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Office of Healthcare Inspections

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Healthcare Inspection Patient Mental Health Care Issues at a Veterans Integrated Service Network 16 Facility

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Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the merit of allegations from a family member about inadequate mental health (MH) care provided to a patient prior to his suicide, at a Veterans Integrated Service Network (VISN) 16 facility.[1]

Specifically, the allegations were:

- The patient effectively managed his bipolar illness with the help of MH professionals and family until 2014, when new providers tapered and then discontinued his long-standing medication treatment of clonazepam against his wishes.
- The patient was not admitted to the facility's Psychosocial Residential Rehabilitation Treatment Program as recommended by MH providers.

We substantiated that after being reasonably stable under the care of a facility psychiatrist for many years, subsequent facility psychiatrists reduced and discontinued the patient's clonazepam. We found that the patient's treatment preferences were not considered, nor was the patient informed of his right to appeal treatment decisions made by facility MH staff. Furthermore, refusal on the part of the patient's psychiatrists to treat the patient unless he agreed to permanently taper off clonazepam created a treatment impasse and violated Veterans Health Administration (VHA) policy, which prohibits practitioners from threatening to deny a patient access to one treatment or procedure unless the patient consents to another treatment or procedure.

During the course of our inspection, we also found deficiencies in the treatment of the patient's bipolar disorder. Discontinuation of his medication that had been used for about 20 years was abrupt relative to the clinical situation. A medically supervised, gradual taper was indicated due to the patient's long history of treatment with clonazepam, hypomanic symptoms, and his reservations about coming off the clonazepam. However, no schedule for the taper was provided, no assessment of the adequacy of the patient's available medication supply was performed, and no specific plan was made for the patient to return to the clinic for follow-up of this significant treatment change. We found that following this discontinuation of the patient's clonazepam, his clinical condition worsened to the point that he made multiple suicide attempts resulting in psychiatric and acute medical care hospitalizations. He was also hospitalized on other occasions for behavioral disturbances.

Despite these hospitalizations and suicide attempts, exploration of other MH treatment options, such as inpatient medication evaluation and management, community partial hospitalization programs, and intensive case management services was limited. Although these additional interventions would have been appropriate to address his

[1] The name of the facility is not being disclosed to protect the privacy rights of the subject of the report pursuant to 38 U.S.C., Section 7332, Confidentiality of Certain Medical Records, January 3, 2012.

underlying bipolar disorder, management of this condition and the patient's suicidality relied primarily on outpatient psychotherapy and infrequent medication management.

We substantiated that the patient was not admitted to the facility's Psychosocial Residential Rehabilitation Treatment Program. We identified several barriers to the patient's admission, including misconceptions about admission criteria, poor communication between providers, and delays in contacting the patient.

The patient did not have timely access to psychiatric care. The length of time between scheduled psychiatry appointments ranged from 44 to 91 days despite the patient's deteriorating condition. The patient was identified by MH providers as at high risk for suicide, but was not seen at the post-discharge frequency required by facility policy. We found that during the last 9 months of his life, 12 of 18 appointments (67 percent) were not compliant with the scheduling requirement. Despite problems with access to care, the patient was not referred to the Veterans Choice Program.

The levels of communication, collaboration, and planning by the patient's MH care providers were not commensurate with the patient's complex psychiatric care needs. His psychiatrist did not regularly attend MH Service interdisciplinary team (IDT) meetings, and during one period was unaware that the patient made multiple suicide attempts during that period while he was being seen by the MH social worker. The patient's MH treatment plan did not show documentation of any IDT collaboration despite having three MH staff providing direct care, and the Suicide Prevention Coordinator providing indirect care. In addition, the patient's MH treatment plan was not revised during any of the patient's transitions from inpatient to outpatient settings, and the treatment goals remained unchanged during the last 9 months of the patient's life despite his worsening condition. We also found no evidence in the electronic health record that the patient was assigned a MH Treatment Coordinator, despite a requirement for this under VHA policy.

The patient's worsening clinical condition was attributed to an unfounded substance use disorder diagnosis rather than his bipolar illness. We found that clinicians did not reconcile the patient's medications at critical transitions of treatment, such as at discharge from community hospitals. Facility staff failed to follow facility requirements for the completion of Suicide Behavior Reports and the screenings to determine whether peer reviews were needed following the patient's suicide attempts. Further, we found that facility managers should have considered disclosing information related to the patient's treatment to the patient's family, after consulting with the Office of Chief Counsel.

We recommended that the Facility Director:

- Disallow usage of unapproved policies and monitor compliance.
- Ensure facility managers revise the patient complaint policy to include the VHA requirement for a clinical appeals process and to educate clinicians about the VHA requirement for clinical appeals and monitor compliance.

- Ensure that the Psychosocial Residential Rehabilitation Treatment Program committee admission screening process is appropriate and timely and monitor compliance.
- Ensure that MH clinicians administer tuberculosis tests (purified protein derivative) when needed for Psychosocial Residential Rehabilitation Treatment Program admission and monitor compliance.
- Ensure that MH services are provided timely for patients designated as high risk for suicide that have been recently discharged from community hospitals.
- Ensure that non-VA care for psychiatric services is offered to patients who need to be seen sooner than VA appointment availability permits.
- Request the VISN MH Program Manager evaluate facility MH Services and programs for opportunities for improvement.
- Ensure that a MH Treatment Coordinator policy is implemented as required by VHA and that all patients receiving MH services are assigned a MH Treatment Coordinator.
- Ensure compliance with medication reconciliation as required by facility policies.
- Ensure that Suicide Behavior Reports are completed for all patient suicide attempts and that the Patient Safety Manager is added as an additional signer as required by facility policy.
- Ensure that peer review screenings are completed for all patients who have attempted suicide within 30 days of seeing a health care professional as required by facility policy.
- Initiate an external peer review to determine whether MH staff appropriately managed the patient's bipolar illness. Based on the results of that peer review, the Facility Director should consult with the Office of Chief Counsel regarding an institutional disclosure, if appropriate.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes B and C, pages 32–38 for the Directors' comments.) We consider recommendations 1, 4, 7, and 9 closed. We will follow up on the planned actions for the remaining recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
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Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the merit of allegations from a patient's family member about inadequate mental health (MH) care provided to a patient, prior to his suicide, at a Veterans Integrated Service Network (VISN) 16 facility (facility).[2]

Background

The facility is part of VISN 16 and provides comprehensive medical and psychiatric care.

Prior reports

An OIG report search did not identify relevant reports for the facility. See Appendix B for other relevant OIG reports published in the past 5 years.

Psychosocial Residential Rehabilitation Treatment Program

A Psychosocial Residential Rehabilitation Treatment Program (PRRTP) is a short-term program for patients whose clinical treatment needs are not severe enough to require more intensive levels of treatment. The program is in a home-like setting located at the facility and offers treatment to patients with substance abuse disorders, post-traumatic stress disorder, and chronic mental illness, and services for homelessness. To facilitate PRRTP access, a screening team determines whether a patient is appropriate for admission to the PRRTP. The screening team is composed of staff who have the necessary competence to make an admission decision and must include at a minimum, a licensed MH professional and a licensed physician or a licensed physician extender.[3] Screenings are conducted on all normal business days.

Patient Centered Care

According to the National Academy of Medicine, patient centered care "…should revolve around the patient, respect patient preferences, and put the patient in control." The concept of patient centered care is emphasized in the Veterans Health Administration (VHA) MH Strategic Plan[4] and the VHA MH Handbook,[5] and is consistent with VHA MH initiatives since 2004. A primary principle of patient centered care is that people with MH disorders, including those with serious mental illness, can be active participants in their treatment and "drivers of MH care." In patient centered

[2] The name of the facility is not being disclosed to protect the privacy rights of the subject of the report pursuant to 38 U.S.C., Section 7332, Confidentiality of Certain Medical Records, January 3, 2012.
[3] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010. Expired December 31, 2015.
[4] *A Comprehensive VHA Strategic Plan for Mental Health Services-Revised*, July 9, 2004.
[5] VHA Handbook 11601.01, *Uniform MH Services in VA Medical Centers and Clinics*, September 11, 2008, Expired September 30, 2013, Amended November 16, 2015. The amendment did not change the expiration date.

care, the patient is the source of control over health care decisions that affect him or her. Case management[6] is a key component of VHA's patient centered health care delivery and has a recognized role in caring for patients with chronic, catastrophic, and/or complex high-risk or high-cost health care issues. VHA has established case management models for specialty populations including patients with severe mental illness and/or post-traumatic stress disorder.

Bipolar Disorder

Bipolar disorder is a mental illness that causes unusual and extreme shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. Mood changes can range from extremely elated and energized behavior (known as manic episodes), to very sad (dysphoric), hopeless, or physically slowed behavior (known as depressive episodes). Less severe manic periods are known as hypomanic episodes (euphoric).[7]

Bipolar disorder is a cyclical lifelong illness with episodes of mania, hypomania, and depression that typically come and go over time. Treatment helps many people gain better control of their illness by reducing the severity, duration, and frequency of mood episodes, and by alleviating residual bipolar symptoms (such as suicide risk and sleep disorders) that may occur between episodes.[8] An effective treatment plan must be individualized to the particular patient, and often includes a combination of medications, as well as psychotherapy. [9][10]

Medications Commonly Used for Treatment of Bipolar Disorder

Providers use several different types of medications to treat bipolar disorder. Because some medications may be ineffective or poorly tolerated, a patient may need to try multiple medications before finding those that work best. Medications generally used to treat bipolar disorder include[11]:

- Mood stabilizers: This class of medication is believed to decrease certain types of abnormal activity in the brain. Mood stabilizing medications include lithium and some drugs that produce anticonvulsant activity.

