



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Inadequate Outpatient
Mental Health Triage and
Care of a Patient at the
Chico Community-Based
Outpatient Clinic in
California



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Executive Summary

The VA Office of Inspector General (OIG) conducted an inspection to evaluate allegations from an anonymous complainant that in early 2022, a patient presented unscheduled to the Chico Community-Based Outpatient Clinic in California (Chico CBOC) “highly agitated” and later was involved in a violent incident with family members. It was further alleged that facility leaders did not address employee concerns related to the adverse clinical outcome, and mental health staffing.¹ During review of the allegations, the OIG identified concerns related to facility staff’s failure to provide same-day access, adequate mental health assessment, mental health triage, and continuity of care for medication management. The OIG also identified concerns that facility leaders failed to consider completing an institutional disclosure and did not address mental health leaders’ concerns about the lack of a therapeutic environment in the Chico CBOC building design.²

Synopsis of the Patient’s Care

The patient was in their 20s upon initiating VA care at the Bakersfield CBOC in late 2016.³ A psychiatrist diagnosed the patient with [posttraumatic stress disorder](#) and a rule out [attention deficit/hyperactivity disorder](#) (ADHD) diagnosis.⁴ The psychiatrist initially prescribed [bupropion](#) for mood and concentration, and about a month later, prescribed [methylphenidate](#) “for ADHD.”⁵

In early summer 2017, the patient, accompanied by two family members (family members 1 and 2), presented to the Chico CBOC seeking mental health treatment after a recent release from an involuntary hold at a non-VA psychiatric unit. A social worker documented that during the visit, the patient exhibited paranoia, agitation, and physical aggression towards family members 1 and 2. Two days later, the patient was again admitted for eight days to a non-VA hospital for symptoms of [psychosis](#). Four days after discharge, a telehealth psychiatrist documented that the patient reported bupropion “for PTSD/ADHD” and methylphenidate were ineffective, and that

¹ Within the context of this report, the OIG considered an adverse clinical outcome to be harm to self or others.

² VHA Directive 1004.08, *Disclosures of Adverse Events to Patients*, October 31, 2018. An institutional disclosure is a formal process for facility leaders and clinicians to inform a patient or patient’s personal representative of events during the patient’s care that resulted in death or serious injury and to provide information about rights and recourse.

³ “Locations,” VA, accessed July 7, 2022, <https://www.va.gov/greater-los-angeles-health-care/locations/>. The Bakersfield CBOC is part of the VA Greater Los Angeles Health Care System. The OIG uses the singular form of they (their) in this instance for privacy purposes.

⁴ The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the “alt” and “left arrow” keys together.

⁵ American Psychological Association, APA Dictionary of Psychology, “differential diagnosis,” accessed July 8, 2022, <https://dictionary.apa.org/differential-diagnosis>. A provider may consider two or more diagnoses if a patient presents with signs or symptoms that are shared by more than one disorder. If additional data is needed to determine the diagnosis, the provider may document diagnoses as differential or rule-out. The OIG considers the terms differential and rule-out diagnoses to be equivalent terms.

the patient was “tolerating [[olanzapine](#)] well” and not exhibiting “paranoia or clear delusions.”⁶ The patient reported “feeling better” and thinking about discontinuing olanzapine upon depletion of the two-week supply. At an appointment three weeks later, the patient reported a plan to “stay off” the olanzapine and the telehealth psychiatrist “cautioned [the] patient to watch for any adverse change in mental status off meds.” The telehealth psychiatrist continued to prescribe medications for [anxiety](#), paranoid thoughts, inattention, sleep, and depression, and the patient remained in outpatient care.

In spring 2020, the patient reported increased anxiety and paranoid thoughts. The telehealth psychiatrist prescribed [risperidone](#) for “thoughts,” [clonazepam](#) for anxiety, [quetiapine](#) for sleep, restarted [sertraline](#), and discontinued [amphetamine-dextroamphetamine](#). About a week later, the patient was voluntarily admitted to the Sacramento VA Medical Center behavioral health intensive care unit for three days with a diagnosis of psychotic disorder, not otherwise specified.⁷ Approximately one week following discharge, the telehealth psychiatrist documented that the patient presented in a “somewhat euphoric and [hypomanic](#) state.” The telehealth psychiatrist diagnosed the patient with [bipolar disorder](#).

The next day, a nurse documented that the patient telephoned and expressed no longer wanting VA services, wanted “to take a break from MH [mental health] care,” and requested “a new doctor.” In early summer 2020, the patient attended a first appointment with a clinical pharmacy specialist who continued medication management including [aripiprazole](#) for mood, and [clonidine](#) for anxiety. The patient continued medication management with the clinical pharmacy specialist through early 2021 when the patient requested transfer of care to another psychiatrist. A medical support assistant scheduled the patient with a clinical resource hub psychiatrist.⁸

Approximately two weeks later, the patient attended the initial telehealth appointment with the clinical resource hub psychiatrist and described depression and anxiety symptoms. The clinical resource hub psychiatrist continued to prescribe medication for mood and inattention. A clinical resource hub nurse documented the patient’s continued stability in late spring 2021.

In early fall 2021, the patient reported a “good” mood, improved sleep, and not wanting “to take any mood stabilizing medication.” The clinical resource hub psychiatrist documented concerns prescribing [stimulant](#) medication without mood stabilizing medication and informed the patient that a stimulant medication would not be prescribed without a mood stabilizer medication. The

⁶ The patient was prescribed olanzapine during the non-VA hospital admission.

⁷ American Psychological Association, “not otherwise specified (NOS),” accessed August 23, 2022, <https://dictionary.apa.org/not-otherwise-specified>. Providers may assign a diagnosis as not otherwise specified when the patient’s symptoms are consistent with a family of disorders “but do not precisely meet the criteria established for specific diagnoses within the family.”

⁸ “Clinical Resource Hubs Information Sheet,” VA, accessed June 7, 2022, https://www.ruralhealth.va.gov/docs/ORH_Clinical_Resource_Hubs-2022_FINAL-508.pdf. Clinical Resource Hubs provide support to underserved medical centers and improve access to care.

patient stated being “fine with that at this time.” The clinical resource hub psychiatrist informed the patient of leaving the clinic the next month and a plan to “remain available for assistance during the transition.”

In a late fall 2021 initial appointment with a facility psychiatric nurse practitioner (nurse practitioner), the patient reported difficulty concentrating, and requested a stimulant medication.⁹ The nurse practitioner documented discussing “concerns regarding stimulant use and bipolar disorder” with the patient, prescribed [atomoxetine](#) for inattention, documented a review of the “risks, benefits, and side effects” of the medication, and scheduled a two-month follow-up appointment. At the patient’s request, the nurse practitioner met with the patient two days later. The patient requested “something that can help quicker,” and the nurse practitioner documented starting bupropion, “continuing atomoxetine,” and wrote again, in the same progress note, the plan to start bupropion and continue atomoxetine.¹⁰

In early 2022, a licensed vocational nurse received a call from family member 1 reporting having received a text message from the patient asking family member 1 to “come be with [the patient],” or take the patient to the hospital “right away.” The licensed vocational nurse consulted with the nurse practitioner and then directed family member 1 to transport the patient to the Chico CBOC for an evaluation by mental health triage staff. Later that afternoon, the patient and family member 1 presented to the Chico CBOC and a triage social worker documented that the patient reported poor sleep and presented “highly agitated, restless/fidgety, teary and demanding to be prescribed [*sic*] [[alprazolam](#)] for anxiety.” The triage social worker documented that the patient “Would not engaged [*sic*] in assessment” of suicidality, violence, lethal means access, and psychosis. Family member 1 reported an increase in the patient’s paranoid [ideation](#) and behavior, current level of stress, and possible psychotic symptoms. The triage social worker documented that family member 1 stated that “they were able to fill [a] prescription for sleep aid and intended to take [the patient] home ‘where [the patient] can sleep’.” Family member 1 acknowledged being “aware of resources” if the patient “was to escalate or present as DTS [danger to self] or DTO [danger to others],” and was given the nurse practitioner’s “next available appointment in 11 days.” The next day, a case manager documented that the patient was “involved with an altercation/assault against” family members, family member 1 “expired at the scene,” and the patient was shot by family member 2 who was also being treated for trauma.

⁹ The nurse practitioner provided services to the patient via telehealth and was based in the Yuba City community-based outpatient clinic.

¹⁰ Ioana Todor, et al., “Evaluation of a Potential Metabolism-Mediated Drug-Drug Interaction Between Atomoxetine and Bupropion in Healthy Volunteers,” (May 28, 2016): 198-207. Combined atomoxetine and bupropion treatment can result in a drug interaction and consequently a greater risk of psychotic or manic symptoms.

OIG Findings

The OIG substantiated that in early 2022, the patient presented unscheduled to the Chico CBOC Mental Health Clinic “highly agitated, and was sent home,” and later that day had a violent altercation with family members. The OIG identified concerns related to same-day access including miscommunication between staff members and inadequate prescribing provider availability. Additionally, the OIG found that staff failed to provide the patient with adequate mental health triage and assessment, provided insufficient continuity of medication management, and facility leaders did not complete an institutional disclosure.¹¹

The Veterans Health Administration (VHA) requires that mental health services be provided when a patient has an “urgent need” for mental health services and that appointments are available for same-day crisis evaluation every day.¹² Facility policy states that prescribing providers “at all sites” must have same-day availability to accommodate those needs.¹³ The OIG found that the nurse practitioner did not have same-day availability to evaluate the patient and address medication change requests on the day of the patient’s unscheduled crisis visit because the nurse practitioner’s schedule was filled with scheduled appointments. Facility and mental health leaders’ failure to ensure prescribing providers’ same-day availability for urgent mental health needs may contribute to patients’ increased risk of adverse clinical outcomes including suicide, violence, and need for a higher level of care.

