The OIG noted the clinical review did not

- include input from the quality management chief nor the patient safety manager,

[98] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[99] The clinical review of the patient's care was presented via a PowerPoint presentation.

- identify the missing C-SSRS screenings during the patient's pain management clinic appointments,
- address the failure to inform the Emergency Department provider of the patient's urgent VCL referral, and
- recognize the deficiencies of the suicide prevention case manager following the patient's VCL call.

The OIG also found the clinical review did not reflect documentation of the patient's extended wait for an intake appointment in the pain management clinic; however, the Facility Director told the OIG of discussing appointment scheduling and the actions of the medical support assistant. The OIG reviewed the follow-up actions generated during the clinical review and learned that 5 of the 10 action items related to the practice of the medical support assistant. The remaining actions included recommendations for peer reviews and initiation of an RCA. On February 23, 2022, the quality management chief told the OIG that peer reviews were the only items requiring any further action and to their knowledge, relevant services were managing the other action items. However, the OIG found no evidence of completion for all 10 action items identified within the clinical review.

The OIG concluded that although the Facility Director initiated a clinical review of the patient's care, the review failed to identify and address multiple deficiencies in care.

Conclusion

The OIG reviewed the patient's care and determined the following failures hindered the patient's referral for further mental health evaluation and timely pain management services:

- PCP 2 failed to follow-up on the patient's positive mental health screenings.
- PCP 3 failed to follow-up on a discontinued mental health consult and order recommended testing.
- Facility staff failed to ensure the patient received a timely pain management appointment.
- Pain management clinic providers failed to perform the patient's required mental health screenings.
- A nurse failed to communicate the patient's urgent VCL referral to a provider prior to the Emergency Department encounter.
- Suicide prevention staff failed to act after the patient's urgent VCL referral.

The OIG did not substantiate that facility leaders "covered up" the patient's death by suicide. The OIG could not determine why the complainant concluded facility leaders attempted to "cover up" the patient's death as the complainant was anonymous. Following the patient's death

in November 2021, facility leaders initiated an immediate response per VHA guidelines, including notification of VISN and VA central office personnel, mobilization of resources, and documentation of the suicide in the EHR. However, facility leaders failed to initiate a timely investigation of the death as a sentinel event.

The OIG learned the Facility Director chartered an initial RCA investigation in February 2022. The OIG found the team's composition did not align with VHA policy to exclude involved individuals and could impact the credibility of the RCA. After discussion with the OIG, the Facility Director chartered two additional RCAs. The OIG reviewed and found the third RCA team composition was in accordance with VHA policy; therefore, did not make a recommendation.

The OIG examined information about quality management reviews, which included a BHA, a FIT-C, and peer reviews. The OIG determined a suicide prevention case manager completed the patient's BHA timely; however, the BHA contained multiple errors and the patient's family was not contacted to complete the FIT-C form as VHA requires. Although facility leaders identified the need for peer review immediately after the patient's death in 2021, the OIG found peer reviews did not begin until February 2022.

The OIG learned that following notification of the OIG hotline inspection, the Facility Director initiated a clinical review of the patient's care at the facility. The OIG noted that the clinical review failed to identify and address multiple deficiencies in care.

Recommendations 1–9

1. The Charlie Norwood VA Medical Center Director ensures primary care teams adhere to Veterans Health Administration policies related to mental health screenings, consult management, and care coordination, and monitors compliance.

2. The Charlie Norwood VA Medical Center Director reviews processes for consult scheduling, including community care referrals, and ensures patients are offered timely appointments in the pain management clinic, per Veterans Health Administration policies.

3. The Charlie Norwood VA Medical Center Director confirms pain management clinic staff receive education of Veterans Health Administration policies related to mandatory suicide risk assessments.

4. The Charlie Norwood VA Medical Center Director develops a process to ensure that Emergency Department staff communicate patients' referral information from the Veterans Crisis Line to Emergency Department providers.

5. The Charlie Norwood VA Medical Center Director ensures that suicide prevention staff documentation is complete and accurate, and actions are taken to resolve issues identified in Veterans Crisis Line referrals prior to closure.

6. The Charlie Norwood VA Medical Center Director reviews Veterans Health Administration policy and guidance regarding completed suicides on VA campuses and actions required as a result, and provides education to relevant staff.

7. The Charlie Norwood VA Medical Center Director ensures completion of accurate and comprehensive Behavioral Health Autopsies and Family Interview Tool Contact forms.

8. The Charlie Norwood VA Medical Center Director reviews and evaluates the peer review process to ensure peer reviews are conducted according to Veterans Health Administration policy.