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[6] Case management focuses on long-range care coordination, and linking patients and their families with needed services, resources, and opportunities for wellness.[6]

[7] Bipolar Disorder. National Institute of Mental Health (NIMH) Web site. https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. Last revised April 2016. Accessed April 5, 2017.

[8] Samalin L, Yon L, Giordana B, Milhet V, Eh Hage W, Courter P, Bellivier F, Llorca P.M, *Residual Symptoms In Bipolar Disorder: How to Define and to Manage Them in Clinical Practice*. 20th Century European Congress of Psychiatry, P-2016.

[9] Psychotherapy is a general term for treating MH problems by talking with a psychiatrist, psychologist or other MH provider. Psychotherapy. Mayo Clinic Web site. http://www.mayoclinic.org/tests-procedures/psychotherapy/home/ovc-20197188. Last revised March 17, 2016. Accessed April 5, 2017.

[10] Bipolar Disorder. NIMH Web site. https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. Last revised April 2016. Accessed April 5, 2017.

[11] Ibid.

- Atypical or second-generation antipsychotics[12]: These are a newer class of medications, compared to the older first generation or "typical" antipsychotics, which are better tolerated with fewer adverse effects. Some atypical antipsychotics have mood stabilizing or antidepressant properties.

- Antidepressants: These medications are intended to help normalize depressed mood. However, treating bipolar depression with antidepressants is controversial because of their potential to destabilize mood in this condition, but are nevertheless an often-used option in both clinical practice and published guidelines.

- Sleep medications: Disturbance of the sleep-wake cycle is a common symptom in bipolar disorder that can contribute to mood destabilization. Treatment of the underlying mood disorder may be helpful with sleep. However, if sleeplessness does not improve, hypnotic sleep medications (including benzodiazepines) may be prescribed.

In some patients with bipolar disorder, commonly prescribed medications may not be effective or tolerable, and medications approved for use for patients with other health problems may be necessary.

Benzodiazepines in the Treatment of Bipolar Disorder and Other MH Conditions

Benzodiazepines are a class of medicines that are used to treat anxiety, sleeping problems (as noted above), and other disorders.[13] Examples include diazepam, lorazepam, and clonazepam. Benzodiazepines work by increasing the inhibitory effects of brain chemicals (neurotransmitters) that transmit messages to certain brain cells. In this way, they decrease the activity of brain cells and can have a sedating or calming effect. Benzodiazepines are used in the treatment of anxiety and sleep problems. These medications also have anticonvulsant properties.

Current literature suggests that clonazepam can be used for patients who have hypomanic, mild to moderate manic, or mixed episodes and cannot tolerate lithium, anticonvulsants, or antipsychotics. Clonazepam is also approved by the Food and Drug Administration for use in panic and seizure disorders, and the maximum approved dose is 4 milligrams (mg) daily for panic disorder and up to 20 mg daily for seizure disorders.[14] Although individuals with substance use disorders can abuse

[12] Second-generation antipsychotics or "atypical" antipsychotics emerged in the 1980s whereas first-generation or "typical" antipsychotics were developed in the 1950s. First-Generation Versus Second-Generation Antipsychotics in Adults: Comparative Effectiveness. Neurology MedLink Web site. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0049165/. Published August 2012. Accessed April 5, 2017.
[13] Benzodiazepines: Uses, Side Effects, and Risks. Medical News Today Web site. https://vaww.portal.oig.va.gov/directorates/54/Hotlines/2016-03576-HI-0677/Work%20Papers/Benzodiazepines_%20Uses,%20Side%20Effects,%20and%20Risks%20-%20Medical%20News%20Today.pdf. Last updated August 25, 2016. Accessed April 5, 2017.
[14] Clonazepam, Klonipin: Drug Facts, Side Effects and Dosing. http://www.pdr.net/drug-summary/Klonopin-clonazepam-3064. Accessed October 27, 2017.

benzodiazepines, it is recognized that this class of medications has a legitimate role in treating certain patients with psychiatric disorders.

Potential Risks of Benzodiazepines

When benzodiazepines are used for extended periods, patients can experience serious health risks associated with discontinuation or withdrawal of the medications including an age-related added risk of fractures, subtle cognitive decline, and benzodiazepine dependence. [15][16]

Benzodiazepine Withdrawal Syndrome

Benzodiazepine withdrawal syndrome is characterized by sleep disturbance, irritability, increased tension and anxiety, panic attacks, hand tremors, sweating, difficulty concentrating, nausea and vomiting, palpitations, headache, muscular pain, and hallucinations. Withdrawal of benzodiazepines can also cause potentially life-threatening seizures and psychotic reactions.[17] Withdrawal symptoms may continue even if the medication is resumed.

VHA Initiatives Targeting Prescribing Safety Practices

Starting in August 2013, VHA implemented prescribing safety practices with a national pain management strategy.[18] Some of the strategies included:

1. Opioid[19] Safety Initiative: Begun in August 2013, this initiative focused on reducing both the use of opioids and co-prescribing opioids with benzodiazepines.

2. Psychotropic[20] Drug Safety Initiative: As of December 2013, this initiative introduced a mandatory nation-wide quality improvement effort addressing overprescribing of psychotropic medications, appropriate clinical management for specific patient populations (the elderly, patients with dementia, patients with PTSD (post-traumatic stress disorder)) receiving psychotropic medications, or patients receiving benzodiazepines without a medical or psychiatric indication.

[15] Olfson M., King M., Schoenbaum M. Benzodiazepine Use in the United States. *JAMA Psychiatry. 2015;72(2): 136−142.doi:10.1001/jamapsychiatry.2014.1763.*
[16] Ashton H. The diagnosis and management of benzodiazepine dependence. *Current Opinion in Psychiatry*. 2005, 18:249−255.
[17] Pètursson H. The benzodiazepine withdrawal syndrome. *Addiction*. The National Center for Biotechnology Information. 1994 Nov; 89(11):1455-9.
[18] "*Statement of Dr. Carolyn Clancy Interim Under Secretary for Health VHA Department of Veterans Affairs Before the Subcommittee on Oversight and Investigations Committee on Veterans' Affairs US House of Representatives,"* June 10, 2015.
[19] Opioids are narcotic medications used to relieve pain.
[20] Psychotropic medication is a medication capable of affecting the mind, emotions, and behavior.

Suicide Risk in Bipolar Disorder

Bipolar disorder is associated with the highest suicide rate among all major psychiatric illnesses. Suicide rates in patients with bipolar disorder are 25 times higher than the general population. Suicidal acts often occur in association with severe depressive and dysphoric-agitated mood states, especially following repeated episodes of severe depression.[21]

Risk of Suicide After Discharge

One of the strongest predictors of ensuing suicide death is hospitalization for psychiatric inpatient care. VA/DoD clinical practice guidelines state, "…the immediate period after discharge is when suicide death is most likely to occur and discharged patients remain at high risk for at least the next year."[22] Studies have shown that the risk of suicide in the 4 weeks after psychiatric inpatient care is around 100 times greater than that for the general population.[23] Reviews and studies of the degree of risk and rates of suicide after psychiatric hospitalization show that prevention of suicide after discharge requires early outpatient follow-up and closer supervision of high-risk patients.[24] For these reasons, it is critical that discharged patients receive prompt follow-up care after hospital discharge.

Transitions of Care

The Joint Commission[25] defines transitions of care as the movement of patients between health care providers, health care settings, and home as their condition and care needs change. Ineffective care transition processes can lead to adverse events, higher readmission rates, and increased costs. VHA policy[26] states, "Facilities must ensure continuity of care during transitions from one level of care to another" and requires that when patients are discharged from inpatient MH settings, they must receive follow-up MH evaluations within 1 week of discharge.[27]

[21] Tondo L, Baldessarini R., *Suicidal Risk In Bipolar Disorder*, Clinical Neuropsychiatry (2005) 2, 1, 55-65.
[22] The Assessment and Management of Risk for Suicide Working Group, *VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide*, Version 1.0 – June 2014, p. 71.
[23] Ibid.
[24] Ibid.
[25] The Joint Commission is an independent, not-for-profit organization that certifies and accredits nearly 21,000 healthcare organizations and programs in the United States. It is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.
[26] VHA Handbook 1160.01, *Uniform MH Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. This Handbook was due for recertification on or before the last working date of September 2013 and has not yet been recertified.
[27] Ibid.

Mental Health Treatment Coordinator

VHA policy[28] states that every patient who receives care in MH services must have a Mental Health Treatment Coordinator (MHTC). The MHTC's role is intended to ensure that each patient has continuity through their MH treatment, especially during times of care transitions. The MHTC fully understands the overall goals of the patient's MH treatment and is a clinical resource for the patient and for other staff. The MHTC ensures that treatment planning is an interdisciplinary and patient-centric process; monitors implementation and documentation of the treatment plan including tracking progress and the outcomes achieved; and ensures that the treatment plan is revised as necessary. Each MHTC collaborates with the Suicide Prevention Coordinator to ensure that patients receive increased monitoring and enhanced care.

Mental Health Intensive Case Management

VHA's required program for veterans with serious mental illness uses an intensive interdisciplinary team approach for ambulatory management and treatment coordinated with community services.[29] Mental Health Intensive Case Management (MHICM) admission criteria are: a patient with a diagnosis of a serious mental illness; a patient who has been inadequately served by conventional clinic-based outpatient treatment; a patient who has had 30 days of inpatient MH care or three or more episodes of MH hospitalizations over the past year; and a patient who clinicians deem is appropriate for outpatient treatment. VHA policy[30] states that patients who meet the definition of the target population for MHICM services cannot be denied service participation solely based on length of current abstinence from alcohol or non-prescribed controlled substances, the use of prescribed controlled substances or previous treatment non-adherence.