Further, the OIG determined that a licensed vocational nurse misinterpreted the nurse practitioner’s instruction that the patient “being assessed is the best option,” and mistakenly directed the patient to present to the Chico CBOC rather than to go to the Sacramento VA Medical Center for an evaluation. The OIG found that the licensed vocational nurse asked the nurse practitioner, through an instant message, whether the patient should present to the Chico CBOC for medication or go to the Sacramento VA Medical Center. The nurse practitioner then advised the licensed vocational nurse that medication was not likely to be helpful and that the patient “being assessed is the best option.” The nurse practitioner told the OIG that the intent of suggesting the patient be assessed was that the patient present to the Sacramento VA Medical

¹¹ VHA Directive 1004.08, *Disclosures of Adverse Events to Patients*, October 31, 2018. “VHA National Center for Patient Safety,” accessed July 21, 2022, <https://www.patientsafety.va.gov/about/faqs.asp>. Sentinel events are “unexpected occurrences involving death or serious physical or psychological injury, or risk thereof.” An institutional disclosure is a formal process for facility leaders and clinicians to inform a patient or patient’s personal representative of events during the patient’s care that resulted in death or serious injury and to provide information about rights and recourse. VHA requires that an institutional disclosure of sentinel events occur, regardless of whether they resulted from an error.

¹² VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. Deputy Under Secretary for Health for Operations and Management, *Eliminating Veteran Suicide: Ensuring Open and Sustained Access in Mental Health*, August 21, 2017, Attachment A, *Mental Health Open Access Standards*.

¹³ VA Northern California Health Care System, *General Mental Health Access Services*, October 13, 2021.

Center for an in-person assessment. However, the OIG found that the licensed vocational nurse mistakenly informed family member 1 that the nurse practitioner recommended the patient present to the Chico CBOC for an evaluation by mental health triage staff.

The triage social worker also noted that the patient “did not appear to be at imminent risk to harm self or others,” and documented the patient’s disposition as “Routine.” The triage social worker told the OIG that the patient did not present as paranoid.

The OIG found that when the patient was unable to engage in the risk assessment, the triage social worker did not follow VHA guidance and document pertinent clinical information including the patient’s risk and protective factors and reasons for the patient’s inability to complete the assessment.¹⁴ Further, the OIG determined that the triage social worker did not attempt to ask the patient’s family member about risk and protective factors. In an interview with the OIG, the triage social worker reported being unfamiliar with appropriate procedures when patients are unable to engage in risk assessments for suicide and violence and a belief that asking the family member would have further agitated the patient. Given the patient’s presentation, unavailability of the nurse practitioner, and the family member’s concerns about the patient’s paranoia, the OIG would have expected the triage social worker to document the reasons for not assessing suicide and violence risk with the patient and family member, and the patient’s risk and protective factors, as required by VHA.¹⁵ Further, the OIG would have expected the triage social worker to engage the patient’s family member to assess risk of suicide, violence, and lethal means access. Failure to assess risk and protective factors and engage family members in assessment of suicide and violence risk, may result in the omission of critical information and underestimation of a patient’s risk.

The OIG found that the nurse practitioner did not align medication management with established treatment guidelines, document a comprehensive rationale for medication choices for this complex patient, document medication instructions accurately, or schedule a follow-up appointment within the expected time frame after prescribing new medications.

Treatment for patients with co-occurring ADHD and bipolar disorder should initially focus on management of bipolar disorder, while use of ADHD medications without a mood stabilizer is not recommended.¹⁶ Further, medication guidelines advise that treating ADHD symptoms may induce a manic episode in patients at risk for bipolar disorder.¹⁷ The OIG found that the nurse

¹⁴ VHA Suicide Risk Identification, *What to do if a Veteran is Unwilling or Unable to Complete the C-SSRS or the VA Comprehensive Suicide Risk Evaluation (CSRE)*, January 20, 2021.

¹⁵ VHA Suicide Risk Identification, *What to do if a Veteran is Unwilling or Unable to Complete the C-SSRS or the VA Comprehensive Suicide Risk Evaluation (CSRE)*, January 20, 2021.

¹⁶ Giulio Perugi & Giulia Vannucchi, “The use of stimulants and atomoxetine in adults with comorbid ADHD and bipolar disorder,” *Expert Opinion on Pharmacotherapy*, (September 12, 2015): 2193-2204.

¹⁷ Eli Lilly and Company, *Strattera Medication Guide*, accessed February 2, 2022, https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/021411s048lbl.pdf.

practitioner prescribed atomoxetine for inattention symptoms, despite the relative contraindications due to the patient's history of bipolar disorder and the patient's declination of treatment for bipolar disorder and psychosis with a mood stabilizer.

Although the nurse practitioner documented that the patient should start bupropion and continue atomoxetine, the nurse practitioner reported that the intention was not for the patient to take both medications, having told the patient to "pick one," and that either medication might help manage symptoms. However, in an interview with the OIG, the nurse practitioner reported believing that the patient was unlikely to take either medication, and inaccurately documenting the medication instructions.

Additionally, the nurse practitioner reported that a one-month follow-up appointment "at a minimum" would have been appropriate but that scheduling challenges necessitated scheduling a follow-up appointment for approximately two months later. Failure to adhere to established treatment guidelines, document rationale and instructions accurately, and monitor new medication response within the expected time frame may contribute to patient and other clinician misunderstanding of medication protocols and a potential [adverse drug reaction](#).

The OIG found that, following the patient's adverse clinical outcome, facility leaders did not complete an institutional disclosure with the patient or the patient's family. The facility patient safety manager told the OIG that the patient's altercation with family members was not considered a sentinel event because "the event didn't happen to the patient, the patient committed a criminal act." The facility risk manager told the OIG that an institutional disclosure was not considered because the event occurred outside of the facility after the patient presented at the Chico CBOC. However, the OIG concluded that a violent act against another person may occur following an inadequate assessment of a patient's risk of harm to self or others and could be considered a sentinel event, regardless of where the violent act takes place. The OIG would expect facility leaders to consider completing an institutional disclosure due to documentation and scheduling deficiencies, as well as inadequacies in medication management and the patient's risk assessment.

The OIG did not substantiate that facility leaders failed to address Chico CBOC employee concerns regarding staff well-being after the patient's adverse clinical outcome, and inadequate mental health staffing levels. Facility mental health leaders also expressed concerns to the OIG about the lack of therapeutic environment in the Chico CBOC building design. The OIG found that facility leaders appropriately responded to staff concerns regarding the lack of a therapeutic environment at the Chico CBOC.

The OIG made five recommendations to the Facility Director related to same-day mental health prescribing provider access, risk assessment documentation, prescriber medication management continuity of care, institutional disclosure, and environmental changes to the Chico CBOC.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided acceptable action plans (see appendixes A and B). The OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.



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Abbreviations

ADHD	attention deficit/hyperactivity disorder
CBOC	community-based outpatient clinic
EHR	electronic health record
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate allegations that a patient presented unscheduled to the Chico Community-Based Outpatient Clinic in California (Chico CBOC) “highly agitated” and later was involved in a violent incident with family members. It was further alleged that facility leaders did not address employee concerns related to the adverse clinical outcome, and mental health staffing.¹ Further, the OIG identified concerns related to facility staff’s failure to provide same-day access, adequate mental health assessment, mental health triage, and continuity of care for medication management. The OIG also identified concerns that facility leaders failed to consider completing an institutional disclosure and did not address Chico CBOC building design issues.²

Background

The VA Northern California Health Care System (facility), part of Veterans Integrated Service Network (VISN) 21, provides services to over 250,000 patients. The VA Northern California Health Care System consists of two medical centers including the Sacramento VA Medical Center and Martinez VA Medical Center, and eight community-based outpatient clinics (CBOCs) including the Chico CBOC.³ The Chico CBOC offers a variety of services including primary care, mental health, and social work, and treated over 8,000 patients in fiscal year 2021.

Allegations and Related Concerns

On January 7, 2022, an anonymous complainant alleged that the patient presented to the Chico CBOC Mental Health Clinic “highly agitated, and was sent home,” and later had a violent incident with family members. During review of this allegation, the OIG identified additional concerns related to facility staff’s lack of same-day access, inadequate mental health assessment and triage, insufficient continuity of care for medication management, and consideration of completing an institutional disclosure. The complainant also alleged that facility leaders did not address Chico CBOC employee concerns including staff well-being after the patient’s adverse clinical outcome and mental health staffing levels. The OIG identified additional employee concerns related to the lack of therapeutic environment in the Chico CBOC building design.

¹ Within the context of this report, the OIG considered an adverse clinical outcome to be harm to self or others.

² VHA Directive 1004.08, *Disclosures of Adverse Events to Patients*, October 31, 2018. An institutional disclosure is a formal process for facility leaders and clinicians to inform a patient or patient’s personal representative of events during the patient’s care that resulted in death or serious injury and to provide information about rights and recourse.

³ The VA Northern California Health Care System CBOCs include the Auburn, Chico, Fairfield, Mare Island, McClellan, Redding, Yuba City, and Yreka clinics.

