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

Office of Healthcare Inspections

**VETERANS HEALTH ADMINISTRATION**

# Deficiencies in Quality of Care at the VA Maine Healthcare System in Augusta

**Healthcare Inspection** | **23-00528-92** | **March 12, 2024**

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# Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to an allegation stating deficiencies in the coordination and care of a patient who, after hospitalization in the community for a stroke, died by suicide at a VA Maine Healthcare System (facility) outpatient clinic.[1] Although the OIG identified deficiencies in the quality of care and completion of quality reviews, the OIG was unable to determine whether a change in care would have resulted in a different outcome for the patient.

## Patient Case Summary

In the fall of 2022, the patient presented to a non-VA community hospital (community hospital 1) emergency department complaining of bilateral arm and right leg weakness, which resulted in falls. At that time, the patient was homeless, in their sixties, and had a medical history that included depression and a stroke.[2] The patient was admitted and a magnetic resonance imaging (MRI) of the brain indicated a stroke.[3] Physical and occupational therapists assessed the patient, and both noted the patient would benefit from outpatient therapy. The following day, the patient was discharged with instructions that included changes to the patient's medications and directed the patient to schedule an appointment with the patient's facility primary care provider within two weeks.

In the morning of the day after discharge from community hospital 1, the patient made two calls to the Veterans Integrated Service Network (VISN) 1 clinical contact center, 12 minutes apart, requesting to speak with a primary care provider and supplying the phone number where the patient was staying at the time. Later in the day, the patient aligned care team (PACT) nurse called the patient to discuss new medications prescribed by the provider at community hospital 1 and offered to connect the patient with primary care mental health integration (PCMHI) services; the patient agreed. The PACT nurse was able to schedule appointments with the patient's primary care provider (primary care provider A) and the PCMHI therapist for that day. The PACT nurse contacted the patient who reported being unable to make the appointments. The patient became frustrated and ended the call by suggesting that medications be sent from the VA so the patient could overdose.

[1] The suicide occurred the same day the patient left a community hospital against medical advice and five days after receiving care at the Bangor community-based outpatient clinic.

[2] The OIG uses the singular form of they, "their" in this instance, for privacy purposes. The patient's initial stroke was approximately eight years prior to the events discussed in this report.

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

The PACT nurse contacted the PCMHI therapist to provide an update on the patient's status and care needs. The patient subsequently called facility administrative staff two additional times, stated no one had called back, and requested a call back from a PACT provider or nurse. The PCMHI therapist contacted the patient that same afternoon and documented that the patient presented with moderate to severe anxiety and moderate levels of depression. However, the patient denied suicidal ideation, thoughts of wanting to die or depression, and reported being safe.

The next day, a PACT social worker contacted the patient by phone to coordinate scheduling a primary care provider appointment for the following day. Primary care provider A was not available so the patient was scheduled with a different provider (primary care provider B). During the call, the patient told the social worker, "I'm suicidal, if [I] had a way to do it, I would." When the PACT social worker attempted to discuss this statement, the patient informed the social worker of not wanting to be checked on by the police and disconnected the call. The social worker contacted the Bangor police department for a welfare check. A police officer performed a welfare check that day and documented the patient was upset and frustrated but not suicidal.

On a Friday afternoon, three days after discharge from community hospital 1, an acting homeless program coordinator from the facility spoke with the patient regarding the patient's living situation. The patient shared being "homeless by choice" and said, "I just want the good Lord to take me away. I have no intentions to kill myself. I don't have the means to do it." The patient became irate and derogatory toward the acting homeless program coordinator when asked follow-up questions about the statement. After trying to de-escalate the patient without success, the call ended.

Later that day, primary care provider B examined the patient at the Bangor community-based outpatient clinic (CBOC). An intermediate care technician completed the suicide risk screening, and noted that the patient did not have thoughts or feelings of suicide. Primary care provider B addressed the patient's medication concerns during the visit and noted the patient complained of left-sided weakness in the arm and leg, numbness, loss of feeling in the left hand, and difficulty ambulating. Primary care provider B shared a plan to refer the patient to occupational and physical therapy, and instructed the patient not to drive.

Three days after the Bangor CBOC visit, the patient presented to an emergency department at a different community hospital (community hospital 2) with a complaint of being unable to provide self-care due to immobility, left shoulder pain, and frequent falls. An MRI showed new strokes on the right and left side of the brain, as well as the previous subacute strokes on the right. Community hospital 2 staff evaluated and admitted the patient. A hospitalist documented that on hospital day 2, in the early evening a nurse reported that the patient had become angry,

refused to speak to the nurse, and wanted to die.[4] The hospitalist documented that the nurse reported a negative suicide risk assessment.

In the morning of hospital day 3, the patient left the hospital against medical advice. The facility suicide prevention coordinator noted in a Suicide Behavior and Overdose report that the patient drove to the Bangor CBOC, exited the vehicle, announced the intent for suicide, and discharged a firearm. The patient was brought to the emergency department of community hospital 2 where the patient died.

## Inspection Results

The OIG received a complaint alleging that the patient was waiting for rehabilitation placement following a stroke, facility staff did not communicate with the patient, and "[rehabilitation] placement was not made."[5] The OIG also reviewed the quality of care provided by facility staff following the stroke.

The OIG did not substantiate that facility staff failed to communicate with the patient. Documentation shows facility staff communicated with the patient multiple times in the week following the first community hospitalization. However, the OIG identified deficiencies in the quality of care provided by facility staff to the patient following discharge from community hospital 1. The deficiencies included: incomplete documentation following the patient's suicidal statements, incomplete assessment of the patient, and lack of care coordination to assist the patient with receiving rehabilitation services. In addition, the OIG found deficiencies with the facility's quality management processes.

### Deficiencies in Quality of Care

The Veterans Health Administration (VHA) requires a suicide risk screening, known as the Columbia-Suicide Severity Rating Scale (C-SSRS), for patients who report suicidal statements and offers guidance for providers about how to document when a patient is unwilling or unable to complete a C-SSRS.[6] Documenting that the C-SSRS was not completed, and why, provides awareness to other clinicians caring for the patient. To facilitate this documentation, the C-SSRS

[4] The documentation of this interaction was not entered into the electronic health record until one day after the patient left against medical advice.

[5] In the context of this report, the OIG considers a rehabilitation placement to be an admission to an inpatient physical medicine rehabilitation unit.

[6] VA Risk ID, 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)*, July 6, 2022, accessed October 27, 2023, https://dvagov.sharepoint.com/sites/ECH/srsa/_vti_history/2048/Shared Documents/Risk ID/C-SSRS and CSRE/CSRE/4. CSRE_and_C-SSRS_Guidance_Re_Unwilling_or_Unable.pdf. (This website is not publicly accessible.)

template includes an option for clinicians to document the inability to complete the tool and the reason it could not be completed.

For patients with "current suicidal ideation, past suicide attempts, suicide preparatory behaviors," clinicians are to establish or update a safety plan with the patient and document the plan in the electronic health record (EHR).[7] VHA clinicians are required to complete suicide prevention training, which includes safety plan training. VHA also provides examples of who may complete safety plans, but does not designate staff who are required to complete safety plans, deferring this determination to facility leaders. The development of a safety plan can help patients identify situations that may trigger a crisis, coping skills, access to lethal means, and plans to engage support when needed.

In 2020, the facility developed a policy for the management of suicidal patients. The policy provides instructions for staff regarding telephone threats of self-directed violence, which included notifying a member of the suicide prevention staff.[8]

Over the course of three days, the patient referenced suicide or wanting to die during three phone contacts with different facility staff members: a PACT nurse, a PACT social worker, and an acting homeless program coordinator. At the time of the encounters, each staff member attempted to address the patient's statement; however, the patient was unwilling to engage in further discussion.

None of the providers who were unable to engage the patient documented their inability to complete the C-SSRS in the EHR or any efforts made to develop a safety plan with the patient. While the OIG was unable to determine if a safety plan would have prevented the patient's suicide, the OIG found the lack of one to be concerning. Additionally, the social worker did not consult with the suicide prevention staff about the patient call that led to the welfare check by Bangor police. The social worker reported discussing the case with a supervisor and noting that a call to suicide prevention staff would have been an option; but that the social worker had chosen to follow-up to ensure the patient made the primary care appointment the next day and, as they had, no further action was taken. Notification to the suicide prevention staff may have allowed the staff to engage the patient.

The OIG learned reasons for not completing the C- SSRS centered around the patient's unwillingness to participate and the facility's practice to involve the mental health staff in the patient's care when a suicidal statement was made.[9] In regard to completing a safety plan, some

[7] VHA Directive 1160.07 *Suicide Prevention Program*, May 24, 2021. Clinicians that may develop a safety plan with a patient include physicians, social workers, nurse practitioners, and registered nurses. The suicide safety plan outlines the patient's warning signs, coping strategies, social contacts that may distract from a crisis, family or friends that can provide support, professionals that can be contacted for help, and ways to make the patient's environment safer by removing lethal means.

[8] Facility Policy 00-20-15(116), *Management of Suicidal Patients,* April 5, 2020.

[9] Facility Policy 00-20-15(116).

staff were unclear as to who was responsible for completion while one staff member shared completion was done if a C-SSRS was positive.

## *Incomplete Assessment of the Patient*

Depression post-stroke is common. Therefore, patients should be evaluated for depression while hospitalized, and at follow-up visits, as symptoms of depression can occur at any time after a stroke.[10] VHA expects providers to produce complete documentation of a patient's health history, present illness, and course of treatment, including evidence of medical decision-making in determining a diagnosis and treatment plan.[11]

Despite the patient having a medical history significant for depression, along with a recent second stroke, primary care provider B's assessment of the patient's psychological and physiological state was minimal.

Primary care provider B failed to complete a comprehensive assessment of the patient during an outpatient appointment. Specifically, the OIG did not find documented evidence that primary care provider B assessed the patient for post-stroke depression or conducted a physical examination that included elements of a neurological assessment to determine the extent of cognitive or neurological impairments that may have been present.[12] The OIG inquired about the patient's risk of increased depression or suicide post stroke. Primary care provider B shared that an intermediate care technician completed the C-SSRS and it was negative. However, primary care provider B also stated being unfamiliar with literature that identified an increased risk of depression and suicide post stroke. The OIG was told by primary care provider B about completing a physical exam while the patient was in a wheelchair. The patient's gait was not assessed, which the primary care provider noted "was a mistake."