The Veterans Access, Choice, and Accountability Act of 2014 (Choice Act)[31]

The Choice Act was passed to improve health care access and quality of care for veterans. VHA released a fact sheet (undated) in response to the Choice Act[32] stating that patients who were unable to schedule an appointment within 30 days of their preferred date[33] or clinically indicated date[34] could receive care from eligible non-VA health care entities or providers.

[28] Deputy Under Secretary for Health for Operations and Management Memorandum, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012.
[29] VHA Directive 2006-004, *VA Mental Health Intensive Case Management (MHICM)*, January 30, 2006. This Directive expired January 31, 2011 and has not yet been updated.
[30] VHA Directive 1163.06, *Intensive Community Mental Health Recovery Services*, January 7, 2016.
[31] Public Law 113-146, *Veterans Access, Choice, and Accountability Act of 2014*.
[32] The Choice Act generally defines wait-time goals for VHA as not more than 30 days from the date on which the veteran requests an appointment for services unless VA submits a report and public notice of an alternative policy.
[33] Preferred date is the date a veteran prefers to be seen for hospital care or medical services.
[34] Clinically indicated date is the date an appointment is deemed clinically appropriate by a VA health care provider.

Institutional Disclosure

VHA outlines a formal process, institutional disclosure, by which facility leader(s) together with clinicians and others, as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse. Institutional disclosure takes place after organizational leaders confer with Regional Counsel to determine what is to be communicated, by whom, and how.[35]

Allegations

On April 27, 2016, the OIG received allegations concerning a patient's MH care at the facility. We subsequently interviewed family members and clarified the allegations as follows:

- The patient effectively managed his bipolar illness with the help of MH care professionals and family until 2014, when new providers tapered and then discontinued his long-standing medication treatment of clonazepam against his wishes.
- The patient was not admitted to the facility's PRRTP as recommended by MH providers.

Scope and Methodology

We began our review in June 20, 2016 and conducted a site visit to the facility on July 25–28, 2016. We interviewed facility senior managers, program managers, clinical staff with direct or indirect involvement in the patient's care, and administrative staff with knowledge about the patient's care issues. We also interviewed the patient's primary care physician at the NH. We interviewed the patient's family members.

We reviewed VHA and facility policies, procedures, and handbooks relevant to medication management, suicidality and MH care, and VA/DoD guidelines for management of patients at risk for suicide. Additionally, we evaluated pertinent documents and reviewed relevant medical literature on bipolar treatment. We reviewed documentation of the patient's care from his Navy civilian employment occupational health records, summaries of care from the patient's community psychiatrist, and a compensation and pension examination note. We also reviewed the patient's VA electronic health record (EHR), DoD health care records, and records for the patient's community emergency department, acute care, and psychiatric hospitalizations.

Eight policies cited in this report were expired or beyond the certification date:

[35] VHA Handbook 1004.8, *Disclosure of Adverse Events to Patient*s, October 12, 2012.

1. VHA 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008, amended November 16, 2015 (expired on the last working day of September 2013).
2. VHA Directive 2006-004, *VHA Mental Health Intensive Case Management* (MHICM), January 30, 2006 (expired January 31, 2011).
3. VHA Handbook 1163.01, *Psychosocial Rehabilitation and Recovery Services*, July 1, 2011 (expired the last working day of July 2016).
4. VHA Directive 2010-025, *Peer Review For Quality Management*, June 3, 2010 (expired June 30, 2015).
5. VHA Handbook 1162.02, *MH Residential Rehabilitation Treatment Program (MH RRTP),* December 22, 2010 (recertification due date was the last working day of December 2015).
6. VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011 (expired March 31, 2016).
7. VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009 (expired the last working day of August 2014).
8. VHA Directive 2006-057, *VHA Clinical Appeals*, October 16, 2006 (expired the last working day of October 2011).

We considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),[36] the VA Under Secretary for Health (USH) mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[37] The USH also tasked the Principal Deputy USH and Deputy USH with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[38]

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts showed the allegations were unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

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

[36] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.
[37] VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document*, June 29, 2016.
[38] Ibid.

Case Summary

The patient was a man in his late 50's with a history of mental illness and psychiatric hospitalization during his teenage years while in the Air Force. He was first diagnosed with bipolar disorder when he was in his early 20's and was treated with various psychiatric medications, including clonazepam, since the 1990s. In 1998, prior to his treatment at the facility, his prescribed dose of clonazepam was 4 mg daily, in conjunction with lithium and olanzapine.[39]

The patient first presented to the facility in 1999. Medications provided by his referring physician included clonazepam 6 mg daily, lithium, and olanzapine. Several months later the patient reported that he had also been taking topiramate,[40] so this medication was added to his regimen. Two months later, the patient's family expressed concern that he was functioning at a decreased level, so due to possible side effects, the topiramate dose was decreased and quetiapine[41] was substituted for olanzapine. He continued to experience some mood cycling over the next 3 years, but overall his condition was manageable. In 2003 the patient requested an increased clonazepam dose after reporting a sense that it was losing effectiveness, and the dose was increased to 7 mg daily. Early in 2004 lithium was discontinued because it caused the patient to develop psoriasis,[42] which is a potential side effect of lithium. [43] His condition remained stable, but he began to complain of increased difficulty sleeping in the following months. In mid-2005 the clonazepam was increased to 8 mg daily in an effort to improve his sleep, and the topiramate was discontinued due to persistent nausea. At this time, the patient's only medications were quetiapine and clonazepam. His mood was stable, and he denied use of alcohol in the preceding year.

The patient's regular psychiatrist at the facility (Psychiatrist A) left for a temporary active duty assignment in the military, and the psychiatrist taking over his care tapered the clonazepam to 4 mg daily in late 2005 because "It is difficult for me to find a rationale for this high level of prescribing..." The patient reported increased anxiety beginning the following month, and he continued to report this over the ensuing months. In the spring of 2007 he resumed treatment with Psychiatrist A, who had returned from active duty. He reported his mood was stable but he was having anxiety "all the time" and "a lot of" insomnia. The patient reported that he was not using alcohol since "several years ago." At this visit, Psychiatrist A increased the clonazepam dose back to 8 mg daily and continued quetiapine. According to the EHR, the patient remained stable on this

[39] Olanzapine is an atypical antipsychotic used in the treatment of schizophrenia and bipolar disorder. https://medlineplus.gov/druginfo/meds/a601213.html. Accessed January 24, 2016.
[40] Topiramate is an anti-convulsive drug used to treat convulsions and mood disorders. https://www.psycom.net/depression.central.topiramate.html. Accessed January 24, 2016.
[41] Quetiapine is an atypical antipsychotic used to treat schizophrenia and bipolar disorder. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011909/?report=details . Accessed June 6, 2017.
[42] Psoriasis is a chronic disease and a common skin condition that changes the life cycle of skin cells. http://www.mayoclinic.org/diseases-conditions/psoriasis/basics/definition/con-20030838. Accessed January 24, 2016.
[43] Kim GK, Del Rosso J, Drug-Provoked Psoriasis: Is It Drug Induced or Drug Aggravated? *JClin Aesthet Dermatol*. 2010 Jan; 3(1): 32−38.

medication regimen for the next 6 years, although he had some temporary symptom exacerbation in 2011 after running out of medication. Non-VA health care records indicate that in 2012 he was involuntarily brought to a community psychiatric hospital for assessment by law enforcement and then admitted, but further details were not available. According to records of a later hospitalization, this incident occurred after he had stopped clonazepam and "had some alcohol."

In the spring of 2013 the patient reported to Psychiatrist A that he was taking a lower dose of clonazepam because he believed that he had an age-related slowing of metabolism, and that this "has bene [sic] working pretty well lately." The psychiatrist changed his medications to a flexible dose of clonazepam up to 6 mg daily, and a flexible dose of quetiapine at either half or the full previous dose. Six months later he presented with mood changes, anxiety, and insomnia. The flexible dose of clonazepam was increased to a maximum of 8 mg daily. His reported alcohol use over the preceding year was 1-2 drinks monthly or less. In the spring of 2014 he had a final visit with Psychiatrist A after 15 years of treatment due to her planned retirement. He reported mild anxiety but otherwise was feeling well. He requested to again lower the clonazepam dose to 6 mg daily and to take both medications "as needed."

Six months later, in the fall of 2014 the patient met with a new psychiatrist (Psychiatrist B). At the visit, he reported anxiety symptoms causing "distress and functional impairment" but denied depression symptoms. He expressed a desire to continue the clonazepam, but questioned the need to continue his quetiapine. He denied misuse of his prescribed drugs, denied recreational drugs, and stated he had not used alcohol for 2 years. He reported "prior significant etoh[44] use, up to a 12 pack in a setting, 'to self-medicate' in the 1980s." Psychiatrist B documented the patient's diagnosis in the EHR as bipolar disorder with possible alcohol use disorder in the 1980s. Psychiatrist B requested a urine drug screen and other lab tests, and informed the patient that his clonazepam would not be renewed until a urine drug screen was obtained. The medication treatment plan was to discontinue quetiapine and gradually taper the dose of clonazepam.

At a second visit with Psychiatrist B 5 weeks later, the patient reported having reduced the clonazepam to 4 mg daily, and reported increased insomnia and anxiety. His urine drug screen from one month earlier was negative for benzodiazepines, and it was unclear why clonazepam had not produced a positive result. The psychiatrist instructed him to take as little clonazepam as necessary and return in 6 months.