Scope and Methodology

The OIG initiated the inspection on February 24, 2022, and conducted a virtual site visit from March 14–17, 2022.⁴

The OIG team interviewed facility staff and leaders, and VISN 22 Clinical Resource Hub staff familiar with the patient’s care and relevant processes.⁵

The OIG reviewed relevant Veterans Health Administration (VHA) directives, handbooks, and memoranda; facility policies, standard operating procedures, organizational charts, peer reviews and peer review committee meeting minutes, and proposed Chico CBOC remodeling designs. The OIG team also reviewed the patient’s electronic health record (EHR).

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

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

⁴ The site visit was conducted virtually due to the Coronavirus (COVID-19) pandemic. “WHO Director-General’s Opening Remarks at the Media Briefing on COVID-19,” World Health Organization, accessed April 19, 2022, <https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-COVID-19---11-march-2020>. Merriam-Webster.com Dictionary, “pandemic,” accessed April 19, 2022, <https://www.merriam-webster.com/dictionary/pandemic>. “A pandemic is a disease outbreak over a wide geographic area that affects most of the population.” “Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It,” World Health Organization, accessed April 19, 2022, [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

⁵ “Clinical Resource Hubs Information Sheet,” VA, accessed June 7, 2022, https://www.ruralhealth.va.gov/docs/ORH_Clinical_Resource_Hubs-2022_FINAL-508.pdf. VA established Clinical Resource Hubs to provide support to underserved medical centers and improve access to care.

Patient Case Summary

The patient was in their 20s upon initiating VA care at the Bakersfield CBOC in late 2016.⁶ A psychiatrist diagnosed the patient with [posttraumatic stress disorder](#) and a rule out [attention deficit/hyperactivity disorder](#) (ADHD) diagnosis.⁷ The psychiatrist prescribed [bupropion](#) for mood and concentration. Approximately a month later, the patient reported the bupropion “was not helping,” and the psychiatrist prescribed [methylphenidate](#) “for ADHD.”

In early summer 2017, the patient, accompanied by two family members (family members 1 and 2), presented to the Chico CBOC seeking mental health treatment. A social worker documented that family member 2 reported that four days prior, the patient was released from an involuntary hold at a non-VA psychiatric unit. The social worker also documented that during the visit, the patient exhibited paranoia, agitation, and physical aggression towards family members 1 and 2. The patient declined “counseling service,” and family member 1 was provided with addresses of hospitals that provided “emergency medication.”⁸ Two days later, the patient was again admitted for eight days to a non-VA hospital for symptoms of [psychosis](#).⁹

Four days after the patient’s discharge from the non-VA hospital, a telehealth psychiatrist documented that the patient was calm and “in the midst of a major psychotic break,” that bupropion and methylphenidate were ineffective, and that [olanzapine](#) was well-tolerated.¹⁰ The patient reported “feeling better” and preferred to stop taking medications upon depletion of the two-week supply of olanzapine. The telehealth psychiatrist encouraged the patient to continue taking olanzapine to prevent rehospitalization.

Three weeks later, the telehealth psychiatrist documented that the patient reported feeling “quite happy” and “amazing” after getting sleep. The patient reported discontinuing and planning to “stay off” the olanzapine. The telehealth psychiatrist “cautioned patient to watch for any adverse change in mental status off meds.” From summer 2017 through late winter 2020, the telehealth psychiatrist intermittently prescribed the patient [benzodiazepine](#) medications for [anxiety](#),

⁶ “Locations,” VA, accessed July 7, 2022, <https://www.va.gov/greater-los-angeles-health-care/locations/>. The Bakersfield CBOC is part of the VA Greater Los Angeles Health Care System. The OIG uses the singular form of they (their) in this instance for privacy purposes.

⁷ American Psychological Association, APA Dictionary of Psychology, “differential diagnosis,” accessed July 8, 2022, <https://dictionary.apa.org/differential-diagnosis>. A provider may consider two or more diagnoses if a patient presents with signs or symptoms that are shared by more than one disorder. If additional data is needed to determine the diagnosis, the provider may document diagnoses as differential or rule-out. The OIG considers the terms differential and rule-out diagnoses to be equivalent terms. The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the “alt” and “left arrow” keys together.

⁸ The patient’s EHR did not contain documentation of non-VA mental health appointments.

⁹ Information regarding the patient’s non-VA hospital admissions was obtained from the patient’s EHR.

¹⁰ The patient was prescribed olanzapine during the non-VA hospital admission.

antipsychotic medication for paranoid thoughts, [amphetamine-dextroamphetamine](#) for inattention, [trazodone](#) for sleep, and [sertraline](#) for depression.

In spring 2020, the patient reported increased anxiety and paranoid thoughts and requested anxiety and antipsychotic medications. The telehealth psychiatrist documented that the patient was responding “well to [amphetamine-dextroamphetamine]” and prescribed [risperidone](#) for “thoughts,” [clonazepam](#) for anxiety, and [quetiapine](#) for sleep. A week later, the telehealth psychiatrist documented that the patient continued to present as paranoid and anxious, restarted sertraline, and discontinued amphetamine-dextroamphetamine.

Approximately a week later, a social worker discussed voluntary inpatient mental health treatment with another family member (family member 3) who presented to the Chico CBOC concerned about the patient’s psychotic symptoms and possible risk of being a danger to others. Family member 3 agreed to contact emergency personnel in case of a mental health crisis.

The next day, the telehealth psychiatrist recommended voluntary inpatient mental health treatment to the patient and family member 3. Later that day, the patient presented to the Sacramento VA Medical Center Emergency Department and was voluntarily admitted to the behavioral health intensive care unit with a diagnosis of psychotic disorder, not otherwise specified.¹¹ An inpatient provider increased the patient’s risperidone dosage and the patient “vastly improved” and “was no longer paranoid, [delusional](#),” and mood was “excellent.” After three days, the provider discharged the patient with a follow-up appointment two days later.

At the scheduled follow-up appointment, the telehealth psychiatrist documented that the patient benefited from the “brief hospitalization.” At the next visit a week later, the telehealth psychiatrist documented that the patient stopped taking all medications and presented in a “somewhat euphoric and [hypomanic](#) state.” The telehealth psychiatrist had a “lengthy discussion about the dangers of patient coming off meds” and the patient “agreed on a compromise” to continue risperidone and discontinue sertraline. A week later, the telehealth psychiatrist diagnosed the patient with [bipolar disorder](#) and documented that the patient reported medication compliance, presented with an “elevated mood” and “minimal insight into [the patient’s] condition.”

The next day, a nurse documented that the patient telephoned and expressed no longer wanting VA services, wanted “to take a break from MH [mental health] care,” and requested “a new doctor.” A social worker consulted with the telehealth psychiatrist and documented that “Vet is not recommended to change providers at this critical moment.”

¹¹ American Psychological Association, “not otherwise specified (NOS),” accessed August 23, 2022, <https://dictionary.apa.org/not-otherwise-specified>. Providers may assign a diagnosis as not otherwise specified when the patient’s symptoms are consistent with a family of disorders “but do not precisely meet the criteria established for specific diagnoses within the family.”

Approximately two weeks later, the social worker documented that the patient's mental health team met and recommended "a change of med [medication] management provider to [another] provider." That day, a clinical pharmacy specialist contacted the patient, scheduled an appointment for two weeks later, and documented the patient's request for [stimulant](#) medication. The clinical pharmacy specialist documented not being "authorized to prescribe stimulants" and referred the stimulant request to the telehealth psychiatrist to "renew prescription if [the telehealth psychiatrist] feels it is appropriate."

In early summer 2020, the patient attended the first appointment with the clinical pharmacy specialist who assessed the patient as "a bit manic," documented that the patient discontinued all psychiatric medications, and recommended the patient "stabilizing [*sic*] prior to adding a stimulant."¹² The patient continued medication management including [aripiprazole](#) for mood, and [clonidine](#) for anxiety with the clinical pharmacy specialist through early 2021 when the patient requested transfer of care to another psychiatrist. The clinical pharmacy specialist documented a plan to "transfer entire case to another provider," and a medical support assistant scheduled the patient with a clinical resource hub psychiatrist.

Approximately two weeks later, the patient attended the initial telehealth appointment with the clinical resource hub psychiatrist and described depression and anxiety symptoms. The clinical resource hub psychiatrist diagnosed "likely bipolar disorder, PTSD [posttraumatic stress disorder], GAD [generalized anxiety disorder], cannabis use," continued aripiprazole, and added [lamotrigine](#) for mood with a plan to "hold off on restarting [amphetamine-dextroamphetamine]" until the patient's mood stabilized." About a month later, the clinical resource hub psychiatrist documented the patient's improved mood, impulsivity, distraction, procrastination, and difficulty with focus, attention, and task completion, and restarted amphetamine-dextroamphetamine. A clinical resource hub nurse documented the patient's continued stability in late spring 2021.

In summer 2021, the patient requested medication for anxiety and another clinical pharmacy specialist prescribed [hydroxyzine](#) for anxiety. About a month later, the patient requested medication for anxiety and sleep and the clinical pharmacy specialist prescribed [gabapentin](#), continued lamotrigine and aripiprazole, and discontinued clonidine and hydroxyzine because the patient was no longer taking the medication. The clinical pharmacy specialist also noted that amphetamine-dextroamphetamine may contribute to anxiety or insomnia and advised the clinical resource hub psychiatrist to consider a decrease in the dosage, discontinuation, or temporary suspension of the medication. At the scheduled follow-up appointment four days later, the clinical resource hub psychiatrist prescribed [zolpidem](#) for poor sleep and [alprazolam](#) for anxiety, and continued amphetamine-dextroamphetamine, lamotrigine, and aripiprazole.¹³ Two weeks

¹² The clinical pharmacy specialist notified the telehealth psychiatrist through the patient's EHR, and the telehealth psychiatrist prescribed amphetamine-dextroamphetamine monthly beginning summer 2020 until early winter 2021.