The OIG determined that had primary care provider B considered the potential impact of the stroke on the patient's mental health, primary care provider B may have recognized the need to perform a post-stroke depression screening to identify patient vulnerabilities or need for additional support. Given the incomplete examination of the patient, primary care provider B may have lacked the information necessary to accurately determine the patient's rehabilitation

[10] VA and Department of Defense (DoD), *VA/DoD Clinical Practice Guideline for the Management of Stroke Rehabilitation,* Version 4.0, July 2019; American Heart Association/American Stroke Association Guideline, *2018 Guidelines for the Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association*, accessed November 29, 2022, https://www.ahajournals.org/doi/epub/10.1161/STR.0000000000000158.

[11] VHA Health Information Management Office of Health Informatics, *VHA Health Record Documentation Program Guide*, Version 1.1, November 29. 2022; VHA Directive 1907.01, *VHA Health Information Management and Health Records*, April 5, 2021.

[12] "Neurological Exam," Johns Hopkins Medicine, accessed March 17, 2023, https://www.hopkinsmedicine.org/health/conditions-and-diseases/neurological-exam. A neurological exam includes "an assessment of motor and sensory skills, balance and coordination, mental status. . . reflexes, and functioning of the nerves."

needs. Therefore, the OIG was unable to determine if primary care provider B's plan of care for the patient was appropriate.

### *Lack of Care Coordination*

Primary care provider B informed the OIG that rehabilitation services and resources available to coordinate access to rehabilitation on a Friday afternoon were limited. However, the OIG learned that the facility community care department has a mechanism for providers to alert their staff of requests for care in the community that need immediate attention. Primary care provider B acknowledged awareness of this practice but noted that most patients go to rehabilitation from a hospital, and there are few who go directly to rehabilitation or a skilled nursing facility from a community setting. As a result, the patient was not referred to, or considered for admission to, inpatient rehabilitation. Primary care provider B told the OIG that placing a consult for outpatient therapies was determined to be the best available resource for the patient. However, the OIG did not find evidence that primary care provider B entered a consult for transportation services so the patient could attend outpatient therapies.[13]

## Deficiencies in Facility Quality Management Reviews

Facility staff completed a root cause analysis (RCA) to review the care of the patient and modifications were made based on a request from the chief of quality management and feedback from facility leaders. VHA's National Center for Patient Safety guidebook states that in situations when the facility director does not concur, a team may choose not to change the RCA. The nonconcurrence should be documented and include the facility director's reason and rationale for not supporting the team's findings.[14] The OIG is concerned that there was a lack of awareness related to the available option for the RCA team not to change the findings when facility leaders disagree, as was the case with this RCA. However, the OIG was unable to determine whether the final RCA would have varied if the team had knowledge of the *management does not concur* option.

VHA policy requires a peer review be conducted when the death of a patient was "preceded by a change in the patient's condition when there are questions regarding response to, management of, and/or communication related to the referenced change."[15] The facility risk manager told the OIG that the patient's suicide did not meet the criteria to trigger a mandatory peer review. According to the risk manager, per VHA policy, an ongoing RCA, as was the case in this

[13] At the time of the interview with the OIG, primary care provider B noted that the therapy consult entered was eventually cancelled after the patient was determined not to be a candidate for outpatient care due to returning to an inpatient status four days after the consult was placed.

[14] VA National Center for Patient Safety, *Guide to performing Root Cause Analysis,* Version 7. The guide states that the patient safety manager and the facility director document this information on a specific web-based software designated for RCAs.

[15] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

situation, would preclude the facility from conducting a peer review. The risk manager recalled discussing this point with the Chief of Staff who agreed that a peer review was not necessary. The Chief of Staff added understanding that a peer review was not done as the event was considered a process issue instead of a problem on the part of the provider. The Facility Director said that no peer reviews were completed and, when asked, the Chief of Staff told the Facility Director a peer review of the care of this patient was not necessary. The OIG did not find evidence in VHA policy that supported an RCA would preclude a peer review and determined that the facility did not conduct a peer review of the provider involved in the patient's care as required.[16]

The OIG made seven recommendations to the Facility Director related to the Columbia-Suicide Severity Rating Scale, safety plans, engagement of suicide prevention staff, root cause analyses, peer reviews, and concurrent quality management reviews.

## VA Comments and OIG Response

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

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[16] VHA Directive 1190.

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# Abbreviations

| | |
|---|---|
| CBOC | community-based outpatient clinic |
| COS | Chief of Staff |
| C-SSRS | Columbia-Suicide Severity Rating Scale |
| EHR | electronic health record |
| OIG | Office of Inspector General |
| PACT | patient aligned care team |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to an allegation stating deficiencies in the coordination and care of a patient who, after hospitalization in the community for a stroke, died by suicide at a VA Maine Healthcare System (facility) outpatient clinic.[1] Although the OIG identified deficiencies in the quality of care and completion of quality reviews, the OIG was unable to determine whether a change in care would have resulted in a different outcome for the patient.

## Background

The facility is part of Veterans Integrated Service Network (VISN) 1, VA New England Healthcare System. The Togus medical center, located in Augusta, Maine, is a Level 2 complexity medical center that has 67 operating beds offering general medical, surgical, and mental health care; and a 100-bed community living center offering long-term, palliative, dementia, and rehabilitative care. In addition, the medical center has outpatient clinics for preventive, specialty, and primary care.[2] The facility provides outpatient care throughout Maine at seven community-based outpatient clinics (CBOCs) in Caribou, Bangor, Calais, Lewiston, Lincoln, Portland, and Rumford, as well as two access clinics in Fort Kent and Houlton.[3] Distances to each clinic vary; the Bangor CBOC is 71 miles from the medical center. From October 1, 2020, through September 30, 2021, the facility served 43,300 patients.

### Cerebral Vascular Accident

A cerebral vascular accident, the medical term for stroke, occurs when the blood supply to the brain is interrupted or stopped leading to the damage of brain tissue.[4] "Stroke is the fifth most common cause of death in the U.S and a leading cause of long-term disability."[5] A stroke can affect different areas of the brain; each area is responsible for different functions. For example, a

[1] The suicide occurred the same day the patient left a community hospital against medical advice and five days after receiving care at the Bangor community-based outpatient clinic (CBOC).

[2] Veterans Health Administration (VHA) Office of Productivity, Efficiency, and Staffing (OPES). "Facility Complexity Model Fact Sheet," January 28, 2021. The Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3. A level 2 facility has medium-volume, low-risk patients; few complex clinical programs; and small or no research and teaching programs.

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

[4] *Merriam-Webster.com Dictionary*, "stroke" accessed February 28, 2023, https://www.merriam-webster.com/dictionary/stroke.

[5] VA and DoD, *VA/DoD Clinical Practice Guideline for the Management of Stroke Rehabilitation*, Version 4.0, July 2019; Cleveland Clinic, "stroke," accessed December 8, 2022, https://my.clevelandclinic.org/health/diseases/5601-stroke.

stroke in the frontal lobe may impact personality, problem-solving, and overall reasoning.[6] Disability from a stroke can present as weakness or paralysis; difficulty with or loss of mobility; reduced or lost sensation; problems swallowing; language deficits involving speech and communication; cognitive impairments, including inattention or memory loss; and emotional disturbances with mood or anxiety.[7]

"The early management of stroke in the form of medical, surgical, or rehabilitation interventions is essential to help reduce disability severity, decrease the risk of further complications, and lessen potentially life-long deficits."[8] Rehabilitation services facilitate functional recovery and the highest level of independence for individuals following a stroke.[9] The intensity of rehabilitation service varies according to the severity of the stroke, the patient's ability to participate in therapies, and the setting. Regardless of the intensity, the goal remains achieving the highest level of function possible.[10]

In addition to physical impairments, psychological impairments, such as depression, are common post-stroke. Patients should be evaluated for depression at post-stroke follow-up visits since symptoms of depression can occur at any time after a stroke. Prior to being discharged from the hospital, a stroke patient should receive a comprehensive physical exam to determine rehabilitation needs.[11]

## Allegations and Related Concerns

The OIG received a complaint alleging deficiencies in the facility's coordination and care of a patient who, after hospitalization in the community for a stroke, died by suicide at the Bangor VA CBOC. Specifically, the complainant alleged that the patient was awaiting rehabilitation placement, facility staff were not communicating with the patient, and "[rehabilitation] placement was not made."[12]

The OIG opened a healthcare inspection to assess the allegations and quality of care provided by facility staff, including a review of

[6] "Let's talk about Stroke – Changes Caused by Stroke" (web page), American Stroke Association, accessed November 23, 2022, https://www.stroke.org/-/media/Stroke-Files/Lets-Talk-About-Stroke/Life-After-Stroke/Changes-Caused-by-Stroke.pdf.

[7] National Institute of Neurological Disorders and Stroke, "Post-Stroke Rehabilitation Fact Sheet," July 25, 2022.

[8] VA and DoD, *VA/DoD Clinical Practice Guideline for the Management of Stroke Rehabilitation*.

[9] American Heart Association (AHA)/American Stroke Association (ASA), *Guidelines for Adult Stroke Rehabilitation and Recovery*, June 2016, accessed on December 7, 2022, https://www.ahajournals.org/doi/epub/10.1161/STR.0000000000000098.

[10] AHA/ASA, *Guidelines for Adult Stroke Rehabilitation and Recovery*.

[11] AHA/ASA, *Guidelines for Adult Stroke Rehabilitation and Recovery*.

[12] In the context of this report, the OIG considers a rehabilitation placement to be an admission to an inpatient physical medicine rehabilitation unit.

- documentation by facility staff following the patient's suicide statements,
- a Bangor CBOC provider's assessment of the patient, and
- post-stroke care coordination for the patient by facility staff.

# Scope and Methodology

The OIG assigned a team and initiated the healthcare inspection on November 21, 2022. An on-site visit was conducted January 10–12, 2023, with virtual interviews concluding March 9, 2023.

The OIG interviewed facility executive leaders; chiefs of primary care, mental health, community care, and quality management; and staff from quality management, primary care, and mental health who were knowledgeable of the issues under review.

The OIG reviewed relevant Veterans Health Administration (VHA) and facility policies; and guidelines related to the management of post-stroke care, suicide prevention, the homeless program and quality of care reviews; and approximately seven months of relevant electronic health record (EHR) documentation prior to the patient's death care. The OIG issued subpoenas for the patient's medical records from two community hospitals; these records were received and reviewed.

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.