In mid-2015, at the next visit 6 months later, the patient reported he had reduced his clonazepam to 2 mg daily, and requested to continue on this dose rather than tapering further and trying other medications for anxiety. Psychiatrist B was agreeable to continuing the clonazepam with a very gradual taper, but required another urine drug screen which the patient was unwilling to complete. Therefore, a refill of medication was not provided, and the patient was to return in 1 month.

[44] Etoh is a shortened medical abbreviation for the word ethanol or ethyl alcohol, which is commonly referred to as alcohol and it is found in alcoholic beverages. http://www.nursetheory.com/etoh/. Accessed January 24, 2016.

The patient had a visit with a different psychiatrist (Psychiatrist C) one month later, stating he was "checking options" and "may go elsewhere to get the medication (clonazepam) he feels works best for him." He reported hypomanic symptoms (euphoria, increased energy, racing thoughts, and insomnia) while taking the clonazepam only when needed, with the last dose being 1 mg the day before his appointment. He denied any current use of alcohol. Psychiatrist C informed him that he should not be treated with benzodiazepines and that he should taper and discontinue the clonazepam. Psychiatrist C also documented the diagnosis as bipolar disorder with possible alcohol use disorder in the 1980s. The psychiatrist discussed restarting quetiapine, but the patient declined. The psychiatrist's plan for care was documented as: "Return to clinic for follow up only if he doesn't seek outside treatment and only if he accepts that he will NOT be treated with a benzodiazepine."

Five weeks later, the patient was involuntarily admitted to a community psychiatric hospital after an interrupted suicide attempt. He was hospitalized for 5 days and his discharge medications were quetiapine, citalopram, and trazodone prn[45]. A post-discharge follow-up visit was arranged with the facility.

Ten days after discharge, the patient was seen by a facility MH social worker (MH SW) for an "Initial session based on referral from uncertain source." The patient reported that he made a suicide attempt in the past month and was involuntarily hospitalized for 5 days. At this first meeting with the MH SW, he reported being free of alcohol for 2 years and denied ever using illicit drugs. The plan was to "Follow up with primary and specialty care providers as scheduled," but none was specified. The MH SW planned to meet with the patient again in 18 days and a high risk for suicide[46] patient record flag (PRF) was placed in the patient's EHR.

One week later, the patient presented to a community hospital emergency department in a confused and agitated state. He was unable to provide a history due to altered mental status. Brain imaging exams were unremarkable, and the patient was involuntarily admitted to a psychiatric unit for bipolar disorder and possible delirium from overdose. While hospitalized, the patient's quetiapine was continued, and oxcarbazepine[47] and a low dose of the benzodiazepine lorazepam were added. The patient reported that his alcohol use was rare in the past 2 years and he denied illicit drug use. He repeatedly voiced his wish to be treated with clonazepam. After 13 days, he was discharged on the same medications as he was prescribed in the hospital. He was scheduled for a follow-up appointment at the facility in 4 days with the MH SW he had previously seen.

[45] Prn is a shortened medical abbreviation meaning when necessary or as needed. http://www.medicinenet.com/script/main/art.asp?articlekey=8309. Accessed January 24, 2016.
[46] VHA uses patient record flags to identify patients who are at high risk for suicide to VHA staff and the presence of it should be considered by VHA staff when making treatment decisions.
[47] Oxcarbazepine is an anticonvulsant drug used to treat epilepsy. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0013295/ Accessed June 6, 2017.

The patient was accompanied by a family member at the follow-up visit. The patient discussed his recent hospitalization and stated that prior to the admission he had ingested a large number of quetiapine tablets, not in a suicide attempt but rather "...trying to get them to work." He stated he planned to pursue treatment with a community psychiatrist. During this visit, the MH SW added "Substance Use Disorder" to the patient's diagnoses. The MH SW documented in the EHR that: "We discussed the substantial discomfort/anguish involved in coming off benzodiazepines, especially after taking them for upwards of 20 years as the Veteran states he has." The MH SW recommended for the patient "to attend some type of 12-step meeting, i.e. AA or NA," but the patient stated he was not inclined to do so.

A primary care provider (PCP) saw the patient at a military hospital 35 days following discharge from his second community hospitalization. The patient reported that he was trying to find a new psychiatrist. The PCP prescribed 90 clonazepam 0.5 mg tablets with instructions to take one tablet up to 3 times a day as needed with no refills, and encouraged the patient to become established with a psychiatrist.

The facility MH SW continued to meet regularly with the patient and a family member over the next 2 months. During this time, the MH SW included the diagnosis "Psychoactive substance use disorder" in the patient's multidisciplinary treatment plan. The patient consulted with a community psychiatrist, but decided not to enter into treatment with that doctor. In the late fall of 2015, the patient's high-risk for suicide PRF was reviewed and continued.

Near the end of 2015 the patient was again involuntarily admitted to a community psychiatric hospital after a serious suicide attempt. He was initially treated medically for self-inflicted injuries and was subsequently prescribed an antidepressant. His condition stabilized over the course of one week, and he was discharged with a plan to follow up with the facility MH SW the next day. His discharge medications were clonazepam 2 mg daily, fluoxetine, gabapentin, and quetiapine. According to documentation, the patient was "...pleased that he is going to be started back on 1 mg twice a day [of clonazepam]."

The patient, accompanied by family members, presented to the facility according to plan and met with the MH SW. EHR documentation from this visit stated: "...the nature of prolonged benzodiazepine use and abuse and the difficulties this presents" as well as "the likely/possible benefit of residential/inpatient care for this" and "It is not indicated currently to make a referral to the PRRTP program because of his recent suicide attempt, but we should consider this in the near future." At this time, he requested treatment with the facility psychiatrist he last saw, Psychiatrist C, and an appointment was scheduled for 2 weeks later. An appointment with an addiction therapist was also scheduled. The patient's high-risk for suicide PRF was continued.

The patient had one additional visit with the MH SW, then 2 weeks post hospital discharge he met with Psychiatrist C, whom he had seen 6 months earlier. His mood was depressed and anxious, but he denied suicidal ideation. Psychiatrist C added

"Anxiolytic Use Disorder"[48] to the patient's diagnoses and specified that his alcohol use disorder was in remission. The psychiatrist declined to renew the clonazepam and recommended tapering and discontinuing this medication. The psychiatrist increased the dose of the antidepressant fluoxetine, and continued quetiapine and gabapentin. The patient was given a return appointment for 7 weeks later.

Over the next 10 days, the patient met twice with the MH SW. He also had an initial visit with the addiction therapist, where the patient described using one clonazepam tablet per day. The addiction therapist diagnosed the patient with bipolar disorder and psychoactive substance use disorder, continuous use. The addiction therapist identified on a checklist, without specifically documenting evidence or rationale, the following indicators of drug dependence:

1. Tolerance.
2. The substance is often taken in larger amounts or over a longer period than was intended.
3. There is a persistent desire or unsuccessful effort to cut down or control substance use.
4. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
5. Important social, occupational, or recreational activities are given up or reduced because of substance use.

The addiction therapist's initial treatment plan was to continue with the outpatient substance use disorder program, work on maintaining sobriety, attend Narcotics Anonymous meetings, identify relapse triggers, identify reasons he uses, and keep all appointments with his psychiatrist.

The next day, the patient made a suspected suicide attempt by chemical ingestion, was taken to a community hospital, admitted to a medical unit, and was discharged a day later. His family brought him back to the community hospital the next day for psychiatric admission because of continued concerns about his safety. He was hospitalized for 2 days. Neuropsychological testing was performed due to concerns of mental impairment due to chemical ingestion. He was discharged at the request of his family so that he could have previously scheduled hand surgery. The fluoxetine and clonazepam were discontinued during the hospitalization. He was discharged on quetiapine, gabapentin[49] and citalopram[50].

[48] Anxiolytic Use Disorder is when a person continues to use antianxiety medications despite clinically significant distress or impairment. http://mentalhealth.com/home/dx/sedativedependence.html . Accessed June 6, 2017.
[49] Gabapentin is an anticonvulsant medication primarily used to treat epilepsy but it is also used as a mood stabilizer in treating bipolar disorder. http://whatmeds.stanford.edu/medications/gabapentin.html. Accessed January 24, 2016.
[50] Citalopram is a medication used to treat depression. http://www.mayoclinic.org/drugs-supplements/citalopram-oral-route/description/drg-20062980. Accessed June 6, 2017.

The patient met with the facility MH SW 10 days post discharge, and a referral for further neuropsychological testing was initiated. This referral was later discontinued. The consulted service stated that the patient's recent chemical ingestion might interfere with their evaluation process. The consult was resubmitted 20 days later with a different consult question and subsequently accepted. Over the next several weeks the patient continued to follow up with the MH SW and addiction therapist. The MH SW recommended referral to the facility PRRTP for extended treatment of substance abuse issues. The patient reported not using any alcohol or clonazepam during the previous 2 months. His high risk for suicide PRF was reviewed and continued.

The patient attended his scheduled appointment with Psychiatrist C in early 2016. He was depressed and reported intermittent suicidal ideation. He stated that he had not taken clonazepam for "two weeks." Psychiatrist C prescribed fluoxetine, quetiapine, and gabapentin. The patient was given a return appointment in 6 weeks. The patient subsequently had visits with the MH SW and addiction therapist. At the visit with the MH SW the patient agreed to a referral to the PRRTP substance abuse program as previously discussed. However, the PRRTP screening committee was unable to contact the patient in order to process the referral and documentation showed difficulty with obtaining medical clearance for PRRTP admission.