9. The Charlie Norwood VA Medical Center Director reviews and evaluates the February 2022 clinical review to identify open actions and monitors the implementation and efficacy of action items to closure.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 4, 2023

From: Director, VA Southeast Network (10N7)

Subj: Healthcare Inspection—Deficient Care of a Patient Who Died by Suicide and Facility Leaders' Response at the Charlie Norwood VA Medical Center in Augusta, Georgia

To: Director, Office of Healthcare Inspections (54HL07)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I have completed a full review of the Healthcare Inspection—Deficient Care of a Patient Who Died by Suicide and Facility Leaders' Response at the Charlie Norwood VA Medical Center in Augusta, Georgia.

2. I concur with the responses and action plans submitted by the Charlie Norwood VA Medical Center in Augusta, Georgia. We will continue to partner with the Office of Inspector General and leadership at the Charlie Norwood VA Medical Center to implement corrective actions to prevent similar situations from occurring in the future. The VA Southeast Network is committed to ensuring Veterans we serve receive exceptional service at our medical centers.

3. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(*Original signed by:*)

David M. Walker, MD, MBA FACHE

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 31, 2023

From: Director, Charlie Norwood VA Medical Center, Augusta, GA (509)

Subj: Healthcare Inspection—Deficient Care of a Patient Who Died by Suicide and Facility Leaders' Response at the Charlie Norwood VA Medical Center in Augusta, Georgia

To: Director, VA Southeast Network (10N7)

1. VA Augusta Health Care System is committed to honoring our Veterans by ensuring they receive high-quality healthcare services. We deeply regret the care that we provided to this Veteran was not able to relieve their suffering. I have reviewed the draft report and concur with all of Office of the Inspector General's (OIG) recommendations.
2. I appreciate the opportunity to improve the care of Veterans at the Charlie Norwood VAMC. While our leadership took prompt and appropriate action to report and investigate this tragedy by completing the mandatory Behavioral Health Autopsy, we took further action and initiated an optional Root Cause Analysis (RCA). The RCA helped us identify additional areas where we can improve our services.
3. I am proud of medical professionals who devote their lives to caring for Veterans every day. We will continue to partner with the OIG, VISN and VA Augusta Leadership to implement corrective actions to prevent similar situations from occurring in the future. We are committed to ensuring Veterans we serve receive exceptional service at our medical center.

(*Original signed by*:)

Robin E. Jackson, Ph.D.
Medical Center Director

Facility Director Response

Recommendation 1

The Charlie Norwood VA Medical Center Director ensures primary care teams adhere to Veterans Health Administration policies related to mental health screenings, consult management, and care coordination, and monitors compliance.

Concur.

Target date for completion: August 31, 2023

Director Comments

In May 2022, the Mental Health Service at the Augusta VA Health Care System established a Standard Work for Same Day Access to Mental Health Care. A Same Day Service Teams Huddle was established to facilitate real time communication of services needed among relevant stakeholders. Primary Care Mental Health Integration Refresher Training was conducted on March 1, 2023, for all Primary Care Staff at Aiken Community-Based Outpatient Clinic.

A random review of Positive Audit-C screens to assess for compliance to VHA policy will be completed. This includes an assessment of 30 charts per month of Aiken providers. Audits will be completed for 6 consecutive months to assess for a compliance rate of 90% or greater.

The Group Practice Manager provides daily oversight of consult management to ensure timely access to care and proper disposition of consults. The VHA Consults Trigger Report is utilized to track and trend timeliness, dispositioning of consults and to monitor for compliance. A random audit of 30 charts per month will be conducted for 6 consecutive months to assess for a compliance rate of 90% or greater.

Recommendation 2

The Charlie Norwood VA Medical Center Director reviews processes for consult scheduling, including community care referrals, and ensures patients are offered timely appointments in the pain management clinic, per Veterans Health Administration policies.

Concur.

Target date for completion: July 31, 2023

Director Comments

The Charlie Norwood VAMC Director reviewed processes for consult scheduling, including community care referrals to ensure patients are offered timely appointments in the pain management clinic. Monthly audits will continue to be conducted on all Medical Support Assistants (MSA) in the pain management clinic per VHA policy. National standards require two

monthly random audits of schedulers. In February 2022, the Health Administration Service enhanced scheduling audits, including increasing monthly random audits to four, exceeding the national requirements.

Recommendation 3

The Charlie Norwood VA Medical Center Director confirms pain management clinic staff receive education of Veterans Health Administration policies related to mandatory suicide risk assessments.

Concur.

Target date for completion: June 1, 2023

Director Comments

Pain Management clinic staff including fellows and residents will receive education of VHA policies related to mandatory suicide risk assessments. Education was initiated on February 16, 2023. The Columbia Suicide Severity Rating Scale will be incorporated into the Pain Management template.

Recommendation 4

The Charlie Norwood VA Medical Center Director develops a process to ensure that Emergency Department staff communicate patients' referral information from the Veterans Crisis Line to Emergency Department providers.