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, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

# Patient Case Summary

The patient, in their late sixties, had a medical history of hypertension, depression, and a stroke that caused loss of vision in the left eye.[13] In mid-spring of 2022, facility staff initiated a behavioral flag in the patient's EHR for verbally threatening and abusive behavior toward facility staff.

The following week, the patient's primary care provider (primary care provider A) placed multiple consults to assist in accessing care and addressing the patient's homelessness, as well as a mental health integration consult for stress. EHR consult documentation indicated that the patient verbalized being "homeless by choice." The homeless program consult was closed after a telephone call took place noting that the patient had no suicidal, homicidal, paranoid or delusional thoughts, and the patient declined further assistance.

Approximately six months later, the patient presented to a non-VA community hospital (community hospital 1) emergency department complaining of falls, feeling disoriented and uncoordinated, with bilateral arm and right leg weakness. The emergency department physician noted the patient expressed concern about having another stroke.

Both the emergency department physician and a nurse noted that starting the prior evening, the patient experienced weakness in all extremities. The nurse also documented the patient complained of decreased left arm and hand dexterity; and right knee weakness, which resulted in a fall.

After examining the patient, the emergency department physician documented the patient was alert and oriented to person, place, and time. The physician noted no motor weakness, and that coordination, gait, and reflexes were normal. The physician documented the patient's mood, behavior, thought content, and judgment were "normal."

The emergency department nurse noted the patient was alert, oriented, obeyed commands, and had normal symmetrical facial movement. Further, the patient had full sensation of the upper and lower extremities, strong hand grips, and movement in the upper extremities; however, the patient reported feeling uncoordinated and weak.

While the patient was in the emergency department, the emergency department physician prescribed aspirin and atorvastatin, a medication for high cholesterol. The emergency department physician consulted a tele-neurology physician who recommended admitting the patient, noting the patient "likely had brainstem ischemia." The patient was admitted to community hospital 1 for continuation of care.

[13] The OIG uses the singular form of they, "their" in this instance, for privacy purposes; The patient's initial stroke was approximately eight years prior to the events discussed in this report.

A hospitalist completed an assessment. An electrocardiogram (ECG) was interpreted as sinus rhythm. A nasopharyngeal, or nose and throat, swab test for COVID-19 and influenza were negative. A computerized tomography (CT) scan of the head demonstrated no evidence of an acute intracranial hemorrhage or other acute intracranial event. The CT angiogram of the intracranial and cervical (neck) arteries showed normal blood flow. A magnetic resonance imaging (MRI) of the brain identified a stroke in the right temporal lobe.

The facility community care transfer care coordinator documented being notified of the patient's emergency department visit and subsequent hospitalization.

The hospitalist at community hospital 1, noted that the patient was alert and oriented with normal strength and sensation, appropriate mood, and affect. The hospitalist stopped the patient's facility provider-prescribed blood pressure medications to allow for permissive hypertension as recommended by the tele-neurologist, but planned to resume the medications in the future. The hospitalist continued aspirin and atorvastatin prescribed in the emergency department, and consulted both physical and occupational therapy.

On the day of admission (hospital day 1) the community hospital 1 physical therapist's assessment noted the patient had decreased sensation and coordination of the left upper extremity and signs of left-sided neglect (a deficit in awareness of the patient's left side); however, the patient walked 150 feet. The community hospital 1 occupational therapist's assessment noted the patient had good hand grips but decreased fine motor control and poor sensation in the left hand. Although neither the physical nor occupational therapists identified acute rehabilitation care (inpatient) physical or occupational therapy needs, both documented the patient would benefit from outpatient physical and occupational therapy. In addition, both noted the patient was homeless and was not safe to drive.

On hospital day 2, a different hospitalist discharged the patient. The case manager at community hospital 1, who was assisting with the patient's discharge, noted the patient's homelessness as the barrier to home occupational and outpatient physical therapy. The case manager provided a list of resources to the community hospital 1 nurse and noted the nurse was reviewing the discharge paperwork with the patient, but the case manager did not speak to the patient about the discharge. The community hospital 1 nurse noted the patient stated needing to be discharged as soon as possible in order to go to a homeless shelter. Staff discharged the patient from community hospital 1.

The hospitalist who discharged the patient prescribed aspirin, atorvastatin, and a new blood pressure medication, metoprolol extended release, and discontinued three medications previously prescribed by a facility provider. The prescriptions were sent to a community pharmacy. The discharge instructions directed the patient to schedule an appointment with the patient's facility primary care provider within two weeks.

The patient's facility EHR showed the facility community care transfer care coordinator documented the patient was discharged and a VISN 1 community care advanced medical support assistant documented that the community hospital 1 discharge information would be faxed over to the facility. The patient care aligned team (PACT) was aware of the hospitalization and discharge.

The day after discharge from community hospital 1, during the early morning., a facility PACT nurse alerted a facility clerk to schedule a follow-up appointment with primary care provider A. Approximately 30 minutes later, the patient called the VISN 1 clinical contact center from a motel room requesting a call back from primary care provider A to discuss the patient's new stroke. The patient did not know the motel phone number and did not have a working cell phone. The VISN 1 clinical contact center alerted the patient's primary care provider A, the PACT nurse, and a PACT nursing staff member about the request. Approximately 12 minutes after the first call ended, the patient called the VISN 1 clinical contact center a second time to provide the motel phone number, discuss the recent stroke, and the medications that had been stopped by staff at community hospital 1.

Later in the day, the PACT nurse called the patient. The patient reported lack of control of the upper extremity that caused the patient to drop cups of coffee. The patient explained that community hospital 1 staff had taken the patient's medications prescribed by facility providers and had not returned them at discharge. The patient explained having new medications prescribed after being discharged from community hospital 1 but did not want to start taking them until reviewing the medications with primary care provider A.

The PACT nurse was able to schedule an appointment for that day with a different primary care provider (primary care provider B) and the primary care mental health integration (PCMHI) therapist. After scheduling the appointments, the PACT nurse spoke with the patient again. The patient reported being unable to attend the appointments due to losing wallet and car keys. The patient ended the call by suggesting that VA send the medications so the patient would be able to overdose. The PACT nurse contacted the PCMHI therapist to provide an update on the patient's status and care needs. Additionally, the PACT social worker attempted to call, but was unable to reach the patient.

The patient made a third call to the facility and spoke with a scheduling assistant in the early afternoon requesting a primary care team call back for help. The patient declined to confirm the call back number and hung up. Five minutes later, The patient called back a fourth time and spoke to a different scheduler. The patient reported being upset because no one had called back; however, the patient declined to provide the motel phone number stating the people who need to contact the patient had the information.

The PCMHI therapist contacted the patient after nursing staff shared concerns about the patient's mental health, homelessness, and possible suicidal ideation. The PCMHI therapist documented that the patient presented with moderate to severe anxiety and moderate levels of depression.

However, the patient denied suicidal ideation or thoughts of wanting to die or depression, and reported being safe. The PCMHI therapist requested a consult for follow-up therapy. Primary care provider A entered an outpatient primary care mental health integration consult.

On the following day, at 12:51 p.m., the patient called the VISN 1 clinical contact center and stated not being suicidal but in physical crisis and unsure what to do since community hospital 1 had kept the patient's medications. The patient verbalized frustration and requested a call back from primary care provider A, or a nurse, to discuss the medications.

Later that day, a PACT social worker contacted the patient by phone and conducted a triage assessment. The patient reported being told rehabilitation was not an option due to being homeless. The patient was informed that the social worker would follow up on the rehabilitation request. The social worker coordinated scheduling a primary care provider appointment for the next day to address the medication concerns. The patient told the social worker, "I'm suicidal, if [I] had a way to do it, I would." When the PACT social worker attempted to question this statement, the patient informed the social worker of not wanting to be checked on by the police and disconnected the call. The social worker contacted the Bangor police department for a welfare check. A welfare check was performed that day and the police officer documented the patient was upset and frustrated, but not suicidal.

Three days after discharge from community hospital 1, the acting homeless program coordinator from the facility spoke with the patient regarding the patient's living situation. The patient shared being "homeless by choice" and said, "I just want the good Lord to take me away. I have no intentions to kill myself. I don't have the means to do it." The patient became irate and derogatory toward the homeless coordinator when asked follow-up questions about the statement. After trying to de-escalate the patient without success, the call ended.

The same day as the call with the acting homeless program coordinator, a different primary care provider (primary care provider B) examined the patient at the Bangor CBOC. An intermediate care technician (care technician) completed the suicide risk screening, which reflected that the patient did not have thoughts or feelings of suicide.

Primary care provider B noted the patient complained of left-sided weakness in the arm and leg, numbness and loss of feeling in the left hand, and difficulty ambulating. The patient was in a wheelchair. Primary care provider B documented the patient's "physical exam [was] limited" and the patient's blood pressure was elevated. The physician described the patient as alert and cooperative with no distress. The physical assessment documentation noted that the patient's head, eyes, ears, nose, and throat were normal, and the left arm and leg had active range of motion. Primary care provider B prescribed the patient's previous blood pressure medications as well as a medication prescribed at discharge from the community hospital and continued aspirin for the right temporal lobe embolic stroke. Primary care provider B shared a plan to refer the patient to occupational and physical therapy, and instructed the patient not to drive.

Three days after the Bangor CBOC visit, the patient presented to the emergency department of a different non-VA community hospital (community hospital 2). Documentation reflected the patient stated, since discharge one week prior from community hospital 1 and while "waiting for the VA to cooridnate [*sic*] a rehab facility," the patient had multiple falls when walking, left shoulder pain, worsening left-sided weakness, as well as right-sided weakness. The patient's chief concern was of being unable to provide self-care due to immobility, frequent falls, and left shoulder pain. The community hospital 2 emergency department physician noted the patient's recent discharge from community hospital 1 and requested the discharge summary via fax as no summary was identified in the health information sharing internet site.

The community hospital 2 emergency department nurse performed the suicide risk screening; the patient answered *no* to all questions related to feeling suicidal. The nurse documented the patient stated having no housing problems and no lack of transportation but noted needing more help with activities of daily living.

The community hospital 2 emergency department physician noted the patient was alert and oriented with clear speech and no facial asymmetry. Additional documentation noted a sensory deficit in the left arm and sensory tingling. The patient could not stand or move out of the wheelchair without near full assist.

An MRI showed new areas of strokes on the right and left side of the brain as well as the previous subacute strokes on the right "concerning for cardioembolic stroke," a form of ischemic stroke. An x-ray of the shoulder did not reveal a fracture. The ECG showed a normal sinus rhythm. The community hospital 2 emergency department physician requested a neurology consultation for a recurrent stroke; physical therapy consult for rehabilitation goals; and a care management consultation for a potential transition to rehabilitation and VA care.