¹³ In summer 2021, another clinical pharmacy specialist prescribed the patient medication for anxiety after a telephone visit and deferred additional medication changes to the clinical resource hub psychiatrist.

later, the clinical resource hub nurse documented that the patient reported discontinuing aripiprazole and lamotrigine, and resuming use of cannabis. In response, the clinical resource hub psychiatrist discontinued zolpidem and alprazolam “since [the patient] noted the reason for increased anxiety and insomnia was no longer using cannabis,” and the patient “restarted using cannabis.”

In early fall 2021, the patient reported a “good” mood, improved sleep, and not wanting “to take any mood stabilizing medication.” The clinical resource hub psychiatrist informed the patient that a stimulant medication would not be prescribed without a mood stabilizer medication, and the patient stated being “fine with that at this time.” The clinical resource hub psychiatrist informed the patient of leaving the clinic the next month and a plan to “remain available for assistance during the transition.”

In late fall 2021, the patient attended the first telehealth appointment with a psychiatric nurse practitioner (nurse practitioner) and reported difficulty concentrating, not taking any psychiatric medications, and requested a stimulant medication.¹⁴ The nurse practitioner discussed “concerns regarding stimulant use and bipolar disorder,” prescribed non-stimulant [atomoxetine](#) for inattention, reviewed the “risks, benefits, and side effects” of the medication, and scheduled a two-month follow-up appointment.

Two days later, the patient called, reported not yet receiving the atomoxetine, and requested “something that can help quicker.” The nurse practitioner started a “time-limited bupropion prescription, continuing atomoxetine,” and wrote again, in the same progress note, the plan to start bupropion and continue atomoxetine.

At 8:30 a.m. in early 2022, 22 days before the patient’s scheduled follow-up appointment, a licensed vocational nurse received a message from a medical support assistant noting that the patient reported “being in crisis and very anxious.” At 9:00 a.m., the licensed vocational nurse left a voicemail message for the patient and an hour later received a call from family member 1 reporting having received a text message from the patient asking family member 1 to “come be with [the patient],” or take the patient to the hospital “right away.” Family member 1 denied that the patient was a danger to self or others. The licensed vocational nurse contacted the nurse practitioner “to advise on best course of action” and then directed family member 1 to transport the patient to the Chico CBOC for an evaluation by mental health triage staff.

At 2:30 p.m., the patient and family member 1 presented to the Chico CBOC. A triage social worker documented that the patient reported poor sleep and presented “highly agitated, restless/fidgety, teary and demanding to be prescribed [*sic*] [alprazolam] for anxiety.” Further, the triage social worker documented that the patient repeatedly interrupted, denied current diagnoses of depression and bipolar disorder, expressed frustration with the recent prescribing provider

¹⁴ The nurse practitioner provided services to the patient via telehealth and was based at the Yuba City community-based outpatient clinic.

change, and declined psychiatric assessment at the Sacramento VA Medical Center. The triage social worker documented that the “Veteran was not open to dialogue,” “Would not engaged [*sic*] in assessment” of suicidality, violence, lethal means access, and psychosis. The triage social worker noted the patient’s disposition as “Routine” and that the patient “did not appear to be at imminent risk to harm self or others.” Family member 1 reported an increase in the patient’s paranoid [ideation](#) and behavior, current level of stress, and possible psychotic symptoms. The triage social worker documented that family member 1 stated that “they were able to fill [a] prescription for sleep aid and intended to take [the patient] home ‘where [the patient] can sleep’.” Family member 1 acknowledged being “aware of resources” if the patient “was to escalate or present as DTS [danger to self] or DTO [danger to others],” and was given the nurse practitioner’s “next available appointment in 11 days.”

The next day, a case manager documented that the patient was in the intensive care unit at a non-VA hospital with “multiple gunshot wounds.” The transitions of care case manager documented that the patient was “involved with an altercation/assault against” family members, family member 1 “expired at the scene,” and the patient was shot by family member 2 who was also being treated for trauma.

The next day, family member 3 told a veterans justice outreach program social worker that the patient “shot and killed” family member 1, was “currently incarcerated,” and believed the patient to have been in a psychotic state. The veterans justice outreach program social worker informed family member 3 about the role of the veterans justice outreach program and would “follow up and do what we can.”¹⁵ Approximately two weeks later, a county sergeant advised a mental health program operations manager that “due to this being an open case, telephone contact for future services would not be approved and any correspondence regarding future services would need to go through [the patient’s] attorney or by mail.”

EHR Documentation Entry Following Adverse Clinical Outcome

Approximately a month after the patient’s unscheduled visit to the Chico CBOC, the triage social worker added an addendum to the progress note from the patient’s visit to triage that stated that the triage social worker “did not find [the patient] to be danger to self or others, but rather [the patient’s] presentation was consistent with drug seeking behavior,” had consulted “directly with [the patient’s] assigned prescriber who did not think a medication adjustment to include [alprazolam] was an appropriate intervention at this time,” and suggested that the patient “present [self] at Mather or Enloe ED for immediate assessment for requested medication.” The triage social worker documented that the patient “abruptly left the room,” and family member 1

¹⁵ “VA Homeless Programs: Veterans Justice Outreach Program,” VA, accessed July 13, 2022, <https://www.va.gov/HOMELESS/vjo.asp>. The veterans justice outreach program facilitates access to VA services for justice-involved veterans through partnerships between VA and the criminal justice system.

voiced a plan to “provide [the patient] with environment to rest, eat and re-assess in the morning if appropriate to take [the patient] to Mather for medication assessment.”

The triage social worker and mental health leaders told the OIG that upon learning of the patient’s adverse clinical outcome, mental health leaders reviewed the care provided, discussed the early 2022 episode of care with the triage social worker, and requested that the triage social worker add factual information to the patient’s EHR that was omitted from the initial documentation. The triage social worker noted that due to unexpected leave, the additional information was added approximately a month later.

Inspection Results

1. Deficiencies in the Patient’s Outpatient Mental Health Care

The OIG substantiated that in early 2022, the patient presented unscheduled to the Chico CBOC Mental Health Clinic “highly agitated, and was sent home,” and later had a violent altercation with family members. The OIG identified concerns related to same-day access including miscommunication between staff members and inadequate prescribing provider availability. The OIG also found that staff failed to provide the patient with adequate mental health triage and assessment that day and provided insufficient continuity of medication management. Further, facility leaders did not complete an institutional disclosure.

Inadequate Prescribing Provider Same-Day Access

VHA requires that mental health services be provided when a patient has an “urgent need” for mental health services and that appointments are available for same-day crisis evaluation every day.¹⁶ Facility policy states that a patient can “walk-in or call in without a scheduled appointment,” for symptom-related complaints or medication needs and instructs that when a patient has a medication-related need, a triage provider or designated clinician or nurse care coordinator will meet with the patient the same day.¹⁷ Facility policy also instructs same-day access clinicians to complete a clinical interview and assessment, determine follow-up plan, and coordinate follow-up appointments.¹⁸ During a triage assessment, the same-day access clinician may determine that an appointment with a prescribing provider is appropriate that day.¹⁹

¹⁶ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. Deputy Under Secretary for Health for Operations and Management, *Eliminating Veteran Suicide: Ensuring Open and Sustained Access in Mental Health*, August 21, 2017, Attachment A, *Mental Health Open Access Standards*.

¹⁷ VA Northern California Health Care System, *Patient Access to Mental Health and/or Substance Abuse Services Care*, June 25, 2016. VA Northern California Health Care System, *General Mental Health Access Services*, September 5, 2021.

¹⁸ VA Northern California Health Care System, *General Mental Health Access Services*, September 5, 2021.

¹⁹ VA Northern California Health Care System, *General Mental Health Access Services*, September 5, 2021.

Prescribing providers “at all sites” must have same-day availability to accommodate those needs.²⁰

On a day in early 2022, a licensed vocational nurse documented a call from family member 1 who reported concerns about the patient’s well-being and denied that the patient expressed suicidal or homicidal ideation. The licensed vocational nurse documented that the nurse practitioner advised the patient to present “to the Chico clinic for face to face evaluation by BH [behavioral health] triage.” The OIG found that the licensed vocational nurse asked the nurse practitioner, through an instant message, “What is the best option? Have [the patient] pick up the [zolpidem] at Chico or go” to the behavioral health intensive care unit at the Sacramento VA Medical Center. The nurse practitioner then advised the licensed vocational nurse that the patient “being assessed is the best option,” and “[zolpidem] isnt [*sic*] likely to have much mood stabilizing effect.” The nurse practitioner told the OIG that the intent of suggesting the patient be assessed was that the patient present to the Sacramento VA Medical Center for an in-person assessment. However, the OIG found that the licensed vocational nurse mistakenly informed family member 1 that the nurse practitioner recommended the patient present to the Chico CBOC for mental health triage.