In the spring of 2016 the patient was involuntarily admitted to a community psychiatric hospital because of erratic behavior, damaging furnishings in his home, and being unable to care for himself. He reported being off medications for several days. Over the course of a 2-week hospitalization he gradually improved, and his family requested that he be discharged. His discharge medications were fluoxetine, lamotrigine,[51] and doxepin.[52] A follow-up visit with the facility MH SW was arranged by the community hospital in 2 weeks, but the patient attended a previously scheduled appointment with the MH SW 8 days after discharge.

Ten days after discharge, the patient, accompanied by a family member, attended his previously scheduled appointment with Psychiatrist C. He reported his recent hospitalization, but was unable to provide complete information on medication changes that were made. He reported ongoing depression, anxiety, and sleep disorder. He reported intermittent passive suicidal ideation[53] but denied active suicidal ideation that day. On the Lethality Assessment, he reported affirmative or conditionally affirmative responses to 10 of 13 risk factors,[54] while 4 of 13 protective factors[55] were rated as

[51] Lamotrigine is a medication used to treat certain types of seizures and is used as a mood stabilizer to treat bipolar disorder. https://medlineplus.gov/druginfo/meds/a695007.html. Accessed January 24, 2016.
[52] Doxepin is a tricyclic antidepressant that is used to treat anxiety, depression, and insomnia. http://www.mayoclinic.org/drugs-supplements/doxepin-oral-route/description/drg-20072083. Accessed January 24, 2016.
[53] Suicide ideation is predictive of or a precursor to suicidal behavior. Scales exist that measure a person's risk for a person's suicide with passive suicide ideation being lower risk and active suicide ideation higher risk.
[54] Risk factors are warning signs that have been shown to be temporally related to the acute onset of suicidal behaviors.
[55] Protective factors may decrease the risk for suicide.

good or positive. Lethality risk[56] was evaluated as moderate on a checklist. The patient was instructed to return home and phone the facility MH clinic nurse with information about his medications so that any necessary adjustments could be determined. He was given a return appointment in 3 months, with a notation that nothing was available sooner. Two days later, the patient died by suicide.

Inspection Results

Issue 1: Medication Management for Bipolar Illness

We substantiated that after being reasonably stable under the care of a particular facility psychiatrist for many years, the patient's clonazepam was reduced and discontinued by subsequent facility psychiatrists against the patient's wishes. Although occasionally throughout the years the patient went off his medications for brief periods, overall, the patient maintained relative stability as demonstrated by his work history, responsible functioning as a parent, meaningful family life, and sustained periods when he did not require hospitalization for his mood disorder.

We interviewed family members who had close contact with the patient for the past 20 years. They acknowledged that the patient struggled intermittently throughout the decades with his bipolar disorder but, overall, they described the patient as a reliable father and brother and a functional member of society. A family member who saw the patient almost daily told us that, prior to the time when efforts were made to discontinue his clonazepam treatment, the patient helped with the family member's business, helped with the care needs of their local family, and was financially stable. The family member told us that the patient would occasionally stop taking medications because of intolerable side effects. Problems would then emerge and the patient would resume taking his medications. The family member reported that in recent years the patient had made great strides in living a healthier lifestyle by exercising, and reducing tobacco usage.

A review of the patient's VA EHR documentation prior to the efforts to discontinue his clonazepam showed that the patient's bipolar disorder was effectively managed for many years while under the care of a facility psychiatrist (Psychiatrist A) and a facility psychologist. The patient had only one psychiatric hospitalization during this time, in 2012, when he reportedly stopped taking his medication. The patient was under the care of these providers until the psychologist left in 2007 and Psychiatrist A left in 2014.

In late 2014, the patient saw a new psychiatrist (Psychiatrist B) who instructed the patient to gradually taper the dose of clonazepam and ordered a urine drug screen, although this test was not required by facility policy . At a subsequent visit, Psychiatrist B wanted to continue tapering the clonazepam dose, but the patient wished to remain on 2 mg daily. Psychiatrist B agreed to refill the clonazepam only if the patient provided a urine drug screen. The patient was unwilling to complete the urine drug screen and

[56] Lethality risk is the patient's level of risk for suicide once all the risk factors have been evaluated.

so the medication was not refilled. A return visit in one month was scheduled, and the patient requested that he see a different psychiatrist. When the patient returned to the clinic the following month he met with Psychiatrist C for the first time.

We substantiated that Psychiatrist C discontinued the patient's clonazepam. Psychiatrist C informed the patient that he should not be treated with benzodiazepines, that he should taper and discontinue this medication, and that he should return to clinic for follow-up only if he accepts that he will not be treated with a benzodiazepine.

Although a taper of the medication was recommended, and the patient acknowledged having a supply of an unspecified amount of medication at home, we concluded that the discontinuation was abrupt relative to the clinical situation. A medically supervised, gradual taper was indicated due to the patient's long history of treatment with clonazepam, current hypomanic symptoms, and reservations about coming off the clonazepam. However, no schedule for the taper was provided, no assessment of the adequacy of the patient's available medication supply was performed, and no specific plan was made for the patient to return to the clinic for follow-up of this significant treatment change.

The following factors may have contributed in a general way to an atmosphere of conservative benzodiazepine prescribing practices at the facility since 2014:

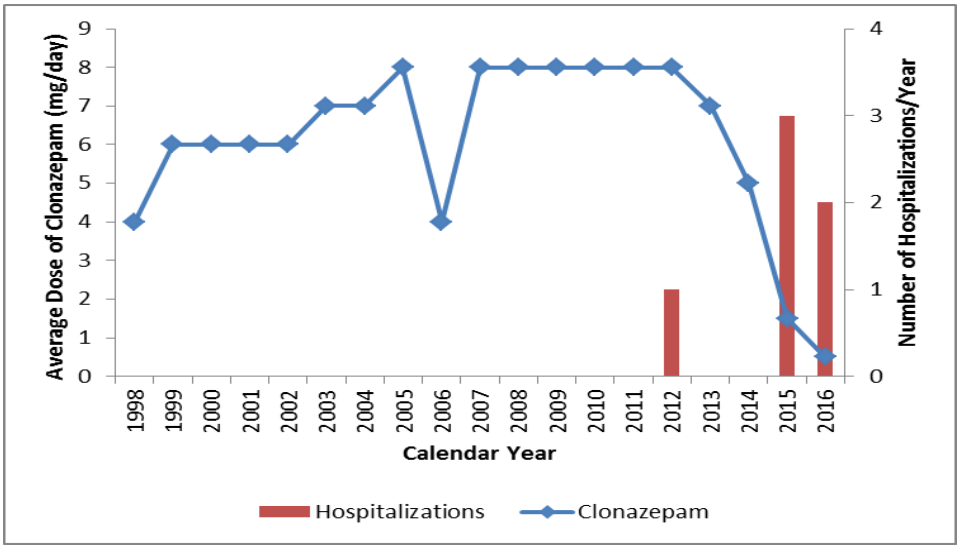
- In FY 2014, the VISN designated Psychotropic Drug Safety Initiative performance metrics for the facility that included reduction of benzodiazepine prescribing for elderly and community living center patients.
- FY 2015 Facility Provider Pay for Performance Contracts began linking pay to evidence of reduction of combined benzodiazepine and opioid prescribing practices.
- A facility workgroup developed an internal policy addressing prescription of benzodiazepines in the outpatient setting.[57] It contained nonstandard[58] procedures for prescribing benzodiazepines and was not approved by the facility. However, facility psychiatrists incorporated elements of this unapproved policy into their practices by July 2015.

We found that following the discontinuation of the patient's clonazepam, his clinical condition worsened to the point that he made multiple suicide attempts resulting in psychiatric and acute medical care hospitalizations. He was also hospitalized on other occasions for behavioral disturbances. In the last 9 months of his life the patient was hospitalized five times, attempted suicide twice with a third attempt suspected, and ultimately died by suicide.

[57]Unapproved facility policy #1, *"Prescription of Benzodiazepines at the Outpatient Setting,* "July 7, 2015.
[58]Examples of these non-standard procedures for prescribing of benzodiazepines include requirements for random drug screenings, bi-annual toxicology screenings, and the signing of a benzodiazepine agreement.

The Figure below illustrates the chronology of the patient's severe episodes of mental illness since 1998 as evidenced by psychiatric hospitalizations in relation to changes in the average daily dose of clonazepam. The patient had more than a decade of uneventful treatment with high doses of clonazepam. In 2012, the patient was briefly hospitalized after stopping his medications. After the clonazepam dose was reduced beginning in 2014, the patient experienced multiple hospitalizations as his bipolar disorder became unmanageable.

Figure: Time Course of Clonazepam Dose Changes and Hospitalizations



Source: VA and DoD EHR and Community Hospital Records. Note: 2016 represents less than a full year due to the patient's death.

Lack of Consideration of Patient's Treatment Preferences

We substantiated that Psychiatrist C discontinued the patient's clonazepam (a treatment that he felt worked best) and did not consider the patient's treatment preferences. We found no evidence that collaborative treatment planning between Psychiatrist C and the patient occurred or that a systematic discussion of the available treatment options, including risks and benefits, took place with the patient.

One of the core values of VHA's psychosocial rehabilitation[59] recovery[60] model,[61] which guides all VHA MH service delivery, is the right of a patient to direct their own treatment, including treatment planning related to their psychiatric illness. In addition, VHA[62]

[59] Psychosocial Rehabilitation is the "recovery, full community integration, and improved quality of life for persons who have been diagnosed with any MH condition that seriously impairs their ability to lead meaningful lives….rehabilitation services must be collaborative, person-directed, individualized, evidenced-based, and an essential element of any health care system."
[60] Recovery is the single most important goal for the MH system. It is the journey of healing and transformation enabling a person with an MH problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.
[61] VHA Handbook, 1163.01, *Psychosocial Rehabilitation and Recovery Services*, July 1, 2011. Expired July 2016.
[62] VHA Handbook 1160.01.

emphasizes the inclusion of the patient's treatment preferences and goals into the treatment plan.