Concur.

Target date for completion: August 31, 2023

Director Comments

The Emergency Department developed a Standard Work for documenting referral calls from the Veterans Crisis Line (VCL) on February 15, 2023. A CPRS note has been created titled Veterans Crisis line Referral Note which is available for the provider to review when the Veteran arrives in the Emergency Department. VCL calls to the Emergency Department are documented in a spread sheet. Education on utilizing the Standard Work and the Veteran's Crisis Line spread sheet was provided to all appropriate staff by March 1, 2023. The VCL process in the Emergency Department will be monitored for compliance monthly for 6 months with 90% compliance.

Recommendation 5

The Charlie Norwood VA Medical Center Director ensures that suicide prevention staff documentation is complete and accurate, and actions are taken to resolve issues identified in Veterans Crisis Line referrals prior to closure.

Concur.

Target date for completion: August 2023

Director Comments

Suicide Prevention (SP) staff have been educated to resolve issues identified in VCL referrals prior to closure. Providers such as Primary Care and/or Mental Health providers are added as signers on the VCL Note in the chart to alert them of a Veteran concern to ensure appropriate action is taken. High Reliability Organization (HRO)/Quality and Patient Safety (QPS) staff will review for accuracy and completed documentation of Veterans Crisis Line referrals. A random review of 30 charts monthly for 6 months with a compliance rate of at least 90% will be completed.

Recommendation 6

The Charlie Norwood VA Medical Center Director reviews Veterans Health Administration policy and guidance regarding completed suicides on VA campuses and actions required as a result, and provides education to relevant staff.

Concur.

Target date for completion: April 2022

Director Comments

The Charlie Norwood VAMC reviewed the policy and guidance and reviewed the actions taken by the VAMC staff. VAMC leadership educated relevant staff. VAMC leadership discussed their understanding of the policy with OIG on March 21, 2022. Actions to resolve this recommendation have been completed. The Medical Center Director respectfully asks OIG to consider closing this recommendation

OIG Comments

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

Recommendation 7

The Charlie Norwood VA Medical Center Director ensures completion of accurate and comprehensive Behavioral Health Autopsies and Family Interview Tool Contact forms.

Concur.

Target date for completion: August 2023

Director Comments

The Charlie Norwood VAMC ensured that Suicide Prevention staff had the Suicide Prevention Program Guide on June 27, 2022. All guidelines were reviewed to ensure both the Behavioral Health Autopsies and Family Interview Tool Contact forms are completed appropriately. Two Behavior Health Autopsies (BHA) have been completed since November 2021. HRO/QPS and SP staff will collaborate to ensure accurate BHAs are submitted. HRO/QPS staff will review for accuracy before submission of BHA, with a compliance rate of 100% for 6 months.

Recommendation 8

The Charlie Norwood VA Medical Center Director reviews and evaluates the peer review process to ensure peer reviews are conducted according to Veterans Health Administration policy.

Concur.

Target date for completion: May 16, 2022

Director Comments

The Charlie Norwood VAMC Director reviewed and evaluated the peer review process to ensure peer reviews are conducted according to VHA Directive 1190. Although this event did not trigger as an automatic required peer review under the directive, an Issue Brief was initiated the day the patient was found deceased that indicated the facility would conduct a peer review. Quality Leadership was not aware of the request for peer review. Once the Director learned of this communication gap on February 4, 2022, the email group was amended to include all Quality Leadership. The email group was updated on February 14, 2022. Quality Leadership now reviews each Issue Brief to communicate with Risk Management a need for a peer review.

On February 2, 2022, a clinical review was completed. During the clinical review several staff were identified for peer review. The first peer review was completed February 28, 2022, and the final peer review completed May 16, 2022. There were six peer reviews for the event, four physicians and two nurse practitioners.

Actions to resolve this recommendation have been completed. The Medical Center Director respectfully asks OIG to consider closing this recommendation.

OIG Comments

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

Recommendation 9

The Charlie Norwood VA Medical Center Director reviews and evaluates the February 2022 clinical review to identify open actions and monitors the implementation and efficacy of action items to closure.

Concur.

Target date for completion: May 16, 2022

Director Comments

There were three action plan items identified; initiate a Root Cause Analysis (RCA), conduct peer reviews, and audit MSA schedulers. An RCA was scheduled and completed on March 29, 2022. Six protected peer reviews were initiated and concluded in accordance with VHA Directive 1190 by May 16, 2022. Monthly scheduling audits of schedulers is continuing in accordance with the national standards. All three action items are closed. Actions to resolve this recommendation have been completed. The Medical Center Director respectfully asks OIG to consider closing this recommendation.

OIG Comments

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

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OIG Contact and Staff Acknowledgments

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