Approximately four hours later, the patient presented to the Chico CBOC and met with the triage social worker. The triage social worker alerted the nurse practitioner to the patient’s request for anxiety medication. The nurse practitioner stated, “I have no plans to prescribe additional medication at this time,” and instructed the triage social worker to “evaluate for appropriate level of care.” The triage social worker scheduled the patient for the nurse practitioner’s “next available appointment in 11 days” and the patient refilled zolpidem.²¹

In addition to declining to prescribe additional medication, the nurse practitioner reported to the OIG not having same-day access availability the day the patient presented to the Chico CBOC in crisis requesting medications.²² The OIG found that the nurse practitioner’s schedule on the day of the event included nine available appointments that were filled with nine scheduled appointments and no same-day availability. The OIG found that the nurse practitioner’s schedule included two 30-minute same-day access appointments. However, that day a new patient was scheduled for a 60-minute appointment during the same-day access appointment times, resulting in no same-day access. The nurse practitioner told the OIG that, at that time, new or established patients were scheduled leaving no same-day access.

The assistant chief, Mental Health Services told the OIG that same-day appointments were reallocated, as clinically needed, due to two prescribing providers no longer providing medication management services at the Chico CBOC facility and underutilization of same-day

²⁰ VA Northern California Health Care System, *General Mental Health Access Services*, September 5, 2021.

²¹ The clinical resource hub psychiatrist initially prescribed zolpidem on August 9, 2021, with three refills.

²² The nurse practitioner had nine appointments scheduled within the 8:00 a.m. to 4:30 p.m. tour of duty.

clinics. Further, the assistant chief, Mental Health Services speculated that the new patient was scheduled into the nurse practitioner's same-day appointment times the day of the patient's unscheduled visit because of the new patient's intensive mental health needs. In March 2022, the nurse practitioner reported to the OIG having one-hour of same-day access four days a week.

The OIG determined that a licensed vocational nurse mistakenly understood the nurse practitioner's instant message to indicate that the patient should present to the Chico CBOC rather than to go to the Sacramento VA Medical Center for evaluation as was suggested. The OIG also found that the nurse practitioner did not have same-day availability to evaluate the patient and address medication change requests on the day of the patient's unscheduled crisis visit. Leaders' failure to ensure prescribing providers' same-day availability for urgent mental health needs may contribute to patients' increased risk of adverse clinical outcomes including suicide, violence, and need for a higher level of care.

Inadequate Mental Health Assessment and Triage

The OIG found that the triage social worker failed to adequately assess the patient's risk of suicide and violence including access to lethal means when the patient presented, in crisis, to the Chico CBOC mental health triage.

Facility procedure states that the triage clinician is responsible for assessing the patient's risk for harm to self or others. The mental health triage note template includes a suicide risk screen, which is completed annually and "when clinically indicated," and prompts the clinician to inquire about assaultive behaviors.²³ VHA instructs that when a patient is unwilling or unable to complete a suicide risk assessment, the provider should document pertinent clinical information including the patient's risk and protective factors and reasons for the patient's inability to complete the assessment.²⁴

Facility mental health leaders told the OIG that facility staff are encouraged to engage family members in assessments of suicide and violence risk, and that efforts to follow up with family or a provider should occur if a patient is unwilling or unable to complete a risk assessment. However, the OIG found that when the patient was unable to engage in the risk assessment, the triage social worker failed to document risk and protective factors and did not engage family member 1 in an assessment of the patient's risk for suicide or violence.

When the patient presented to the Chico CBOC triage clinic, the triage social worker documented that the patient was "highly agitated, restless/fidgety, teary and demanding to be prescribed [*sic*] [alprazolam] for anxiety," "was not open to dialogue," and "Would not engaged [*sic*] in assessment" of suicidality, violence, lethal means access, or psychosis. The triage social

²³ VA Northern California Health Care System, *General Mental Health Access Services*, September 5, 2021.

²⁴ VHA Suicide Risk Identification, *What to do if a Veteran is Unwilling or Unable to Complete the C-SSRS or the VA Comprehensive Suicide Risk Evaluation (CSRE)*, January 20, 2021.

worker told the OIG that the patient did not present as paranoid. The triage social worker also noted that the patient “did not appear to be at imminent risk to harm self or others,” and documented the patient’s disposition as “Routine.” The triage social worker documented that family member 1 stated being “aware of resources” if the patient “was to escalate or present as DTS [danger to self] or DTO [danger to others],” that “they were able to fill prescription for sleep aid and intended to take [the patient] home ‘where [the patient] can sleep’.” In an interview with the OIG, the triage social worker recalled that family member 1 planned to take the patient home to get some sleep, would reassess the need for assistance the next day, and knew how to access help if needed emergently.

In an interview with the OIG, the triage social worker reported an inability to engage the patient in lethality assessments for suicide and homicide and reported being unfamiliar with appropriate procedures when patients are unable to engage in risk assessments for suicide and violence. The triage social worker told the OIG that family member 1 was not asked questions about the patient’s risk for suicide and violence because of the belief that asking the family member would have further agitated the patient. The triage social worker told the OIG that the family member was aware of emergency resources and was provided with the triage social worker’s contact information.

The OIG found that when the patient was unable to engage in the risk assessment, the triage social worker failed to follow VHA guidance and document pertinent clinical information including the patient’s risk and protective factors and reasons for the patient’s inability to complete the assessment.²⁵ Further, the OIG determined that the triage social worker did not attempt to ask the patient’s family member about risk and protective factors. Given the patient’s presentation, unavailability of the prescribing provider, and the family member’s concerns about the patient’s paranoia and possible psychosis, the OIG would have expected the triage social worker to document the reasons for not assessing suicide and violence risk with the patient and family member, and the patient’s risk and protective factors, as required by VHA.²⁶ Further, the OIG would have expected the triage social worker to engage the patient’s family member to assess risk of suicide, violence, and lethal means access. Failure to assess risk and protective factors and engage family members in assessment of suicide and violence risk, may result in the omission of critical information and underestimation of a patient’s risk.

Deficiencies in Continuity of Care for Medication Management

The OIG found that the nurse practitioner prescribed medication for inattention symptoms, despite the relative contraindications due to the patient’s history of bipolar disorder and the

²⁵ VHA Suicide Risk Identification, *What to do if a Veteran is Unwilling or Unable to Complete the C-SSRS or the VA Comprehensive Suicide Risk Evaluation (CSRE)*, January 20, 2021.

²⁶ VHA Suicide Risk Identification, *What to do if a Veteran is Unwilling or Unable to Complete the C-SSRS or the VA Comprehensive Suicide Risk Evaluation (CSRE)*, January 20, 2021.

patient's declination of treatment for bipolar disorder and psychosis with a mood stabilizer. Additionally, the nurse practitioner failed to accurately document the medication management plan in the patient's EHR and schedule timely follow-up.

VHA and facility policy require that prescribing providers utilize evidence-based pharmacotherapy strategies to choose medications, monitor patients' side effects and outcomes, and modify treatment as appropriate.²⁷ Facility policy further states that providers will monitor treatment "with an appropriate frequency."²⁸ Treatment guidelines and research recommend to "treat bipolar symptoms first with mood stabilizers and/or [atypical antipsychotics](#) to stabilize mood before considering treatment for ADHD symptoms."²⁹ Clinical practice guidelines state that patients who have had one or more manic episodes "should be encouraged to continue on life-long" treatment with a mood stabilizer or antipsychotic medication.³⁰ Treatment for patients with co-occurring ADHD and bipolar disorder should initially focus on management of bipolar disorder, while use of ADHD medications without a mood stabilizer is not recommended.³¹ Further, medication guidelines advise that treating ADHD symptoms may induce a manic episode in patients at risk for bipolar disorder.³²

Stimulant medications are the most prescribed medication to treat ADHD.³³ Facility policy encourages prescribing providers to consider a trial of an alternative medication prior to using stimulant medications and to document the rationale for [off-label](#) medication use.³⁴ Atomoxetine

²⁷ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. Facility Standard Operating Procedure 116-26, *Standard Procedures for Prescription of Psychotropic Medications*, October 27, 2020.

²⁸ Facility Standard Operating Procedure 116-26, *Standard Procedures for Prescription of Psychotropic Medications*, October 27, 2020.

²⁹ Lakshmi M. Yatham, et al., "Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder," *Bipolar Disorders*, (April 21, 2018): 97-170. Giulio Perugi & Giulia Vannucchi, "The use of stimulants and atomoxetine in adults with comorbid ADHD and bipolar disorder," *Expert Opinion on Pharmacotherapy*, (September 12, 2015): 2193-2204.

³⁰ VA/DoD Clinical Practice Guideline for Management of Bipolar Disorder in Adults, *Management of Bipolar Disorder in Adults (BD)*, May 2010.

³¹ Giulio Perugi & Giulia Vannucchi, "The use of stimulants and atomoxetine in adults with comorbid ADHD and bipolar disorder," *Expert Opinion on Pharmacotherapy*, (September 12, 2015): 2193-2204.

³² Eli Lilly and Company, *Strattera Medication Guide*, accessed February 2, 2022, https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/021411s0481bl.pdf.

³³ Mayo Clinic, "Adult attention-deficit/hyperactivity disorder (ADHD)," accessed June 24, 2022, <https://www.mayoclinic.org/diseases-conditions/adult-adhd/symptoms-causes/syc-20350878>.