A neurologist at community hospital 2 was consulted. The neurologist completed a physical examination in the emergency department and noted the patient was oriented, with memory intact, fluent speech, a minor left-sided facial droop, and decreased sensation on the left side of the face. The left side strength was decreased in the upper and lower limbs. The touch sensation was absent on the left side. The neurologist diagnosed a new stroke [additional to the stroke diagnosed at community hospital 1] and recommended inpatient admission, medication management, and physical and occupational therapy consults. An echocardiogram was performed which demonstrated mitral valve calcification that could be a potential embolic source.

The patient was admitted to community hospital 2. The admitting provider noted the patient was alert, oriented, with normal speech, left leg and arm weakness, and decreased sensation on the left side. The provider assessed the patient as "cooperative, appropriate mood and affect." The provider also noted the patient had not picked up the discharge medications from community hospital 1 until one or two days before this admission. The patient stated that aspirin was not included in the dispensed medications, and therefore, had not been taken. A hospitalist

documented that a nurse called in the early evening on hospital day 2 to report the patient had become angry, refused to take medications, and refused to speak to the nurse.[14] The nurse reported the patient stated wanting to die. The hospitalist reported speaking to the patient and notified the nurse that the patient also did not want to talk. The hospitalist documented that the nurse reported a negative suicide risk assessment, so the patient was not placed on suicide precautions but continued to be observed by staff.

In the morning of hospital day 3, the patient left against medical advice. The facility suicide prevention coordinator noted in the Suicide Behavior and Overdose report, that the patient drove the patient's car to the Bangor CBOC, exited the vehicle, announced the intent for suicide, and subsequently discharged a firearm.

The patient was brought to the emergency department of community hospital 2 where the patient died.

# Inspection Results

## 1. Deficiencies in Quality of Care

The OIG determined that there were deficiencies in the quality of care provided by facility staff to the patient following discharge from community hospital 1. Specifically, the OIG found

- incomplete documentation following the patient's suicidal statements,
- incomplete assessment of the patient, and
- lack of care coordination.

Of note, as supported in the Patient Case Summary above, the OIG did not substantiate that the facility staff failed to communicate with the patient.

### Incomplete Documentation Following Suicidal Statements

Facility staff did not complete VHA required documentation following a patient's suicidal statements.[15] The OIG found that facility staff were unable to engage the patient to complete a

[14] The documentation of this interaction was not entered into the EHR until one day after the patient left against medical advice.

[15] VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum to VISN Director, VISN Chief Medical Officers, VISN Chief Mental Health Officers, Medical Center Directors, November 13, 2020; VA Risk ID, 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)*, July 6, 2022, accessed October 27, 2023, https://dvagov.sharepoint.com/sites/ECH/srsa/_vti_history/2048/Shared Documents/Risk ID/C-SSRS and CSRE/CSRE/4. CSRE_and_C-SSRS_Guidance_Re_Unwilling_or_Unable.pdf (This website is not publicly accessible.); VHA Directive 1160.07 *Suicide Prevention Program*, May 24, 2021.

formal suicide risk screening; however, staff did not document an inability to complete the screening per VHA guidance.[16] Additionally, the OIG determined that prior to having the stroke, the patient did not have a safety plan in the EHR and facility staff did not document or report taking steps to ensure that the patient had a safety plan in place after making suicidal statements. Furthermore, a staff member did not follow the facility policy of notifying suicide prevention staff to garner support for the patient after initiating a welfare check when the patient made a suicidal statement.

In November 2020, VHA implemented a standardized suicide risk identification strategy, which included a suicide risk screening for use at all VA health care systems.[17] The suicide risk screening tool, known as the Columbia-Suicide Severity Rating Scale (C-SSRS), is a standardized eight-item questionnaire used to identify patients who are at risk for suicide and require further evaluation. All patients should be screened annually and when presenting with a new behavioral health concern, including statements of suicide.[18] VHA offers guidance for providers about how to document when a patient is unwilling or unable to complete a C-SSRS.[19] Documenting that the C-SSRS was not completed and why provides awareness to other clinicians caring for the patient. To facilitate this documentation, the C-SSRS template includes an option for clinicians to document the inability to complete the tool and reason it could not be completed.

For patients with "current suicidal ideation, past suicide attempts, suicide preparatory behaviors," clinicians are to establish or update a safety plan with the patient and document the plan in the EHR.[20] The suicide prevention coordinator told the OIG that the creation of a safety plan is not dependent on completion of a suicide screen and, when used, can help patients identify when they are in crisis and "guide them through specific steps to reduce risk."[21] In a written response to an OIG request for information, VHA's Suicide Prevention Program staff stated that training

[16] VA Risk ID, Suicide Risk Identification, *What to do if a Veteran is Unwilling or Unable to Complete the C-SSRS*.

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

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

[19] VA Risk ID, Suicide Risk Identification, *What to do if a Veteran is Unwilling or Unable to Complete the C-SSRS*.

[20] VHA Directive 1160.07 *Suicide Prevention Program*, May 24, 2021. Clinicians that may develop a safety plan with a patient include physicians, social workers, nurse practitioners and registered nurses. The suicide safety plan outlines the patient's warning signs, coping strategies, social contacts that may distract from a crisis, family or friends that can provide support, professionals that can be contacted for help, and ways to make the patient's environment safer by removing lethal means.

[21] VHA Assistant Under Secretary for Health for Clinical Services/CMO, "Update to Use of National Standardized Suicide Prevention Safety Plan Progress Notes (VIEWS 8214920)," memorandum to VISN Director, VISN Chief Medical Officers, VISN Chief Mental Health Officers, August 17, 2022.

on safety planning is included in the suicide prevention training available online and is mandatory for all VHA health providers.[22]

In 2020, the facility developed a policy for the management of suicidal patients. The policy provides instructions for staff regarding telephone threats of self-directed violence, which included notification of a member of the suicide prevention staff.[23] Over the course of three days, the patient made three suicidal statements during phone contacts, with different facility staff members: a PACT nurse, a PACT social worker, and an acting homeless program coordinator. Although at the time of the encounter, each staff member attempted to address the suicidal statements made by the patient, the facility staff failed to document the inability to complete the C-SSRS and any efforts made to develop a safety plan with the patient.

The first statement was made to the PACT nurse who documented the patient's suicidal statement in the EHR; however, there was no evidence in the EHR that the PACT nurse completed a C-SSRS, or a safety plan. In an interview with the OIG, the PACT nurse explained facility practice was to involve the mental health team in a patient's care when a suicidal statement was made, and that in retrospect, a C-SSRS could have been completed. Following the call with the patient, the PACT nurse alerted a PCMHI therapist, who called the patient later that day to discuss the statement.The PACT nurse informed the OIG that PACT nurses were not trained or expected to complete safety plans.

The suicide prevention coordinator shared that VHA guidance supports nurses developing safety plans and provides safety plan training but did not believe the training for PACT nurses was required. The OIG learned that VHA clinicians, including PACT RNs, are required to complete suicide prevention training, which covers safety plan training. VHA also provides examples of who may complete safety plans but does not designate staff who are required to complete safety plans, deferring this determination to facility leaders.

The second statement was made to the PACT social worker. In an interview with the OIG, the PACT social worker stated that during their call, the patient was not willing to answer any questions related to the suicidal statement and, therefore, the social worker did not make an attempt to complete a C-SSRS. In regard to safety plans, the social worker reported understanding that safety plans were done once a patient had a positive suicide screen. The social worker also shared that when attempting to address the suicidal statement, the patient abruptly ended their telephone call. Based on the PACT social worker's concern for the patient's well-being, the PACT social worker contacted the Bangor police department who conducted a welfare check the same day. The police reported that the patient was "very upset [and] frustrated but is

[22] VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training,* May 11, 2022, Amended June 21, 2022. "A VHA Health care provider is defined as a full-time, part-time or intermittent clinical employee serving as a licensed independent practitioner or advanced practice provider. . . as well as any employee serving in the capacity of RN, case manager. . . "

[23] Facility Policy 00-20-15(116), *Management of Suicidal Patients,* April 5, 2020.

not suicidal." In an interview with the OIG, the social worker reported discussing the case with a supervisor and stated that a call to the suicide prevention team would have been an option but that the social worker had chosen to follow-up to ensure the patient attended the primary care appointment the next day and after confirming, no further action was taken.

Given the suicidal statement that was made by the patient and that the concern for the patient's well-being escalated to the level of a welfare check, the OIG would have expected the social worker to document attempts to engage the patient in completing a safety plan including unsuccessful efforts. The development of a safety plan can help patients identify situations that may trigger a crisis, coping skills, access to lethal means, and plans to engage support when needed. Additionally, the social worker did not consult with suicide prevention staff about the events that led to the welfare check by Bangor police.

The third statement was made during a call between the acting homeless program coordinator and the patient to address housing instability. The homeless coordinator's EHR documentation reflects the patient was irate throughout the call. In response to the patient saying, "I just want the good Lord to take me away. I have no intentions to kill myself. I don't have the means to do it," the acting homeless program coordinator told the OIG that an attempt was made to engage the patient regarding possible suicidal planning or intent. However, the patient became increasingly angry. Although not documented in the patient's EHR, in written correspondence with the OIG, the acting homeless program coordinator reported that the patient responded "no" when asked if the patient had any plans to commit suicide over the last 30 days or if the patient had any intention to commit self-harm. While the acting homeless program coordinator reported asking follow-up questions after the patient's statement, a C-SSRS was not used to document the interaction nor was there documentation regarding attempts made to develop a safety plan with the patient.

The OIG concluded that several providers during different encounters tried to engage the patient to complete a C-SSRS but were unsuccessful. Despite their inability to conduct a formal risk screening, none of the providers documented an inability to complete the C-SSRS on the C-SSRS template or ensured the patient had a safety plan. The OIG found some staff were unclear as to who was responsible for completing the safety plan. While the OIG cannot determine whether having a safety plan in place would have prevented this patient's death by suicide, the OIG found the absence of a safety plan to be concerning. Additionally, despite Bangor police performing a welfare check at the request of a facility staff member, suicide prevention staff was not notified. Notification to the suicide prevention staff may have allowed the staff to engage the patient.