During the patient's first visit with Psychiatrist C in mid-2015, the psychiatrist documented in the EHR, "Today may be only visit as he may go elsewhere to get the medication (benzodiazepine) he feels works best for him." "Return to clinic for follow up only if he doesn't seek outside treatment and only if he accepts that he will NOT be treated with a benzodiazepine." The psychiatrist's note further stated, "This veteran should not be prescribed benzodiazepines, and has been previously instructed to taper and discontinue the clonazepam… all he is desirous of is clonazepam."

As the patient became unstable and less able to communicate with providers, family members began attending the patient's appointments with him at the facility, in the community, and at the NH. A family member told us the patient told facility health care professionals, including Psychiatrist C, that clonazepam was the medication he needed, but nobody would listen and that the patient eventually just "shut down."

Notable are text messages the patient sent to a family member in October 2015 that reflected the patient's thoughts about his treatment:

- "Then cutting back on benzos and stopping them was supposed to be good, NOT, freaking VA docs should have known better."
- "There are some really bad dangers in stopping certain meds."
- "New shrinks say they can cause demesne [sic] and alzhiemers [sic] in some people and think people can just stop taking them…bad medicine to use that approach…"
- "Drs. need to air [sic] on side of caution when taking someone off those benzo's, bad […] can happen."
- "I was completely off over a month and my body and psyche was really getting messed up, earthquake…some people describe a death feeling, it happened…scary."
- "I cut way back pretty good, though it was starting to mess with me, after a month of being totally off body and mind decided to get freaky…strange."
- "Like I said, Drs had better take a good look at taking people off them safely or cutting them back safely I may need to take a benzo a long time."

Treatment Impasse & Resolution Processes

Ethical ramifications were created because of Psychiatrist C's position that the patient could only return to clinic "if he doesn't seek outside treatment" and "if he accepts he will not be treated with a benzodiazepine." If the patient wanted to continue clonazepam, the treatment ultimatum put forth constrained his access to the facility's psychiatric

services and did not comply with VHA guidance,[63] which prohibits practitioners from threatening to deny a patient access to one treatment or procedure unless the patient consents to another treatment or procedure. Although we recognized that the psychiatrist, based on her clinical judgement, had the right to choose not to prescribe the patient clonazepam, the patient had a right to request a treatment that he felt worked best for him. This situation created a treatment impasse.

VHA's Integrated Ethics policy[64] provides guidance for patients and/or treating providers to resolve issues when divergent yet defensible opinions about treatments arise or conflicts about values emerge. At the facility level, this process would be implemented by placing a consult to the Ethics Consultation Coordinator. We determined that no one considered the ethics consultation process for resolution of this treatment impasse and that no one had informed the patient of his right to initiate an ethics consult.

VHA Clinical Appeals policy[65] requires that facilities must have written policy and procedures in place on how to handle internal clinical appeals (a method of resolution of patient issues, including disagreement with treatment plans). The facility did not have a policy specifically addressing clinical appeals processes. The only reference to a clinical appeals process was in the facility's patient complaints policy.[66] This policy stated that a patient had to file a complaint and then exhaust all steps to resolve it before they were informed of their right to a clinical appeal, but no further details were included in the policy about the process for initiating a clinical appeal. The policy did not recognize that a patient could pursue a clinical appeal without registering a complaint. We found no evidence that the patient was informed of his right to a clinical appeal, and that no complaints or appeals were lodged by the patient in 2015 or 2016. In fact, Psychiatrist C told us she was unaware that the patient had a right to a clinical appeal.

Issue 2: Admission Barriers to the PRRTP

We substantiated that the patient was not admitted to the PRRTP as recommended by a facility MH SW and psychiatrist. We concluded this was due to poor care coordination. By the time the admissions team successfully contacted the patient's family for the screening appointment, the patient had died.

In late 2015, following a serious suicide attempt, the MH SW met with the patient, who was accompanied by a family member, and discussed the potential benefits of the PRRTP for substance abuse treatment. However, the EHR reflects that the MH SW also told them that because of the patient's recent suicide attempt he was not currently eligible for PRRTP admission. The MH SW encouraged them to seek residential treatment outside the VA. The MH SW was incorrect about the PRRTP's admission criteria. According to the PRRTP program manager, a recent suicide attempt was not

[63] VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures,* August 14, 2009, scheduled for recertification on the last working day of August 2014.
[64] VHA Handbook 1004.06, *Integrated Ethics,* August 29, 2013, scheduled for recertification on or before the last working date of August 2018.
[65] VHA Directive 2006-057, *VHA Clinical Appeals*, published October 16, 2006. Expired October 31, 2011.
[66] Facility Memorandum.

an acceptable reason to deny a patient admission to the program. In addition, neither VHA policy[67] nor the facility's policy[68] listed a recent suicide attempt as an exclusionary criterion for PRRTP admission.

In early spring 2016, the MH SW documented that a referral to the PRRTP was appropriate and that the patient was agreeable to entering the program. The MH SW placed a consult for PRRTP admission. The PRRTP Screening Committee (PSC) members reviewed the consult 2 days later and scheduled a telephone screening appointment for 13 days after the consult placement. On the day of the appointment, the patient was an inpatient in a community hospital. The PSC members documented in the EHR that they were unsuccessful in contacting the patient that day, referred the patient back to the MH provider, and left the consult open for 30 days. The SW saw the patient 8 days after his community hospital discharge, but we found no documentation that any action was taken by the SW to inform the PSC of the patient's status.

The facility consultations policy[69] required that the consult requestor take appropriate action based on recommendations of the consulted service or provider. The PSC members documented in the PRTTP consult that for the patient to be admitted he needed: lab work, a history and physical, a tuberculosis test (PPD) and confirmation that the patient could perform activities of daily living.[70] The MH SW saw the patient 14 days after the PSC members responded to the consult, but did not document that any of the actions requested by the PSC members for the patient's PRRTP admission were addressed.

The psychiatrist saw the patient 16 days after the PSC members responded to the consult and addressed some of the PRRTP admission requirements. The psychiatrist documented that the patient's PCP was at the military hospital and that his labs could be accessed by EHR. The PSC members responded the same day and stated that they had reviewed the patient's military hospital records, but he was still not medically cleared for program admission. While we found documentation of the military hospital PCP visit in the EHR, we did not find evidence of a PPD test.

The military hospital EHR had a history and physical documented by a PCP prior to the PRTTP consult. In January 2015, the facility had identified that timely PPD testing was an obstacle to PRRTP admission and permitted MH staff to administer the test. However, we found no evidence in the EHR that the patient's MH providers attempted to complete the test.

[67] VHA Handbook 1162.02, *MH Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010. VHA Handbook was scheduled for recertification on or before the last working day of December 2015.
[68] Facility Memorandum.
[69] Facility Memorandum.
[70] Activities of daily living (ADLs) are the classic measure of the severity of need for personal assistance services. ADLs comprise bathing, dressing, toileting, transferring, continence, and eating. LaPlante, M., The Classic Measure of Disability in Activities of Daily Living Is Biased by Age but an Expanded IADL/ADL Measure Is Not. J *Gerontol B Psychol Sci Soc Sci.* 2010 Nov; 65B(6): 720-732.

A second PSC telephone screening appointment with the patient was scheduled for early in the morning in mid-2016 The patient's family member told us that the patient had become increasingly paranoid over the last few months of his life and was not answering his phone, so the family member agreed to be the phone contact for the PSC telephone screening appointment. A family member told us that on the day of the appointment, she and the patient waited by the phone all day. Late in the day, someone from the facility called and said the doctor was not available so the screening was postponed.

Facility documentation confirmed that PSC staff were aware that the patient was to be called in the morning for the screening appointment, but the person who was to make the call was "hung up with another issue." When PSC staff called the patient 3 days later to complete the telephone screening, they learned that he had completed suicide.

Issue 3: Delay in the Patient Receiving Timely Psychiatric Care

Although not part of the original allegations, we found that because of limited availability of psychiatry appointments, the patient did not have timely access to psychiatric care after his discharges from community psychiatric hospitals and as his MH condition worsened. When the patient resumed seeing Psychiatrist C, due to scheduling constraints, the length of time between scheduled psychiatry appointments ranged from 44 to 91 days despite the patient's deteriorating condition. The patient was not referred to the Veterans Choice Program.[71]

VHA Handbook 1160.01[72] states that patients are entitled to timely access to MH care and strongly encourages that patients recently discharged from an inpatient MH stay be contacted to schedule necessary follow up within 48 hours. The handbook states that patients should receive MH evaluations within 7 days of discharge (telephone contact is sufficient), and have a face-to-face evaluation within 2 weeks of discharge. The handbook does not specify what type of MH provider should perform the evaluation. The handbook further states, "Any indications of clinical deterioration, nonadherence to treatment, or danger to the veteran or others must trigger appropriate and timely interventions."

The patient presented to the MH SW the day after being discharged from a community psychiatric hospital following a late 2015 suicide attempt, which was the most lethal attempt. The patient asked to see Psychiatrist C, and an appointment was scheduled for 17 days later. The patient's next appointment with the psychiatrist was scheduled for 50 days later. The psychiatrist told us that the patient should have been seen sooner but no appointment slots were available to schedule the patient any earlier. She said that some patients were not being seen as frequently as needed because of a shortage of facility providers.