³⁴ Facility Standard Operating Procedure 116-26, *Standard Procedures for Prescription of Psychotropic Medications*, October 27, 2020. VA Center for Medication Safety And VHA Pharmacy Benefits Management Strategic Healthcare Group and the VA Medical Advisory Panel, "Pharmaceutical Use Outside of Approved Indications, Guidance on 'Off-Label' Prescribing," May 2004, accessed November 3, 2022, <https://www.pbm.va.gov/PBM/vacenterformedicationsafety/directive/GuidanceOffLabelPrescribing.pdf>. VHA does not specifically require providers to discuss off-label use of medication with patients and advises that "Evidence of benefit (and importantly, risk) should be explicitly reviewed."

is a non-stimulant medication approved to treat ADHD. Bupropion is approved for the treatment of depression. Off-label uses of bupropion include the treatment of ADHD.³⁵ Combined atomoxetine and bupropion treatment can result in a drug interaction and consequently a greater risk of an [adverse drug reaction](#) including psychotic or manic symptoms.³⁶

In late fall 2021, the nurse practitioner documented the patient's history of bipolar disorder and ADHD diagnoses and prescribed atomoxetine for the treatment of attentional difficulties. The nurse practitioner discussed "concerns regarding stimulant use and bipolar disorder," and the patient reported previous stimulant trials without a mood stabilizer "and I've been fine." In the next scheduled visit two days later, the nurse practitioner documented that the patient reported having not received the ordered atomoxetine and requested a medication "that can help quicker." The nurse practitioner documented instructions twice in the note from that day's visit for the patient to start bupropion and continue atomoxetine.

The nurse practitioner told the OIG that the patient wanted a stimulant medication for inattention, was not agreeable to a mood stabilizer, and did not exhibit current symptoms of psychosis or bipolar disorder. The nurse practitioner reported prescribing a non-stimulant ADHD medication, atomoxetine, as an alternative to the patient's request for a stimulant medication. The nurse practitioner told the OIG that when the patient returned two days after the initial visit, the patient expressed not wanting to take the atomoxetine, although the medication was already processed and in the mail. Although the nurse practitioner documented that the patient should start bupropion and continue atomoxetine, the nurse practitioner reported that the intention was not for the patient to take both medications, having told the patient to "pick one," and that either medication might help manage symptoms. The nurse practitioner acknowledged a lack of evidence to support atomoxetine and bupropion as having less risk than stimulant medication. However, in an interview with the OIG, the nurse practitioner reported believing that the patient was unlikely to take either medication, and inaccurately documenting the medication instructions.

Further, the nurse practitioner documented that the patient should follow up "in 2 months or sooner if needed." In an interview with the OIG, the nurse practitioner reported that a one-month follow-up appointment "at minimum" would have been appropriate but that scheduling challenges necessitated scheduling a follow-up appointment for approximately two months later.

³⁵ Ioana Todor, et al., "Evaluation of a Potential Metabolism-Mediated Drug-Drug Interaction Between Atomoxetine and Bupropion in Healthy Volunteers," (May 28, 2016): 198-207. Food and Drug Administration, *Understanding Unapproved Use of Approved Drugs "Off Label,"* accessed June 24, 2022, <https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/understanding-unapproved-use-approved-drugs-label>. Once a medication is FDA approved, providers may prescribe the medication for an unapproved use if deemed "medically appropriate" for the patient.

³⁶ Ioana Todor, et al., "Evaluation of a Potential Metabolism-Mediated Drug-Drug Interaction Between Atomoxetine and Bupropion in Healthy Volunteers," (May 28, 2016): 198-207.

Additionally, the chief medical director, Mental Health Services (medical director), told the OIG that a two-week follow-up would be “ideal” and four-week follow-up “reasonable.”

In an interview with the OIG, the medical director denied concerns about the nurse practitioner’s medication management of the patient despite acknowledging a risk of triggering manic symptoms. The medical director was unaware that the nurse practitioner documented adding bupropion to atomoxetine, and was not concerned about the established drug interaction.³⁷

The OIG found that the nurse practitioner did not

- align medication management with established treatment guidelines,
- document a comprehensive rationale for medication choices for this complex patient,
- document medication instructions accurately, or
- schedule a follow-up appointment within the expected time frame after prescribing new medications.

Failure to adhere to established treatment guidelines, document rationale and instructions accurately, and monitor new medication response within the expected time frame may contribute to patient and other clinician misunderstanding of medication protocols and adverse drug reactions.

Institutional Disclosure Considerations

An institutional disclosure is a formal process for facility leaders and clinicians to inform a patient or patient’s personal representative of events during the patient’s care that resulted in death or serious injury and to provide information about rights and recourse. VHA requires that an institutional disclosure of sentinel events occur, regardless of whether they resulted from an error.³⁸ The institutional disclosure must be completed regardless of when the sentinel event is discovered.³⁹

Facility leaders did not complete an institutional disclosure with the patient or the patient’s family. The facility patient safety manager told the OIG that the patient’s altercation with family members was not considered a sentinel event because “the event didn’t happen to the patient, the patient committed a criminal act.” The facility risk manager told the OIG that an institutional disclosure was not considered because the event occurred outside of the facility after the patient presented at the Chico CBOC. However, the OIG concluded that a violent act against another

³⁷ Ioana Todor, et al., “Evaluation of a Potential Metabolism-Mediated Drug-Drug Interaction Between Atomoxetine and Bupropion in Healthy Volunteers,” (May 28, 2016): 198-207.

³⁸ VHA Directive 1004.08, *Disclosures of Adverse Events to Patients*, October 31, 2018. “VHA National Center for Patient Safety,” VA, accessed July 21, 2022, <https://www.patientsafety.va.gov/about/faqs.asp>. Sentinel events are “unexpected occurrences involving death or serious physical or psychological injury, or risk thereof.”

³⁹ VHA Directive 1004.08.

person may occur following an inadequate assessment of a patient’s risk of harm to self or others and could be considered a sentinel event, regardless of where the violent act took place.

The medical director reported a discussion with the nurse practitioner about the deficiencies in EHR documentation and the expectation of a sooner follow-up appointment based on starting an ADHD medication without a mood stabilizer. In addition to documentation and scheduling deficiencies, the OIG identified concerns related to medication management prior to the patient’s mental health crisis in early 2022. Further, as discussed above, the OIG found that the triage social worker failed to adequately assess the patient’s risk of suicide and violence. As such, the OIG would expect facility leaders to consider completing an institutional disclosure.

2. Facility Leaders’ Response to Employee Concerns

The OIG did not substantiate that facility leaders failed to address Chico CBOC employee concerns regarding staff well-being after the patient’s adverse clinical outcome, and inadequate mental health staffing levels.

VA requires that employee relations programs “identify, prevent, and make reasonable efforts to resolve employee dissatisfactions.”⁴⁰ Further, VA supervisors “are expected to give full and fair consideration to employee complaints and causes of dissatisfaction.”⁴¹ VHA also requires that if gaps are identified in care, there must be an increase in staffing or telemental health, referrals made to mental health community services, or referrals to a “nearby VA facility.”⁴²

The OIG found that facility leaders were attentive to employees’ well-being after the patient’s adverse clinical outcome. Chico CBOC staff told the OIG that after the adverse clinical outcome, the program operations manager notified staff individually, provided support and Employee Assistance Program resources, and offered staff time off. Further, facility leaders facilitated group debriefing sessions with facility chaplains on three occasions, as well as opportunities for staff to meet individually with a chaplain, during the two weeks following the adverse clinical outcome.

In early December 2021, VISN leaders reviewed facility leaders’ proposal for increased mental health staff and funding. In interviews with the OIG, Chico CBOC staff reported shortages of mental health providers, including not having an on-site prescribing provider. Facility leaders told the OIG that the staff shortages were, in part, due to staff turn-over as well as difficulty recruiting new providers. In response to the staff shortages and recruitment challenges, facility

⁴⁰ VA Directive 5021, *Employee/Management Relations*, April 15, 2002, revised December 28, 2017. Unless otherwise specified, the language in the April 2002 was retained in the 2017 revision.

⁴¹ VA Directive 5021, *Employee/Management Relations*, April 15, 2002, revised December 28, 2017. Unless otherwise specified, the language in the April 2002 was retained in the 2017 revision.

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

leaders ensured the use of telehealth and community care.⁴³ Facility leaders told the OIG that a psychiatrist and social worker began providing treatment at the Chico CBOC in January and June 2022, respectively. Additionally, as of October 13, 2022, a nurse and social worker were selected and pending start dates.

Facility mental health leaders also expressed concerns to the OIG about the lack of therapeutic environment in the Chico CBOC building design. Facility mental health leaders told the OIG that the Chico CBOC Mental Health Clinic did not allow for privacy or confidentiality because it was designed as a large common area, did not have a “warm” or “homey” feel, and did not have a private waiting area. VHA outpatient mental health clinics must (1) be an “attractive, therapeutic environment,” (2) preserve patient confidentiality, and (3) provide a private waiting area that can be observed from the reception area.⁴⁴ The associate chief of staff, Mental Health told the OIG that concerns about the clinic design had been communicated to the facility’s Associate Director. The facility’s Associate Director told the OIG about planned corrective actions including interior design and re-constructing mental health space.

A January 2022 renovation proposal noted that, although the rooms meet the needs of medical exam rooms, “they fail to provide the needed sense of welcoming and emotional safety when providing mental health treatment,” and that a “registration and front desk area for mental health has never been established.” The renovation proposal included plans to enhance the comfort of the environment to support mental health work more effectively including reconfiguring space, painting, and adding artwork and furniture. As of July 2022, the facility’s Associate Director reported that interior design renovations were completed and that the timeline for re-construction was pending budget approval and funding availability.