## Incomplete Assessment of the Patient and Documentation of Care

The OIG determined that during the Bangor CBOC appointment with the patient, primary care provider B failed to complete a comprehensive assessment of the patient. Specifically, the OIG

found that primary care provider B did not complete a full neurological examination, or assess for post-stroke depression. Without a complete assessment, the provider may have lacked information necessary to determine the patient's rehabilitation needs.

During interviews, the OIG learned that primary care provider B examined the patient at the Bangor CBOC on a Friday afternoon, three days after the patient was discharged from community hospital 1. The patient, who was new to primary care provider B, presented to the appointment in a wheelchair and had multiple questions about medications and access to stroke rehabilitation. Primary care provider B told the OIG that the patient lacked understanding of the new medications (from community hospital 1) and the majority of the visit was spent reviewing medications and discussing options for rehabilitation placement. Primary care provider B informed the OIG that their small town had very little in the way of rehabilitation services. Because of the limited resources available to coordinate access to rehabilitation on a Friday afternoon, the recommendation was made for the patient to return to an emergency department for further evaluation and possible admission. However, the patient declined to go back to the local emergency department and instead asked to be sent to the Togus medical center, which was 71 miles away. Primary care provider B told the patient that there were no options for direct admission into the facility from the Bangor CBOC due to a lack of transportation from Bangor to Togus on Friday afternoons. Primary care provider B shared with the OIG that placing a consult for outpatient therapies was the best available resource for the patient. Primary care provider B's plan of care for the patient included: medication management for hypertension, high cholesterol, and embolic stroke, as well as a referral for outpatient physical therapy and a return to the Bangor CBOC in one month.

### *Physical Exam*

VHA expects providers to produce complete, timely, and reliable documentation of a patient's health history, present illness, and course of treatment., Documentation should include observations, test outcomes, procedures, and treatments as well as evidence of medical decision-making in determining a diagnosis and treatment plan.[24] Additionally, the facility's bylaws and rules directed providers to include a progress note with relevant history of illness and physical findings.[25]

The OIG did not find documented evidence that primary care provider B completed elements of a neurological examination relevant to assessing the patient. The OIG would have expected primary care provider B to conduct and document a complete physical examination and neurological assessment to include the evaluation of reflexes, strength, coordination, gait, and

[24] VHA Health Information Management Office of Health Informatics, *VHA Health Record Documentation Program Guide*, Version 1.1,November 29. 2022; VHA Directive 1907.01, *VHA Health Information Management and Health Records*, April 5, 2021.

[25] Bylaws and Rules of the Medical Staff, July 12, 2021.

sensation to determine the extent of neurological or cognitive impairments that may have been present.[26] Inclusion of these examination elements may have informed decisions regarding appropriate rehabilitation options.

Primary care provider B told the OIG that the patient was not resistant to being examined and that not assessing the patient's gait "was a mistake." In an interview with the OIG, the Chief of Staff (COS) indicated that after reviewing the documentation in the EHR, "documentation of that exam could have been more thorough."

## *Behavioral Assessment*

Emotional changes may occur as a result of injury to the brain caused by a stroke.[27] According to the *VA/[Department of Defense] DoD Clinical Practice Guideline for the Management of Stroke Rehabilitation*, "depression is common after stroke (approximately 30 % incidence rate) and is associated with increased rates of disability and mortality," indicating treatment and prevention efforts are important.[28] Both the VA and Department of Defense (DoD), as well as the American Heart Association and American Stroke Association, guidelines recommend routine screening for post-stroke depression.[29]

The OIG learned that the intermediate care technician (care technician) completed the patient's check-in process for the visit and documented a negative C-SSRS. During an OIG interview, the care technician reported spending 45 minutes talking with the patient regarding medication requests, current living arrangements, military experience, and mental health. The care technician shared that the patient's visit with primary care provider B lasted two hours and recalled the patient exhibiting continued agitation and frustration during the visit.

Although not documented in the patient's EHR, primary care provider B informed the OIG that at the time of the visit, the patient was angry and upset with the care provided. Primary care provider B explained that a behavior flag warning was in the patient's EHR prior to the stroke and that, before seeing the patient, a Bangor CBOC staff member and primary care provider A

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[26] "Neurological Exam," Johns Hopkins Medicine, accessed March 17, 2023, https://www.hopkinsmedicine.org/health/conditions-and-diseases/neurological-exam. A neurological exam includes "an assessment of motor and sensory skills, balance and coordination, mental status. . .reflexes, and functioning of the nerves."

[27] "Let's talk about Emotional Changes after Stroke" (web page), American Heart Association/American Stroke Association, accessed May 3, 2023, https://www.stroke.org/-/media/Stroke-Files/Lets-Talk-About-Stroke/Life-After-Stroke/LTAS_Emotional-Changes-After-Stroke.pdf.

[28] VA and DoD, *VA/DoD Clinical Practice Guideline for the Management of Stroke Rehabilitation,* Version 4.0, July 2019.

[29] VA and DoD, *VA/DoD Clinical Practice Guideline for the Management of Stroke Rehabilitation*, Version 4.0; American Heart Association/American Stroke Association Guideline, *2018 Guidelines for the Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association*, accessed November 29, 2022, https://www.ahajournals.org/doi/epub/10.1161/STR.0000000000000158.

mentioned that the patient had a history of loud speech and challenging behavior.[30] Primary care provider B expressed believing that the behavior demonstrated by the patient during the visit was not a result of the stroke.

The OIG found that despite the patient having a medical history significant for depression, and a recent second stroke, primary care provider B's assessment of the patient's psychological state was minimal. Primary care provider B's EHR documentation reflected that the patient was cooperative, and noted that the patient was not being treated by mental health or taking psychiatric medications but did not include a screening for depression. The OIG inquired about the patient's risk of increased depression or suicide post stroke; primary care provider B shared that a care technician completed the C-SSRS and it was negative. Primary care provider B also stated being unfamiliar with literature that identified an increased risk of depression and suicide post stroke.

The OIG concluded that as a result of the incomplete physical exam, primary care provider B could not accurately determine the patient's specific rehabilitation needs. Due to the lack of a patient specific neurological assessment, the OIG was unable to determine if primary care provider B's plan of care for the patient was appropriate. Additionally, had primary care provider B considered the potential impact the stroke had on the patient's mental health, primary care provider B may have recognized the need to perform a post-stroke depression screening to identify patient vulnerabilities or need for additional support.

## Lack of Care Coordination

The OIG substantiated that inpatient rehabilitation placement was not made for the patient, and that staff at community hospital 1 assessed the patient's functional status and determined the patient met criteria for outpatient therapy upon discharge. However, at the time of the patient's Bangor CBOC visit, primary care provider B did not consider all options for rehabilitation care or enter the consult to arrange transportation necessary for the patient to attend outpatient therapies. The OIG did not substantiate that facility staff had not communicated with the patient.

VHA requires patients' care be coordinated to ensure that care does not lapse; "relevant information is communicated to involved providers"; and recommended care is incorporated "to avoid duplication, poor timing or missed care opportunities."[31] VHA policy states, "When a patient requests health care, the patient's request is evaluated promptly by the PACT staff member who has appropriate competency."[32] In addition, VHA requires PACT staff to provide

[30] Documentation in the progress note from the Bangor CBOC visit reflected the patient had a diagnosis of personality disorder. The OIG reviewed the patient's EHR as well as non-VA medical records and found no evidence of this diagnosis.

[31] VHA Handbook 1101.10(1).

[32] VHA Handbook 1101.10(1).

care that is clinically indicated and considers the patient's preferences.[33] If care in the community is warranted, a VHA provider enters a community care consult on behalf of the patient.[34] Maine has been identified as the most rural state in the nation as half of the state is nearly uninhabited.[35] Barriers to healthcare access in rural communities include a lack of transportation and workforce shortages.[36]

The discharge plan outlined in community hospital 1 directed the patient to follow-up with a VA primary care provider at the facility within one to two weeks and to go to an emergency department if experiencing new or worsening stroke symptoms. In addition, community hospital 1 physical and occupational therapy notes indicated that the patient could independently complete activities of daily living, should not drive and recommended outpatient therapy. However, there were no physical or occupational therapy discharge orders in place at the time of discharge.

The patient's facility EHR indicated that the patient's PACT was aware of the patient's admission to and discharge from community hospital 1. Facility staff communicated with the patient multiple times in the week following hospitalization and the patient was scheduled to see a primary care provider three days after discharge. Although not documented in the EHR, primary care provider B told the OIG that physical rehabilitation service options were requested by and discussed with the patient during the appointment.

During an interview, the OIG learned that primary care provider B believed rehabilitation care options available directly from the Bangor CBOC were limited at the time of the appointment. Primary care provider B explained that based on the patient's stated preference for inpatient rehabilitation care, the provider recommended the patient return to a community emergency department for further evaluation and possible admission to a hospital. Primary care provider B acknowledged that this discussion should have been documented in the EHR. Primary care provider B told the OIG that patients must be admitted to the hospital for three nights in order to get Medicare coverage for inpatient rehabilitation care. When the patient declined going to a community emergency department, primary care provider B placed a consult for outpatient

[33] VHA Handbook 1101.10(1).

[34] VHA, *VHA Office of Community Care Field Guidebook*, "Chapter 3: How to Perform Care Coordination," December 1, 2022.

[35] "Rural Health and Primary Care," Maine Department of Health and Human Services, accessed March 17, 2023, https://www.maine.gov/dhhs/mecdc/public-health-systems/rhpc/rural-health.shtml.

[36] "Rural Health," CDC National Center for Chronic Disease Prevention and Health Promotion, accessed April 24, 2023, https://www.cdc.gov/chronicdisease/resources/publications/factsheets/rural-health.htm.

physical therapy and documented instructing the patient not to drive. However, the OIG found that primary care provider B did not enter a consult for transportation services for the patient.[37]

To gain an understanding of the options that may have been available to the patient, the OIG interviewed the chief of community care. The chief of community care stated that at the time of the patient's visit, available rehabilitation services in the community included inpatient rehabilitation and skilled agencies that provide home physical therapy and occupational therapy. The chief of community care added that patients do not have to be sent to a local community hospital in order to be referred for inpatient rehabilitation care. Further, this patient could have been referred for rehabilitation care directly through a community care consult with the provider alerting community care staff of the immediate need. The chief of community care noted that given the scarcity of healthcare resources in Maine, managing the expectations of the patient is important and that there would be a challenge to get home-based services for rehabilitation for this patient since not all agencies provide care to persons residing at a motel. The chief of community care also shared that community care did not receive a consult to coordinate any aspect of the patient's care.