[71] Veterans Choice Program (VCP) was established by VA following passage of the Veterans Access, Choice, and Accountability Act of 2014. VCP is a program to furnish hospital and medical services to eligible veterans through eligible non-VA health care providers.
[72] VHA Handbook 1160.01

Although Psychiatrist C felt that the patient should have been seen sooner, she took no actions to submit a consult for non-VA care, which the Veterans Choice Program authorizes when a patient has been or will be waiting more than 30 days for VHA medical care.[73] The patient's EHR contained no documentation that a consult was placed for non-VA care.

In early 2016 the patient's family called the MH SW 11 days after the patient was last seen by Psychiatrist C and 1 day after he was seen by the MH SW, and reported that they feared the patient made another suicide attempt. The patient was hospitalized again and the MH SW saw the patient 10 days after he was discharged. Psychiatrist C saw the patient 36 days after his hospital discharge. At this visit, the psychiatrist documented that the patient had worsening MH symptoms, but his next appointment with the psychiatrist was scheduled for 44 days later.

When Psychiatrist C saw the patient again, he had been recently discharged following another psychiatric hospitalization. Psychiatrist C documented the patient's worsening MH symptoms, his desire to enter the PRRTP, and the unmet PRRTP admission needs. His next appointment was scheduled for 91 days later, and the psychiatrist documented in the EHR that "nothing was available sooner."

At the time of our visit in July 2016, the Acting Chief of Staff acknowledged a timeliness problem with next available appointments for MH patients and that appointments for patients to return to a prescriber[74] averaged 75 days. The Acting Chief of Staff stated that a shortage of prescribers at the facility had caused the delays and that they were trying to hire MH prescribers but that these efforts had limited success. This difficulty hiring MH prescribers mirrored findings in a recent Government Accountability Office report,[75] which demonstrated that although the VA had met MH hiring initiative goals, facilities still reported continued challenges in hiring MH staff and meeting the growing demand for MH care.

Issue 4: Management of the Patient's Bipolar Illness, Unfounded Diagnosis of Substance Abuse, and Care Coordination

Although not part of the original allegations, we found that, despite the increase in the patient's community psychiatric hospitalizations and suicide attempts during the last 9 months of his life, exploration of other MH treatment options, such as inpatient medication evaluation and management, community partial hospitalization programs, and intensive case management services was limited. These additional interventions would have been appropriate to address his underlying bipolar disorder, which was the likely cause for the patient's suicidal thinking and behavior. Management of the

[73] Public Law 114-41, *Surface Transportation and Veterans Health Care Choice Improvement Act of 2105,* July 31, 2015.
[74] Prescribers are medical professionals licensed to prescribe an order for medicine for a patient. http://dictionary.cambridge.org/us/dictionary/english/prescriber, accessed January 23, 2016.
[75] United States Government Accountability Office, *VA Mental Health Clearer Guidance on Access Policies and Wait-Time Data Needed,* GAO-16-24: October 2015.

patient's suicidality during the final 9 months of his life relied primarily on outpatient psychotherapy and infrequent medication management.

In late 2015, the MH SW did address community residential placement with the patient and family. However, the family pursued this treatment option without any assistance from the MH SW. A family member told us that one of the residential facilities they contacted was beyond their financial means and the other had a long wait time. The patient's EHR contained no documentation that the MH SW assisted the family with any of the community residential care referrals and/or coordination outside of providing them with the name of a residential treatment program.

Both the MH SW and Psychiatrist C saw the patient in early 2016. The psychiatrist told us that "something was not right with him," and that she noted indications of a "strong mood disorder." At one visit, Psychiatrist C discussed the limitations of outpatient psychiatric treatment and recommended the PRRTP. The patient was not interested in PRRTP at this time because of an upcoming surgery and his next psychiatrist visit was scheduled for 44 days later, which was the earliest available appointment.

Of interest is that during Psychiatrist C's visit with the patient when she discussed the limitations of outpatient treatment and the need for more intensive care options, she did not document in the EHR any discussion with the patient about his recent hospitalization. We asked Psychiatrist C why she did not document the discussion of the patient's hospitalization and she told us that the admission was likely caused by the patient's "huffing."[76] However, community hospital records documented that the patient's discharge diagnosis was bipolar disorder with a recent severe depressive episode and that he was admitted for a suspected suicide attempt.

Although the facility had a MHICM program, Psychiatrist C had not considered referring the patient to it and did not realize he met MHICM program criteria. The MH SW told us he did not consider referring the patient to the MHICM program because of the patient's perceived substance abuse problem. Even assuming there was a clinical basis to diagnose a substance use disorder (which OIG did not find in reviewing the evidence) VHA policy[77]does not deny MHICM services based solely upon a patient's substance abuse problems as evidenced by the following policy excerpt:

> *Services cannot be denied…based solely upon the length of current abstinence from alcohol or non-prescribed controlled substances, the use of prescribed controlled substances, the number of previous treatment episodes, legal history, homelessness, personality disorder, or previous treatment non-adherence.*

[76] Inhalant abuse (commonly called "huffing") is the intentional inhalation of chemical vapors to attain a mental "high" or euphoric effect. http://www.medicinenet.com/script/main/art.asp?articlekey=47975. Accessed March 14, 2017.
[77] VHA Directive 1163.06, Intensive Community Mental Health Recovery Services, January 7, 2016. Expires January 2021.

We found that facility providers interpreted the patient's ongoing request for clonazepam treatment as drug seeking behavior[78] symptomatic of a perceived substance use disorder. The patient's treating providers did not address and/or consider alternative explanations for his MH condition, such as that he was seeking relief from his poorly controlled bipolar disorder symptoms with a medication that had been effective in the past, or was suffering from ongoing clonazepam withdrawal after his prolonged treatment with high doses of this medication.

Despite the patient's and family's report of his worsening MH symptoms from early fall 2015 until his death, and the patient's persistent suicidal ideation, the MH SW and Psychiatrist C's treatment efforts centered on his perceived substance use disorder. The MH SW told us that the patient's behavior was that of a "manipulative drug addict" and that he first needed to be "clean from clonazepam" to evaluate what was wrong with him, his long history of clinical stability while taking prescribed clonazepam notwithstanding. Psychiatrist C also believed that the patient was a "drug addict" because of his history of alcohol abuse, "stash" of medications at his home, and his lack of candor when discussing his medications.

The MH SW referred the patient to the facility substance use disorder treatment program, where he was evaluated by an addiction therapist in early 2016. The addiction therapist identified on a checklist (without specifically documenting evidence or rationale) that the patient had the following indicators of drug dependence:

1. Tolerance.
2. The substance is often taken in larger amounts or over a longer period than was intended.
3. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
4. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
5. Important social, occupational, or recreational activities are given up or reduced because of substance use.

The above indicators are general, templated criteria for identification of potential substance use disorder, but each must be applied in the clinical context of a specific patient. Substance dependence can occur in drug abusers, but these indicators could be misapplied to patients following the advice of previous prescribing physicians. Identification of the "tolerance" indicator by the addiction therapist was supported by the high doses of clonazepam the patient took. However, this medication was increased by providers over the years to obtain needed therapeutic results for his bipolar disorder. There is no evidence that the patient took clonazepam in higher doses or for a longer

[78] Although the term "drug seeking behavior" is frequently used in healthcare, it is not well defined. Drug seeking behavior generally means the patient is addicted to opioids, the patient is abusing pain medicine, or the patient is manipulative.

duration than instructed by his physicians for most of the time that he was treated. On the contrary, the medication and dosage was part of the medically supervised treatment, as was the long period of medication use. Additionally, while the patient experienced withdrawal at times when he abruptly stopped clonazepam, he was able to successfully reduce the dose of medication when instructed to do so and properly supervised, although at times this led to a return of symptoms from his underlying psychiatric disorder. The only evidence of indicator 4 in the list on page 25 was the patient's repeated requests to be treated with clonazepam, which some providers interpreted as pathological "drug-seeking" behavior when, in fact, it demonstrated only that the patient was understandably seeking treatment with a drug that had been effective in treating his bipolar disorder for many years. The remaining indicator identified by the addiction therapist was not supported by evidence in the EHR, either from their own note, or notes by the MH SW and Psychiatrist C.

Care Coordination Deficiencies

In the course of our inspection, we identified deficiencies in the patient's care coordination given his multiple psychiatric hospitalizations, various facility and community providers, and his deteriorating MH. The communication, collaboration, and planning by the patient's MH care providers was not commensurate with the patient's complex psychiatric care needs. The patient's MH care required more intensive care coordination services that, although available, were not used.

Interdisciplinary Team Efforts

The facility MH Service had an interdisciplinary team (IDT), including but not limited to: the MH Service Program Manager, social workers, psychiatrists, and the Suicide Prevention Coordinator. The team met weekly to review patients at high risk for suicide and other sentinel events.[79] Discussions were informal and not documented so it is not known if treatment planning or care management for individual patients was done. Psychiatrist C did not regularly attend the IDT meetings because she viewed these meetings as a forum for administrative issues where patient care and treatment planning did not occur. The psychiatrist saw the patient in mid-2015 and not again until early 2016. She was unaware that the patient made multiple suicide attempts during that period while he was being seen by the MH SW.

The patient's MH treatment plan did not show documentation of any IDT collaboration despite having three MH staff (MH SW, other therapist, MH psychiatrist) providing direct care, and the Suicide Prevention Coordinator providing indirect care. In addition, the patient's MH treatment plan was not revised during any of the patient's transitions from inpatient to outpatient settings, and the treatment goals remained unchanged during the

[79] A Sentinel Event is defined by The Joint Commission as any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness. https://www.jointcommission.org/sentinel_event_policy_and_procedures/ Accessed January 9, 2017.

last 9 months of the patient's life despite his worsening condition and unabated symptoms.