The OIG did not substantiate that facility leaders failed to address Chico CBOC employee concerns including staff well-being after the patient’s adverse clinical outcome, and mental health staffing levels. Facility leaders offered support and facilitated staff debriefing meetings following the patient’s adverse clinical outcome. Additionally, facility leaders appropriately responded to staff concerns regarding mental health staffing and the lack of a therapeutic environment at the Chico CBOC.

⁴³ Facility leaders told the OIG that a clinical pharmacy specialist, nurse practitioner, and psychiatrists provided treatment virtually at the Chico CBOC and provided data demonstrating utilization of community care for mental health services from October 1, 2019, through September 30, 2021.

⁴⁴ VA, Office of Construction and Facilities Management, *Mental Health Facilities Design Guide*, December 2010, revised December 1, 2017.

Conclusion

The OIG substantiated that in early 2022, the patient presented unscheduled to the Chico CBOC Mental Health Clinic “highly agitated, and was sent home,” and later had a violent altercation with family members.

A nurse practitioner did not have same-day availability to evaluate the patient and address medication change requests on the day of the patient’s unscheduled crisis visit because the nurse practitioner’s schedule was filled with scheduled appointments, inconsistent with VHA requirements.⁴⁵ A licensed vocational nurse misinterpreted the nurse practitioner’s instruction that the patient “being assessed is the best option,” and mistakenly directed the patient to present to the Chico CBOC rather than to go to the Sacramento VA Medical Center for an evaluation. Leaders’ failure to ensure prescribing providers’ same-day availability for urgent mental health needs may contribute to patients’ increased risk of adverse clinical outcomes including suicide, violence, and need for a higher level of care.

The triage social worker did not follow VHA guidance and document pertinent clinical information including the patient’s risk and protective factors and reasons for the patient’s inability to complete the assessment when the patient was unable to engage in the risk assessment.⁴⁶ The triage social worker did not attempt to ask the patient’s family member about risk and protective factors. Given the patient’s presentation, unavailability of the prescribing provider, and the family member’s concerns about the patient’s paranoia and possible psychosis, the OIG would have expected the triage social worker to document the reasons for not assessing suicide and violence risk with the patient and family member, and the patient’s risk and protective factors, as required by VHA.⁴⁷ Failure to assess risk and protective factors and engage family members in assessment of suicide and violence risk, may result in the omission of critical information and underestimation of a patient’s risk.

The nurse practitioner did not align medication management with established treatment guidelines, document a comprehensive rationale for medication choices for this complex patient, document medication instructions accurately, or schedule a follow-up appointment within the expected time frame after prescribing new medications. Failure to adhere to established treatment guidelines, document rationale and instructions accurately, and monitor new

⁴⁵ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. Deputy Under Secretary for Health for Operations and Management, *Eliminating Veteran Suicide: Ensuring Open and Sustained Access in Mental Health*, August 21, 2017, Attachment A, *Mental Health Open Access Standards*. VA Northern California Health Care System, *General Mental Health Access Services*, October 13, 2021.

⁴⁶ VHA Suicide Risk Identification, *What to do if a Veteran is Unwilling or Unable to Complete the C-SSRS or the VA Comprehensive Suicide Risk Evaluation (CSRE)*, January 20, 2021.

⁴⁷ VHA Suicide Risk Identification, *What to do if a Veteran is Unwilling or Unable to Complete the C-SSRS or the VA Comprehensive Suicide Risk Evaluation (CSRE)*, January 20, 2021.

medication response within the expected time frame may contribute to patient and other clinician misunderstanding of medication protocols and adverse drug reactions.

Following the patient's adverse clinical outcome, facility leaders did not complete an institutional disclosure with the patient or the patient's family. The OIG would expect facility leaders to consider completing an institutional disclosure due to documentation and scheduling deficiencies, as well as inadequacies in medication management and the patient's risk assessment.

The OIG did not substantiate that facility leaders failed to address Chico CBOC employee concerns regarding staff well-being after the patient's adverse clinical outcome, and inadequate mental health staffing levels. Facility mental health leaders also expressed concerns to the OIG about the lack of therapeutic environment in the Chico CBOC building design. Facility leaders appropriately responded to staff concerns regarding the lack of a therapeutic environment at the Chico CBOC.

Recommendations 1–5

1. The VA Northern California Health Care System Director ensures mental health prescribing provider same-day access.
2. The VA Northern California Health Care System Director makes certain that when a patient cannot engage in a risk assessment, the provider documents the reasons for the patient's inability to complete the assessment, and risk and protective factors, as required by the Veterans Health Administration.
3. The VA Northern California Health Care System Director ensures the nurse practitioner documents in patients' electronic health records the comprehensive rationale for medication choices, schedules follow-up appointments consistent with clinical monitoring needs, and accurately documents medication instructions.
4. The VA Northern California Health Care System Director conducts a full review of the patient's care, determines if an institutional disclosure is warranted, and takes action as indicated.
5. The VA Northern California Health Care System Director expedites planned environmental changes to the Chico Community-Based Outpatient Mental Health Clinic.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 27, 2022

From: Director, Sierra Pacific Network (10N21)

Subj: Healthcare Inspection—Inadequate Outpatient Mental Health Triage and Care of a Patient at the
Chico Community-Based Outpatient Clinic in California

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

1. I have reviewed and concur with the responses provided by the VA Northern California Health Care System.
2. If you have additional questions or need further information, please contact the VISN 21 Quality Management Officer.

(Original signed by:)

John Brandecker, MBA, MPH
Network Director
VA Sierra Pacific Network, VISN 21

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 21, 2022

From: Director, Chico Community-Based Outpatient Clinic (612/00)

Subj: Healthcare Inspection—Inadequate Outpatient Mental Health Triage and Care of a Patient at the Chico Community-Based Outpatient Clinic in California

To: Director, Sierra Pacific Network (10N21)

1. We appreciate the opportunity to review the draft report of recommendations from the OIG Health Care virtual inspections conducted at the VA Northern California Healthcare System from March 14–17, 2022.
2. Please find the attached response to each recommendation included in the report. We have completed, or in the process of completing, actions to resolve these issues.

(Original signed by:)

David Stockwell, MHA
Medical Center Director
VA Northern California Healthcare System

Facility Director Response

Recommendation 1

The VA Northern California Health Care System Director ensures mental health prescribing provider same-day access.

Concur.

Target date for completion: January 30, 2023

Director Comments

On June 21, 2022, the Associate Chief of Staff (ACOS), Mental Health (MH) immediately instituted, Standard Operating Procedure (SOP), titled Utilization and Scheduling of Same-Day/Open Access Capacity at Outpatient Behavioral Health Clinics. The purpose is to establish procedures on the utilization, screening and scheduling of same-day/open-access capacity for Veterans indicating an urgent need. On January 30, 2022, the Chico Outpatient Clinic hired a full-time provider at the site to assist with the same day access (SDA). The ACOS, Mental Health monitors the SDA daily to ensure there are available prescriber slots at all sites, and coverage for unplanned call outs.

OIG Comment

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

Recommendation 2

The VA Northern California Health Care System Director makes certain that when a patient cannot engage in a risk assessment, the provider documents the reasons for the patient's inability to complete the assessment, and risk and protective factors, as required by the Veterans Health Administration.

Concur.

Target date for completion: January 30, 2023

Director Comments

During the month of June 2022 through August 2022, MH Service Leadership provided a series of educational sessions on appropriate clinical response and documentation around challenging issues in risk assessment and management. The Medical Facility is continuing to work to ensure compliance with suicide prevention training requirements for Licensed Independent Practitioners (LIP), internal and external to the MH Service.

The Medical Facility staff are currently at 89% completion rate for the VA, Signs, Ask, Validate Encourage (S.A.V.E) New Employee Orientation training and 94% for S.A.V.E the refresher-annual training with a goal of 95% completion. MH leadership has made documentation of risk management a focus in ongoing professional practice evaluation (OPPE)/focused professional practice evaluation (FPPE) reviews.

OIG Comment

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

Recommendation 3

The VA Northern California Health Care System Director ensures the nurse practitioner documents in patients' electronic health records the comprehensive rationale for medication choices, schedules follow-up appointments consistent with clinical monitoring needs, and accurately documents medication instructions.

Concur.

Target date for completion: January 30, 2023

Director Comments

The ACOS, MH, conducted an internal and external inquiry into the nurse practitioner actions and provided direct training and supervision to the triage provider and prescriber involved in the event. The NP provider resigned as the review was being completed, avoiding an FPPE being implemented, but exit interview does reflect facility concerns with performance.

The ACOS, MH and Medical Director, MH continue to meet monthly with all providers to engage in clinical case review and present educational events.

OIG Comment

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

Recommendation 4

The VA Northern California Health Care System Director conducts a full review of the patient's care, determines if an institutional disclosure is warranted, and takes action as indicated.

Concur.

Target date for completion: January 30, 2023

Director Comments

The Chief of Staff will determine if an institutional disclosure is warranted and take action as indicated.

OIG Comment

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

Recommendation 5

The VA Northern California Health Care System Director expedites planned environmental changes to the Chico Community-Based Outpatient Mental Health Clinic.

Concur.

Target date for completion: October 1, 2023

Director Comments

The Associate Director, Sacramento Valley Division and Chief, Engineer will complete a review of making changes according to the recommendation(s) of MH staff and VA standards to accomplish the improved environment as recommended in the OIG findings.