In an OIG interview, primary care provider B confirmed knowledge of the process to notify community care staff of consults that need immediate attention. When the OIG inquired as to whether consideration was given to placing a community care consult for this patient, primary care provider B responded that most patients go to rehabilitation from a hospital, and there are few who are admitted directly to rehabilitation or a skilled nursing facility from a community setting. The OIG understood this to be the rationale provided for not placing a community care consult.

The OIG determined that primary care provider B developed and documented a care plan without utilizing all options to access potential rehabilitation care for the patient. Specifically, a community care consult for rehabilitation in the community was not discussed or entered in the EHR. As a result, the patient was not referred to, or considered for admission to, inpatient rehabilitation care. Additionally, although primary care provider B placed a consult for outpatient physical therapy, a consult for transportation to therapy was not entered to ensure the patient's rehabilitation care needs were met.

## 2. Deficiencies in Facility Quality Management Reviews

The OIG determined there were deficiencies related to facility quality management processes. Specific concerns included the facility's process for completing a root cause analysis (RCA) as well as the failure to identify the need for and completion of a peer review.

[37] At the time of the interview with the OIG, primary care provider B noted that the therapy consult entered was eventually cancelled after the patient was determined not to be a candidate for outpatient care. The patient was not a candidate due to returning to an inpatient status four days after the consult was placed.

## RCA Process Knowledge Deficiencies

The OIG determined that the RCA team did not follow the VA's National Center for Patient Safety (NCPS) process for facility leaders' nonconcurrence with RCA findings. The OIG was unable to determine whether use of this process would have impacted the outcome of the final RCA.

According to VHA, "RCAs are required for any sentinel event, serious safety event, or for any patient safety event that poses a substantial, direct, and high probability that a serious safety event would have occurred but did not occur due to intervention or chance."[38] "An RCA is interdisciplinary in nature, identifies system vulnerabilities of risks and their potential contributions to the adverse event,. . . and identifies changes that can be made in systems" performance to "reduce the risk of event recurrence."[39] The RCA team, which includes a subject matter expert, conducts interviews, collects data, performs a cause-and-effect analysis, and formulates an action plan based on their findings. Once finalized, "RCA actions and outcomes must be monitored and tracked for completion and sustainment."[40] In completing their work, RCA teams may also identify lessons learned. Lessons learned are findings that are of value to the organization but "do not directly influence the outcome of the event under analysis."[41]

Further, the team presents the final RCA to the facility director and executive leaders to facilitate concurrence of the action plan. However, VHA only requires the facility director's concurrence and signature on the final RCA.[42] In situations where the facility director does not concur with the RCA team's action plan, NCPS guidance states:

> the team should meet again to decide if there is another action that may address the root cause. It is not appropriate for the Director or leadership team to decide the action to replace the one the team generated. In this situation, it is recommended the team reconvene and discuss the options suggested, however, if the team strongly believes the root cause and action/s were appropriately identified, the [Patient Safety Manager] would check "[Management] does not concur" under that specific [recommendation]/ Action / Outcome". . . [and] the Director is required to provide a statement. . . with the reason and rationale to explain why the RCA team's actions are not being supported. . . This non-concur action will not remove the actions and outcomes from the table; however, the

[38] NCPS, *Guide to Performing Root Cause Analysis*, Version 7; A death by suicide on a VA campus is considered a sentinel event (serious incident). VA, *Guidance for Action Following a Suicide on a VA Campus*, October 2019.

[39] NCPS, Guide to Performing Root Cause Analysis.

[40] NCPS, Guide to Performing Root Cause Analysis.

[41] NCPS, Guide to Performing Root Cause Analysis.

[42] NCPS, Guide to Performing Root Cause Analysis.

actions will not require follow-up. The non-concur action will remain a part of the RCA as non-actionable.[43]

Two days after the patient's death, the Facility Director chartered an interdisciplinary RCA team to review the patient's suicide. The OIG reviewed the process and documentation for the RCA and determined that the chief of quality management and members of the RCA team were unaware of the NCPS process related to facility leaders' nonconcurrence with an RCA team's findings and recommended actions.[44]

Interviewees reported to the OIG that the team presented their final draft of the RCA to facility leaders, including the Facility Director, Associate Director, COS, and the chief of quality management. The team's presentation included multiple root causes, each with corresponding action plans. The OIG also learned that during the presentation, facility leaders commented on and questioned the cause-and-effect relationship between the identified root causes, action plans, and the patient's suicide. The Associate Director told the OIG that the finalized RCA was not ready for the Facility Director to authenticate completion by signing the RCA on the day of the presentation.

The chief of quality management told the OIG that the facility patient safety manager was the RCA team lead. The patient safety manager reported having an individual meeting with the chief of quality management after the RCA presentation. During the meeting, the chief of quality management shared concerns facility leaders had about some of the root causes and action items and requested that the team change several of the action items. The team lead also told the OIG that the Facility Director did not explicitly say that changes must be made before the Facility Director would sign the RCA. The chief of quality management told the OIG of discussion about the language of the action items taking place after the presentation, but did not recall requesting the team make changes, sharing the understanding that the changes were made based on feedback from the executive leaders in attendance at the RCA team's presentation.

Members of the RCA team confirmed meeting after the presentation, and that the team lead summarized the concerns of facility leaders. A team member recalled hearing that facility leaders wanted the team to develop one main contributor [root cause], rather than the multiple root causes presented. After discussion, the RCA team made modifications based on the feedback received while presenting their final draft and later from the chief of quality management. The OIG found that the final signed RCA reflected one root cause with a corresponding action and

[43] The guidance provided states that the patient safety manager and the facility director document this information on a VHA specific web-based form designated for RCAs. NCPS, *Guide to Performing Root Cause Analysis*.

[44] NCPS, *Guide to Performing Root Cause Analysis*. RCAs are quality assurance documents and protected under 38 U.S.C. § 5705. In this section pertaining to RCAs, the OIG has not identified practitioners, patients or reviewers, or any specific discussion related to the quality of medical care. The discussion only involves the RCA process.

six lessons learned. Some of the lessons learned incorporated items from the original RCA presentation.[45]

The OIG inquired about actions outlined in VHA's NCPS RCA guidebook regarding steps that may be taken if facility leaders do not concur with an RCA team's action plan. The chief of quality management reported being unaware of this process. The Facility Director acknowledged the process but was unsure if this RCA team considered use of the option. In written correspondence with the OIG, RCA team members shared that the option was not considered as it was not known to them and had not been offered as an option by the team leader. The team lead confirmed in writing that the option was not considered, adding it "should have been on further review and learning."

The RCA process outlined by NCPS describes the presentation to leadership as a time for questions to be asked and discussion to occur but not a forum for leaders to change the work of the team. The authority to change root cause(s) and action(s) rests with the RCA team who, after hearing input of others, have options on how to proceed. The team may decide to leave the RCA as is, in which case it will remain unsigned and open indefinitely, or to make edits to the document and resubmit it for concurrence or select the *management does not concur* option for some or all items. An RCA team's documentation of the facility director's nonconcurrence including rationale is a transparent process to memorialize firmly held differing points of view in the official RCA record. The flexibility built into the process that allows teams to reconvene, consider the input of leaders, and edit the RCA as the team determines has the potential to strengthen the end product but relies on teams acting independently of the influence of leaders.

The OIG concluded that facility leaders shared their concerns related to the original root causes and respective action plans with the RCA team during their presentation, per VHA policy. The OIG confirmed that the team met and discussed their concerns; however, the OIG was unable to determine whether the final RCA would have varied if the team had knowledge of the *management does not concur* option. While the OIG does not have evidence to support that the team did not act independently, the OIG is concerned with the lack of knowledge of options to manage RCAs and document when leaders and the team may differ in their assessment of the incident.

## Failure to Conduct a Peer Review for Quality Management

The OIG determined that the facility did not conduct a peer review of the provider involved in the patient's care, as required by VHA policy.[46] The OIG determined that the patient had a change in condition prior to, and after, receiving care from primary care provider B.

[45] NCPS, *Guide to Performing Root Cause Analysis*. Lessons learned are not considered RCA actions that need to "be monitored and tracked."

[46] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

Per VHA, the peer review for quality management (peer review) process is an evaluation of the "care provided by individual clinicians within a selected episode of care" to determine if the provider's clinical decision-making and actions met the standard of care.[47] The peer review process "is intended to promote confidential and non-punitive assessments of care at the individual clinician level" with the intent of identifying opportunities for improvement in clinical practice.[48]

VHA policy requires a peer review be conducted when the death of a patient was "preceded by a change in the patient's condition when there are questions regarding response to, management of, and/or communication related to the referenced change."[49]

The risk manager shared that initially, due to the severity of the incident, the patient's care was reviewed and a peer review was under consideration. The risk manager later added that the incident did not meet any of the criteria to trigger a mandatory peer review and expounded by providing clinical events that would require one. According to the risk manager, per VHA policy, an ongoing RCA, as was the case in this situation, would preclude the facility from conducting a peer review. The risk manager recalled discussing this point with the COS who agreed that a peer review was not necessary because of the RCA. However, the OIG did not find support in VHA policy that an RCA would preclude a peer review.

In interviews with the OIG, the COS initially said that a peer review was in process but later clarified that an RCA was conducted instead of initiating a peer review. The COS added understanding that a peer review was not done as the event was considered a process issue rather than concern about the provider's care of the patient. The Facility Director said that no peer reviews related to the care of the patient were completed and, when asked, the COS told the Facility Director a peer review was not necessary. After conversations with the OIG and reviewing the patient's EHR in early 2023, the COS reported planning to confer with the risk manager again to consider initiating a peer review for the care of the patient.

The OIG determined that VHA's clinical event criteria for peer review was met based on the patient's death being preceded by a change in condition, specifically a stroke, when there are questions regarding care management prior to death. Additionally, per VHA policy, an active RCA does not preclude or replace completion of a peer review.[50] Facility staff's failure to recognize the need for a peer review resulted in a missed opportunity to identify potential

[47] VHA Directive 1190. VHA defines standard of care as "a diagnostic and/or treatment process that a clinician should follow for a certain type of patient, illness, or clinical circumstance. It is how similarly qualified clinicians would have managed the patient's care under the same or similar circumstances."

[48] VHA Directive 1190.

[49] VHA Directive 1190.

[50] VHA Directive 1190.

vulnerabilities in the healthcare decisions made by a provider and potentially improve care provided to future patients.

# Conclusion

The OIG determined that facility staff did not complete VHA required documentation following a patient's suicidal statements during different encounters with several providers. Although staff attempted to screen the patient for suicide risk, they were met with resistance from the patient and were unable to complete the C-SSRS. None of the providers who were unable to engage the patient documented their inability to complete the C-SSRS in the EHR per VHA. Documenting the inability to complete the C-SSRS provides awareness to other clinicians about the patient's circumstances during a specific interaction. In addition, the EHR lacked evidence that facility staff ensured that the patient had a safety plan in place. The OIG learned some staff were unclear as to who was responsible for completion of a safety plan while one staff member shared completion was done if the C-SSRS was positive. While the OIG was unable to determine if a safety plan would have prevented the patient's suicide, the OIG found the lack of one to be concerning. Additionally, despite Bangor police performing a welfare check at the request of a facility staff member, suicide prevention staff were not notified. Notification to the suicide prevention staff may have allowed the staff to engage the patient.

Primary care provider B failed to complete a comprehensive assessment of the patient during an outpatient appointment. Specifically, the OIG did not find documentation of elements of a neurological examination relevant to this patient or an assessment of the patient for post-stroke depression. The OIG determined that had primary care provider B considered the potential impact of the stroke on the patient's mental health, primary care provider B may have recognized the need to perform a post-stroke depression screening to identify patient vulnerabilities or need for additional support. Given the lack of a complete examination of the patient, primary care provider B may have lacked the information necessary to accurately determine the patient's rehabilitation needs. Therefore, the OIG was unable to determine if the primary care provider B's plan of care for the patient was appropriate.

The OIG did not substantiate that facility staff failed to communicate with the patient. Documentation shows facility staff spoke with the patient multiple times in the week following the first hospitalization and the patient was scheduled to see a primary care provider three days after discharge. The OIG learned that staff at community hospital 1 assessed the patient's functional status and determined the patient met criteria for outpatient therapy upon discharge. The OIG substantiated that, once in the care of facility staff, an inpatient rehabilitation placement was not made and primary care provider B did not consider all options for rehabilitative care or enter a consult to arrange transportation necessary for the patient to attend outpatient therapy.

The OIG concluded that the facility staff completed an RCA to review the care of the patient but found the RCA team did not follow the VA's NCPS process for facility leaders' nonconcurrence

with RCA findings. The OIG determined that facility leaders shared concerns specific to the root causes and respective action plans with the RCA team, who then met and edited the final RCA. The OIG was unable to determine whether the final RCA would have varied if the team had knowledge of and used the *management does not concur* option to document leaders' nonconcurrence with their findings. While the OIG does not have evidence to support that the team did not act independently, the OIG is concerned with staff's lack of knowledge of the process to manage RCAs when leaders and the team have differing views on the root causes.

The OIG determined that the facility did not recognize the need for or conduct a peer review of the provider involved in the patient's care as required by VHA policy. In failing to do so, the facility missed the opportunity to improve care provided to future patients through the identification of potential vulnerabilities, if any, in the provider's healthcare decision-making process.

# Recommendations 1–7

1. The VA Maine Healthcare System Director confirms that staff complete the Columbia-Suicide Severity Rating Scale and document on the Veterans Health Administration template when patients are unwilling to participate in completion of the screening.

2. The VA Maine Healthcare System Director oversees a review to determine whether a VA Maine Healthcare System policy in which clinical staff will be expected to develop safety plans with patients is needed; and if so, ensures one is created.

3. The VA Maine Healthcare System Director verifies that patients identified as having suicidal ideations or behaviors have personalized safety plans documented in the electronic health record, and monitors compliance.

4. The VA Maine Healthcare System Director assesses staff knowledge of when to notify the VA Maine Healthcare System suicide prevention staff about a patient who has made a threat of self-directed violence during a phone call with VA staff, and takes action as warranted.

5. The VA Maine Healthcare System Director ensures that VA Maine Healthcare System leaders and root cause analysis teams are trained in the process for responding to concerns with root cause analysis team findings according to VA National Center for Patient Safety guidance, and monitors adherence.

6. The VA Maine Healthcare System Director ensures that a review of the episode of care prior to the patient's death is completed to determine whether peer reviews are warranted, and takes action accordingly.

7. The VA Maine Healthcare System Director confirms that VA Maine Healthcare System leaders, risk managers, and patient safety staff have knowledge of the types of quality management reviews that can and cannot be done concurrently.

# Appendix A: VISN Director Memorandum

## Department of Veterans Affairs Memorandum

Date: December 5, 2023

From: Director, VA New England Healthcare System (10N1)

Subj: Healthcare Inspection—Deficiencies in Quality of Care at the VA Maine Healthcare System in Augusta

To: Director, Office of Healthcare Inspections (54HL05)

Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. Thank you for the opportunity to review and comment on the draft report regarding the healthcare inspection report at the VA Maine Healthcare System in Augusta. The VA New England Healthcare System is committed to providing exceptional healthcare to Veterans. This includes building a Just Culture that supports the prevention of patient harm and continuous process improvement as a High Reliability Organization.

*2.* I thank the OIG team for their recommendations which identified areas for improvement. I offer my sincerest condolences to this Veteran's family and friends. It was our privilege and honor to care for this Veteran.

3. The leadership teams at VA Maine Healthcare System and the Veterans Integrated Network Office are committed to implementing corrective actions and will diligently pursue all measures to ensure safe, high-quality care for the Veterans that we serve.

Ryan Lilly, MPA
VISN 1 Network Director
VA New England Healthcare System

[**OIG comment**: The OIG received the above memorandum from the VISN Director on February 7, 2024.]

# Appendix B: Facility Director Memorandum

## Department of Veterans Affairs Memorandum

Date: December 5, 2023

From: Director, VA Maine Healthcare System (402)

Subj: Healthcare Inspection—Deficiencies in Quality of Care at the VA Maine Healthcare System in Augusta

To: Director, VA New England Healthcare System (10N1)

1. We are deeply saddened by the passing of this Veteran, and our sympathies go out to the Veteran's family and loved ones. There is nothing more important to us at VA than preventing Veteran suicide, and we are utilizing this review to improve suicide prevention at VA Maine through the recommendations provided in the Office of the Inspector General's (OIG) report.

2. VA Maine is committed to honoring our Veterans by ensuring they receive high-quality health care services. I am proud of the health care professionals at the Bangor VA Clinic for their devotion to our mission, the care they provide, and the manner at which they responded to this heartbreaking event. I appreciate the opportunity and always look to improve care provided by the VA Maine Healthcare System.

3. We value the hard-earned trust of the community and the more that 53,000 Veterans we are privileged to serve at VA Maine. We learned a great deal from this tragedy and are improving processes to provide continued high quality care to Veterans.

4. Please find the attached response to each recommendation included in the report. VA Maine completed, or is in process of completing, the OIG's recommended actions to strengthen the care we provide.

Tracye B. Davis
Medical Center Director
VA Maine Healthcare System

[**OIG comment**: The OIG received the above memorandum from the Facility Director on February 7, 2024.]

# Facility Director Response

## Recommendation 1

The VA Maine Healthcare System Director confirms that staff complete the Columbia-Suicide Severity Rating Scale and document on the Veterans Health Administration template when patients are unwilling to participate in completion of the screening.

_X_ Concur

____Nonconcur

Target date for completion: June 30, 2024

## Director Comments

The VA Maine Healthcare System Director reviewed and evaluated additional reasons for noncompliance. The VA Maine Healthcare System Director assigned the Suicide Prevention Committee with the development of competency-based training to be administered to all current clinical staff and all new clinical staff within 90 days of hire. The VA Maine Healthcare System Director will monitor the completion of training until 90% compliance has been achieved for six consecutive months. Compliance will be documented in the Suicide Prevention Committee minutes.

## Recommendation 2

The VA Maine Healthcare System Director oversees a review to determine whether a VA Maine Healthcare System policy in which clinical staff will be expected to develop safety plans with patients is needed; and if so, ensures one is created.

_X_ Concur

____Nonconcur

Target date for completion: January 31, 2024

## Director Comments

The VA Maine Healthcare System Director reviewed and evaluated the need for a VA Maine Healthcare System policy in which clinical staff will be expected to develop safety plans and determined a need for revision of the current Suicide Prevention Policy to include comprehensive language regarding safety planning. The Accreditation Specialist will facilitate the completion of a draft policy with the required revisions by December 21, 2023. Following a two-week review period, a final draft will be completed and published in the VA Maine Healthcare System document control system no later than January 31, 2024.

## OIG Comment

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

## Recommendation 3

The VA Maine Healthcare System Director verifies that patients identified as having suicidal ideations or behaviors have personalized safety plans documented in the electronic health record, and monitors compliance.

_X_ Concur

____Nonconcur

Target date for completion: June 30, 2024

## Director Comments

The VA Maine Healthcare System Director reviewed and evaluated the process for the completion of safety planning. The facility Suicide Prevention Committee will audit and track 100% of all positive Comprehensive Suicide Risk Evaluations for the presence of safety plans in compliance with VHA Directive 1160.07 until 90% compliance has been achieved for six consecutive months. Compliance will be documented in the Suicide Prevention Committee minutes.

## Recommendation 4

The VA Maine Healthcare System Director assesses staff knowledge of when to notify the VA Maine Healthcare System suicide prevention staff about a patient who has made a threat of self-directed violence during a phone call with VA staff, and takes action as warranted.

_X_ Concur

____Nonconcur

Target date for completion: March 14, 2024

## Director Comments

The VA Maine Healthcare System Director reviewed and evaluated reasons for noncompliance with reporting threats of self-directed violence to the suicide prevention staff. The Suicide Prevention Coordinator will be responsible for the development of local training outlining when and how to alert suicide prevention staff when Veterans make threats of self-directed violence. The training will include a competency-based post-test required for completion. This training will be administered to all current clinical staff and all new clinical employees within 90 days of

hire. The Suicide Prevention Committee will track new hire completion within 90 days until 90% compliance has been achieved for six consecutive months. Evidence of compliance will be documented in the Suicide Prevention Committee minutes.

## Recommendation 5

The VA Maine Healthcare System Director ensures that VA Maine Healthcare System leaders and root cause analysis teams are trained in the process for responding to concerns with root cause analysis team findings according to VA National Center for Patient Safety guidance, and monitors adherence.