Glossary

To go back, press “alt” and “left arrow” keys.

adverse drug reaction. An unwanted or harmful reaction following the administration of a drug under normal conditions of use and suspected to be related to the drug.¹

alprazolam. A benzodiazepine medication prescribed for anxiety.²

amphetamine-dextroamphetamine. A stimulant medication prescribed to treat ADHD symptoms of inattention and restlessness.³

anxiety. An expected part of life that involves worry or fear. For individuals with an anxiety disorder, it can get worse over time and can interfere with daily activities to include job performance, schoolwork, and relationships.⁴

aripiprazole. An antipsychotic medication sometimes used as add-on therapy for the treatment of bipolar and major depressive disorder.⁵

atomoxetine. A medication used to treat ADHD.⁶

attention deficit/hyperactive disorder. A mental health disorder characterized by persistent problems, such as inattention, hyperactivity, and impulsivity that “can lead to unstable relationships, poor work or school performance, and low self-esteem.”⁷

atypical antipsychotic. A medication prescribed to treat disorders characterized by psychotic symptoms that produces fewer adverse side effects than conventional antipsychotic medications.⁸

¹ VHA Directive 1070, https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=8831.

² Mayo Clinic, “Alprazolam (Oral Route),” accessed November 4, 2022, <https://www.mayoclinic.org/drugs-supplements/alprazolam-oral-route/description/drg-20061040?p=1>.

³ Mayo Clinic, “Dextroamphetamine and Amphetamine,” accessed June 1, 2022, <https://www.mayoclinic.org/drugs-supplements/dextroamphetamine-and-amphetamine-oral-route/description/drg-20071758>.

⁴ National Institute of Mental Health, “Anxiety Disorders,” accessed November 4, 2022, [NIMH » Anxiety Disorders \(nih.gov\)](https://www.nimh.nih.gov/health/topics/anxiety-disorders/).

⁵ Mayo Clinic, “Aripiprazole,” accessed November 4, 2022, <https://www.mayoclinic.org/drugs-supplements/aripiprazole-oral-route/description/drg-20066890>.

⁶ Mayo Clinic, “Atomoxetine (Oral Route),” accessed June 23, 2022, [Atomoxetine \(Oral Route\) Description and Brand Names - Mayo Clinic](https://www.mayoclinic.org/drugs-supplements/atomoxetine-oral-route/description/drg-20066890).

⁷ Mayo Clinic, “Adult attention-deficit/hyperactivity disorder (ADHD),” accessed November 4, 2022, <https://www.mayoclinic.org/diseases-conditions/adult-adhd/symptoms-causes/syc-20350878>.

⁸ American Psychological Association, “atypical antipsychotic,” accessed August 29, 2022, <https://dictionary.apa.org/atypical-antipsychotic>.

benzodiazepine. A medication that slows down the central nervous system and can produce sedation, induce sleep, relieve anxiety, and prevent seizures.⁹

bipolar disorder. A disturbance of a person's mood characterized by a manic episode including a period of elevated or irritable mood and increase in energy or activity level that is abnormal and persistent.¹⁰

bupropion. An antidepressant medication that is sometimes used “off-label to treat ADHD.”¹¹

clonazepam. A benzodiazepine medication prescribed to treat panic disorders.¹²

clonidine. A medication used to treat hypertension and ADHD.¹³

delusional. “[R]elating to, based on, or affected by delusions,” which are false beliefs about reality “despite indisputable evidence to the contrary.”¹⁴

gabapentin. A medication used for off-label treatment for anxiety and sleep.¹⁵

hydroxyzine. An antihistamine medication used to treat anxiety and sleep.¹⁶

hypomanic. A period of at least four days of abnormal elevation in mood, emotions or energy level that can be a symptom of bipolar disorder.¹⁷

⁹ National Library of Medicine, “Benzodiazepines: Uses, Dangers, and Clinical Considerations,” accessed November 4, 2022, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8629021/>.

¹⁰ Mayo Clinic, “Bipolar Disorder,” accessed November 4, 2022, [Symptoms and causes - Mayo Clinic](https://www.mayoclinic.org/symptoms/causes/symptoms-and-causes/symptoms-and-causes-2025723).

¹¹ Mayo Clinic, “Bupropion,” accessed November 4, 2022, <https://www.mayoclinic.org/drugs-supplements/bupropion-oral-route/description/drg-20062478>; Lakshmi M. Yatham, et al., “Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder,” *Bipolar Disorders*, (April, 21, 2018): 97-170.

¹² Mayo Clinic, “Clonazepam,” accessed June 1, 2022, <https://www.mayoclinic.org/drugs-supplements/clonazepam-oral-route/description/drg-20072102>.

¹³ Mayo Clinic, “Clonidine,” accessed June 1, 2022, <https://www.mayoclinic.org/drugs-supplements/clonidine-oral-route/description/drg-20063252>.

¹⁴ *Merriam-Webster.com Dictionary*, “delusional,” accessed September 26, 2022, <https://www.merriam-webster.com/medical/delusional>.

¹⁵ Substance Abuse Research and Treatment, “Gabapentin for Off-Label Use: Evidence-Based or Cause for Concern?,” accessed July 19, 2022, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6153543/>.

¹⁶ Mayo Clinic, “Hydroxyzine,” accessed August 6, 2020, <https://www.mayoclinic.org/drugs-supplements/hydroxyzine-oral-route/description/drg-20311434>.

¹⁷ Cleveland Clinic, “hypomania,” <https://my.clevelandclinic.org/health/diseases/21774-hypomania>, accessed August 29, 2022.

ideation. The process of forming a thought.¹⁸

lamotrigine. A medication prescribed to treat bipolar disorder.¹⁹

methylphenidate. A stimulant medication used to treat ADHD.²⁰

off-label. A prescribing provider’s use of a medication to treat a medical condition that the drug was not approved to treat. VHA does not specifically require providers to discuss off-label use of medication with patients and advises that “Evidence of benefit (and importantly, risk) should be explicitly reviewed.”²¹

olanzapine. An antipsychotic drug administered in the treatment of schizophrenia and acute manic episodes of bipolar disorder.²²

posttraumatic stress disorder. A mental health condition triggered by experiencing or witnessing a terrifying event and characterized by flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event.²³

psychosis. A psychological condition in which an individual loses touch with reality and characterized by hallucinations and delusional beliefs.²⁴

quetiapine. An antipsychotic drug used to treat schizophrenia and bipolar disorder.²⁵

¹⁸ Merriam-Webster.com Dictionary, “ideation,” accessed June 1, 2022, <https://www.merriam-webster.com/dictionary/ideation>.

¹⁹ Mayo Clinic, “Lamotrigine,” accessed June 1, 2022, <https://www.mayoclinic.org/drugs-supplements/lamotrigine-oral-route/description/drg-20067449>.

²⁰ Prescribers’ Digital Reference, “Methylphenidate hydrochloride – Drug Summary,” accessed July 13, 2022, <https://pdr.net/drug-summary/Methylphenidate-Hydrochloride-ER-methylphenidate-hydrochloride-24298#3>.

²¹ Food and Drug Administration, “Understanding Unapproved Use of Approved Drugs “Off Label,” accessed June 24, 2022, <https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/understanding-unapproved-use-approved-drugs-label>; Department of Veterans Affairs Center for Medication Safety and Veterans Health Administration Pharmacy Benefits Management Strategic Healthcare Group and the VA Medical Advisory Panel, *Pharmaceutical Use Outside of Approved Indications Guidance on “Off-Label” Prescribing*, May 2004, accessed November 3, 2022, <https://www.pbm.va.gov/PBM/vacenterformedicationsafety/directive/GuidanceOffLabelPrescribing.pdf>.

²² Merriam-Webster.com Dictionary, “Medical definition of olanzapine,” accessed November 20, 2019, <https://www.merriam-webster.com/medical/olanzapine>.

²³ Mayo Clinic, “Post-traumatic stress disorder,” accessed August 29, 2022, <https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967>.

²⁴ Merriam-Webster.com Dictionary, “psychosis,” accessed May 26, 2022, <https://www.merriam-webster.com/dictionary/psychosis>.

²⁵ Merriam-Webster.com Dictionary, “Medical definition of quetiapine,” accessed November 4, 2019, <https://www.merriam-webster.com/medical/quetiapine>.

risperidone. An antipsychotic drug used to treat schizophrenia and bipolar disorder.²⁶

sertraline. A medication used to treat depression and anxiety.²⁷

stimulant. A medication often prescribed to treat individuals diagnosed with ADHD.²⁸

trazodone. An antidepressant medication that is used to treat major depressive disorder and at low doses to treat sleep problems.²⁹

zolpidem. A medication used to treat sleep disturbances.³⁰

²⁶ Prescribers' Digital Reference, "risperidone - Drug Summary," accessed August 29, 2022, <https://pdr.net/drug-summary/Risperidone-risperidone-3120.8240#3>.

²⁷ Veterans Health Library, "Sertraline oral tablet," accessed May 26, 2022, <https://www.veteranshealthlibrary.va.gov/Search/208,11467-8095>.

²⁸ National Institute on Drug Abuse, "Stimulant ADHD Medications: Methylphenidate and Amphetamines," accessed July 13, 2022, https://nida.nih.gov/sites/default/files/drugfacts_stimulantadhd_1.pdf.

²⁹ Merck Manual Professional Version, "Trazodone," accessed August 16, 2019, <https://www.merckmanuals.com/professional/resources/brand-names-of-some-commonly-used-drugs>.

³⁰ Mayo Clinic, "Zolpidem (Oral Route)," accessed August 25, 2020, <https://www.mayoclinic.org/drugs-supplements/zolpidem-oral-route/proper-use/drg-20061195>.

OIG Contact and Staff Acknowledgments

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