_X_ Concur

____Nonconcur

Target date for completion: February 21, 2023

## Director Comments

The VA Maine Healthcare System Director had previously reviewed and evaluated the process for responding to concerns with root cause analysis team findings in accordance with VA National Center for Patient Safety guidance. On February 21, 2023, the facility Chief of Quality Management presented a review of the Root Cause Analysis processes, principles, and guidebook to facility executive leadership. Facility leadership verbalized understanding of the content. The same presentation and expectations were shared with the facility patient safety staff, who provided this information to all root cause analysis team members. To ensure ongoing compliance, all new patient safety hires will receive the same education. We would like to request closure of this recommendation prior to publication based on supporting evidence provided to the OIG.

## OIG Comments

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

## Recommendation 6

The VA Maine Healthcare System Director ensures that a review of the episode of care prior to the patient's death is completed to determine whether peer reviews are warranted, and takes action accordingly.

_X_ Concur

____Nonconcur

Target date for completion: April 18, 2023

## Director Comments

On February 22, 2023, following the OIG inspection, the VA Maine Healthcare System Director requested the Veteran's care be referred for peer review. The VA Maine Healthcare System takes all patient safety events, including suicides very seriously, and, while the circumstances of this event were initially reviewed and deemed not to necessitate an RCA in this instance, we appreciate the recommendation from the OIG. Peer reviews were completed on April 18, 2023.

## OIG Comments

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

## Recommendation 7

The VA Maine Healthcare System Director confirms that VA Maine Healthcare System leaders, risk managers, and patient safety staff have knowledge of the types of quality management reviews that can and cannot be done concurrently.

_X_ Concur

____Nonconcur

Target date for completion: May 30, 2023

## Director Comments

The VA Maine Healthcare System Director had previously reviewed and evaluated the types of quality management reviews that can and cannot be done concurrently. A review of VHA Directive 1190, VHA Directive 1050.01, VHA Directive 0700, and VHA Handbook 0700 has been completed to ensure leaders, risk managers, and patient safety staff have the required knowledge regarding concurrent reviews. Starting May 30, 2023, the facility risk manager and patient safety staff began weekly collaborative meetings to discuss all Safety Assessment Code (SAC) 3 and potential SAC 3 Joint Patient Safety Reporting events to determine the required reviews, including the need for concurrent reviews. The scope of each review is clearly identified and agreed upon by the risk manager and patient safety staff. We would like to request closure of this recommendation prior to publication based on the outlined process.

## OIG Comments

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

# Glossary

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

**access clinics.** Access clinics are a part of the facility located in Fort Kent and Houlton that are open one day per week to provide primary care, lab services, and support to initiate an online My HealtheVet account.[1]

**adverse event.** "Untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical facility, outpatient clinic, or other VHA facility."[2]

**calcification.** "Abnormal deposition of calcium salts within soft tissue often causing thickening or hardening."[3]

**cardioembolic stroke.** A type of ischemic stroke in which an emboli, or clot, travels from the heart to the brain.[4]

**computed tomography angiogram.** "An imaging test to view your blood vessels and tissues. It uses an injection of contrast dye and specialized X-rays."[5]

**computerized tomography scan.** A scan that uses a series of x-rays to create cross-sectional images of bones, blood vessels, and soft tissues to diagnose disease or injury.[6]

**consult.** "A request for clinical services on behalf of a patient. In VHA, consult requests are made through an electronic document [in the EHR] communicating service requests and/or results."[7]

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[1] "Houlton VA Clinic" (web page), VA Maine Health Care System, accessed February 28, 2023, https://www.va.gov/maine-health-care/locations/houlton-va-clinic/ and "Fort Kent VA Clinic" (web page), VA Maine Health Care, accessed February 28, 2023, https://www.va.gov/maine-health-care/locations/fort-kent-va-clinic/.

[2] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

[3] *Merriam-Webster.com Dictionary*, "calcification," accessed May 24, 2023, https://www.merriam-webster.com/medical/calcification.

[4] A. Arboix and J. Alio, "Cardioembolic Stroke: Clinical Features, Specific Cardiac Disorders and Prognosis," *Current Cardiology Reviews*, (August 2010):.150-61, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2994107/.

[5] "CT Angiogram" (web page), Cleveland Clinic, accessed March 29, 2023, https://my.clevelandclinic.org/health/diagnostics/16899-coronary-computed-tomography-angiogram.

[6] Mayo Clinic, "CT scan," accessed June 5, 2023, https://www.mayoclinic.org/tests-procedures/ct-scan/about/pac-20393675.

[7] VHA Directive 1232(5), *Consult Processes and Procedures*, August 24, 2016, amended December 5, 2022.

**echocardiogram.** A study that produces images of the heart by using sound waves. It is used to determine how the heart is pumping blood and if the patient has heart disease.[8]

**electrocardiogram.** A non-invasive diagnostic test which records the electrical signals in the heart and is used to detect problems or monitor the heart's status.[9]

**embolic stroke.** "Embolic strokes are usually caused by a blood clot that forms elsewhere in the body (embolus) and travels through the bloodstream to the brain."[10]

**hypertension.** Abnormally high blood pressure and especially arterial blood pressure.[11]

**intermediate care technician.** Former military corpsmen, combat medics and medical technicians hired by VHA as a part of the medical team to use clinical skills and care coordination to increase access to care, nursing and medicine productivity and patient satisfaction.[12]

**intracranial hemorrhage.** "Bleeding between the brain tissue and skull or within the brain tissue itself."[13]

**ischemia.** A deficient supply of blood to a body part (such as the heart or brain) due to obstruction of arterial blood.[14]

**ischemic stroke.** "An ischemic stroke occurs when the blood supply to part of the brain is interrupted or reduced, preventing brain tissue from getting oxygen and nutrients. Brain cells begin to die in minutes."[15]

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[8] Mayo Clinic, "Echocardiogram," accessed June 8, 2023, https://www.mayoclinic.org/tests-procedures/echocardiogram/about/pac-20393856?p=1.

[9] Mayo Clinic, "Electrocardiogram (ECG or EKG)," accessed June 8, 2023, https://www.mayoclinic.org/tests-procedures/ekg/about/pac-20384983.

[10] "Types of Stroke" (web page), Johns Hopkins Medicine, accessed October 6, 2023, https://www.hopkinsmedicine.org/health/conditions-and-diseases/stroke/types-of-stroke.

[11] *Merriam-Webster.com Dictionary*, "hypertension," accessed February 28, 2023, https://www.merriam-webster.com/dictionary/hypertension."

[12] "Clinical Strong Practice – Intermediate Care Technician" (web page), accessed March 13, 2023, https://www.va.gov/covidtraining/docs/CSP_Intermediate_Care_Technician_final.pdf.

[13] Cleveland Clinic, "Brain Bleed, Hemorrhage (Intracranial Hemorrhage)," accessed May 24, 2023, https://my.clevelandclinic.org/health/diseases/14480-brain-bleed-hemorrhage-intracranial-hemorrhage.

[14] *Merriam-Webster.com Dictionary*, "ischemia," accessed June 8, 2023, https://www.merriam-webster.com/dictionary/ischemia#medicalDictionary.

[15] Mayo Clinic, "Stroke," accessed February 28, 2023, https://www.mayoclinic.org/diseases-conditions/stroke/symptoms-causes/syc-20350113.

**magnetic resonance imaging.** "Medical imaging technique that uses a magnetic field and computer-generated radio waves to create detailed images of the organs and tissues in your body."[16]

**mitral valve.** "The mitral valve is one of four valves in the heart that keep blood flowing in the right direction."[17]

**neurological examination.** "[A]n evaluation of a person's nervous system that can be done in the healthcare provider's office." "There are many aspects of this exam, including an assessment of motor and sensory skills, balance and coordination, reflexes, and functioning of the nerves."[18]

**patient aligned care team.** Provides "patient-driven, proactive, personalized, team-based care focused on wellness and disease prevention resulting in improvements in Veteran satisfaction, improved healthcare outcomes, and costs."[19]

**permissive hypertension.** A technique that is used to maintain higher blood pressure for up to 24 to 48 hours to improve blood flow.[20]

**root cause analysis.** A review to identify contributing factors, determine cause-and-effect related to an adverse event or close call.[21]

**safety plan.** "A prioritized written list of coping strategies and sources of support developed in collaboration with patients that can be used before or during suicidal crises."[22]

**sentinel event.** According to The Joint Commission, sentinel events are adverse events that occurred unexpectedly "involving death, serious physical or psychological injury, or risk thereof."[23]

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[16] Mayo Clinic, "MRI," (web page), accessed March 22, 2023, https://www.mayoclinic.org/tests-procedures/mri/about/pac-20384768?p=1.

[17] Mayo Clinic, "Mitral valve disease," accessed May 24, 2023, https://www.mayoclinic.org/diseases-conditions/mitral-valve-disease/symptoms-causes/syc-20355107.

[18] Johns Hopkins Medicine, "Neurological Exam," accessed October 10, 2023, https://www.hopkinsmedicine.org/health/conditions-and-diseases/neurological-exam.

[19] "Patient Care Services" (web page), VA, accessed March 14, 2023, https://www.patientcare.va.gov/primarycare/PACT.asp.

[20] Eva A. Mistry et al, "Systolic Blood Pressure Within 24 Hours After Thrombectomy for Acute Ischemic Stroke Correlates With Outcome," Journal of the American Heart Association, 2017. Accessed October 13, 2023, https://www.ahajournals.org/doi/epdf/10.1161/JAHA.117.006167; M. McManus and D. S. Liebeskind, "Blood Pressure in Acute Ischemic Stroke," Journal of Clinical Neurology, 2016, accessed October 17, 2023, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4828558/pdf/jcn-12-137.pdf.

[21] VHA Handbook 1050.01.

[22] VHA Directive 1160.07.

[23] VHA Handbook 1050.01.

**sinus rhythm.** The rhythm of the heartbeat produced by impulses from the sinoatrial node.[24]

**suicidal ideation.** "The act of thinking about or a state of preoccupation with taking one's own life: the act of considering or planning suicide."[25]

**suicide behavior and overdose reports.** A standardized reporting process that collects "information on suicidal behaviors and non-suicidal overdoses that result in an adverse event."[26]

[24] *Merriam-Webster.com Dictionary*, "Sinus rhythm" (web page), accessed March 29, 2023 from https://www.merriam-webster.com/dictionary/sinus rhythm.

[25] *Merriam-Webster.com Dictionary*, "suicidal ideation" (web page), accessed October 17, 2023 https://www.merriam-webster.com/dictionary/suicidal ideation.

[26] VA Suicide Prevention Safety Plan and Suicide Behavior and Overdose Report (SBOR) Templates *Staff-Specific Guidance,* August 17, 2022.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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