Mental Health Treatment Coordinator

Although not part of the allegations, we found that the patient was not assigned an MHTC and that the facility did not have a MHTC policy as required.[80] VHA policy requires that the MHTC must be made clear to the patient and identified in the EHR.[81] We found no evidence in the EHR that the patient was assigned a MHTC. Facility managers told us they did not have an MHTC policy. They provided us with a Principal MH Provider (MHTC's previous title) position description but informed us that the position was currently not filled.

Issue 5: Failure to Follow Facility Policies

The patient received MH care at the facility, inpatient psychiatric hospitalizations in the community, and primary care at the NH. While the military hospital and the facility have separate EHRs, the military hospital's EHRs were available to facility clinicians. Psychiatrist C at the facility did not provide medication reconciliation as required following hospital discharges, when medications were likely to have been changed.

The joint sharing agreement between the facility and the military hospital required that both organizations ensure access to medication documentation for continuity of care. The facility policy[82] addressing management of patient medications requires that all patients receive well-coordinated, safe, appropriate, and patient-centered care through all transitions of care. Specifically, the policy states:

> *Whenever a patient moves from one setting, service, practitioner, or level of care within or outside of the facility, the complete and current list of that patient's medications will be communicated to the next provider of service to be compared (reconciled) with the medications to be provided in/by the new setting, service, practitioner, or level of care. This process actively involves the patient who is responsible for informing health care providers regarding medications he/she is or is not taking, dosages, frequency, and routes. The medication list reflects changes that occur during each episode of care. Health care providers with prescribing privileges (i.e. physicians, nurse practitioners, physician assistants, and pharmacists) are ultimately responsible for correcting discrepancies, [and] documenting completion of medication reconciliation within 24 hours of the encounter.*

Psychiatrist C saw the patient 35 days following a community psychiatric hospitalization. She did not document awareness of the patient's recent psychiatric hospitalization or medication changes.

At the time of the patient's last appointment with Psychiatrist C, 10 days following another psychiatric hospitalization, his discharge medications had been filled and a list

[80] DUSHOM, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012.
[81] DUSHOM, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012.
[82] Facility Memorandum.

was available in the military hospital EHR. However, when Psychiatrist C saw the patient she documented in the facility EHR that the patient did not bring a medication list or bottles and his medications were filled at a community pharmacy. The patient was instructed to call back with a list of his medications; however, he did not call back and no one followed up.

Facility policy[83] for patients at risk for suicidal behaviors requires that all patients identified as at high risk for suicide are to have appointments scheduled as follows from the date of discharge from an inpatient facility: the patient's first four appointments are to be scheduled within 7 days of each other for the first 4 weeks, and the last two appointments are to be scheduled at a minimum of monthly for 2 months.

The patient was identified by MH providers as at high risk for suicide, but was not seen at the required frequency. We reviewed all MH appointments at the facility following each of the patient's hospital discharges in the last 9 months of his life, and evaluated if the appointments were scheduled as required. We found that 12 of 18 appointments (67 percent) were not compliant with the scheduling requirement.

Facility policy[84] for intervention of patients with suicidal behaviors states that Suicide Behavior Reports are to be completed on all suicide attempts and/or other self-directed violence, and that the Suicide Prevention Coordinator and Patient Safety Manager are to be included as additional signers. The EHR showed that the reports were completed for two of the patient's five suicide attempts/suicide, and that the Patient Safety Manager did not sign them.

Inadequate Internal Screening Reviews

Although not part of the allegations, we found that facility staff had not completed screenings to determine the need for a peer review following the patient's medication overdose in 2015, serious suicide attempt in late 2015, or suspected suicide attempt in early 2016. The facility's policy requires a screening for the need for a peer review of patients who have suicide attempts or suicides within 30 days of an encounter with a health care professional. We asked managers why staff had not completed screenings following the patient's suicide attempts as required by facility policy and they acknowledged the noncompliance, but their responses were insufficient in helping us determine why facility processes were not followed in accordance with facility policy.

Additionally, managers should have considered disclosing information related to the patient's treatment to his family members following his death, after consulting with the Office of Chief Counsel.

[83] Facility Memorandum.
[84] Facility Memorandum.

Conclusions

The patient lived with a major mental illness for his entire adult life. Overall, he effectively managed his bipolar illness with the help of MH professionals and family until 2014, when new providers tapered and then discontinued his long-standing medication treatment of clonazepam. Two psychiatrists at the facility followed a conservative approach to prescribing clonazepam that might have been influenced by recently implemented VISN performance metrics and facility pay contracts, as well as an unapproved facility policy aimed at reducing the prescribing of benzodiazepines in certain circumstances. Psychiatrist C stopped the clonazepam and unilaterally issued the patient a treatment ultimatum that he could only return to the facility if he agreed with a treatment plan that did not include clonazepam. The psychiatrist's treatment position did not reflect patient centered care, and created a treatment impasse, and neither the patient nor his family was informed of his right to obtain an ethics consultation or appeal this treatment decision.

Any transition from the patient's customary and long-standing use of this medication in high doses could be both psychologically and physically difficult and involve some element of risk. This would necessitate a plan for carefully supervised withdrawal, which should have included the patient's preferences as to rate and timing. Psychiatrist C did not engage the patient in the development of a supervised withdrawal plan, nor did she include the patient's preferences in her treatment decisions.

We substantiated that the patient was not admitted to the facility's PRRTP as recommended by MH providers. We identified several barriers to the patient's admission, including delays in PPD testing, misconceptions about admission criteria, poor communication between providers, and delays in contacting the patient.

Facility providers interpreted the patient's ongoing requests for clonazepam treatment as aberrant drug seeking behavior, even in the absence of other tangible signs of substance use disorder and despite his long history of successful treatment with this medication. The alternative explanation, that the patient was seeking relief from his poorly controlled bipolar disorder symptoms, was not viewed as credible.

Management of the patient's bipolar illness and suicidality during the final 9 months of his life consisted primarily of psychotherapy with limited medication management and no other intensive interventions such as hospitalization or MHICM to address his underlying bipolar disorder. The patient's poorly managed bipolar illness was the likely underlying cause for his suicidal thinking and suicide.

Even though the patient had worsening MH symptoms, with multiple suicide attempts and psychiatric hospitalizations, we found no evidence of a collaborative treatment approach between MH providers to help the patient manage his bipolar illness. The patient received care in multiple locations and lacked adequate care coordination. We concluded that his care was fragmented and did not provide the level of MH care and services required for a patient with his complex psychiatric needs.

Medication reconciliation was not consistently done by MH providers who saw the patient following discharges from community psychiatric hospitalizations. Consequently, appropriate decisions could not be made regarding medication management for the patient.

The patient was identified by MH providers as at high risk for suicide, but was not seen at the required frequency. Suicide Behavior Reports were not consistently completed nor were all required clinical staff included as signers. Staff did not complete peer review screenings for this patient who had suicide attempts, as required. Additionally, managers should have considered disclosing information related to the patient's treatment to his family members following his death, after consulting with the Office of Chief Counsel.

Recommendations

1. We recommended that the Facility Director ensure usage of only approved policies regarding use of benzodiazepines and facility managers monitor compliance.

2. We recommended that the Facility Director ensure facility managers revise the patient complaint policy to include the VHA requirement for a clinical appeals process and to educate clinicians about the VHA requirement for clinical appeals and monitor compliance.

3. We recommended that the Facility Director ensure that the Psychosocial Residential Rehabilitation Treatment Program committee admission screening process is appropriate and timely and that facility managers monitor compliance.

4. We recommended that the Facility Director ensure that mental health clinicians administer tuberculosis tests (purified protein derivative) when needed for Psychosocial Residential Rehabilitation Treatment Program admission and that facility managers monitor compliance.

5. We recommended that the Facility Director ensure that Mental Health services are provided timely for patients designated as high risk for suicide that have been recently discharged from community hospitals.

6. We recommended that the Facility Director ensure that non-VA care for psychiatric services is offered to patients who need to be seen sooner than VA appointment availability permits.

7. We recommended that the Facility Director request that the Veterans Integrated Service Network Mental Health Program Manager evaluate facility Mental Health Services and programs for opportunities for improvement.

8. We recommended that the Facility Director ensure that a Mental Health Treatment Coordinator policy is implemented as required by the Veterans Health Administration and that all patients receiving mental health services are assigned a Mental Health Treatment Coordinator.

9. We recommended that the Facility Director ensure compliance with medication reconciliation as required by facility policies.

10. We recommended that the Facility Director ensure that Suicide Behavior Reports are completed for all patient suicide attempts and that the Patient Safety Manager is added as a signer as required by facility policy.

11. We recommended that the Facility Director ensure that a peer review screening is completed for patients who have attempted suicide within 30 days of seeing a health care professional as required by facility policy.

12. We recommended that the Facility Director initiate an external peer review to determine whether mental health staff appropriately managed the patient's bipolar illness. Based on the results of that peer review, the Facility Director should consult with the Office of Chief Counsel regarding an institutional disclosure, if appropriate.

Appendix A

Topic Related Reports

Healthcare Inspection – Review of Complaints Regarding Mental Health Services Clinical and Administrative Processes, VA St. Louis Health Care System, St. Louis, Missouri
12/13/2016 | 14-03434-102 |

Healthcare Inspection – Mental Health-Related Concerns, W. G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina
11/9/2016 | 15-05180-75 |

Healthcare Inspection – Emergency Department, Mental Health Service, and Suicide Prevention Training Concerns, Mann-Grandstaff VA Medical Center, Spokane, Washington
9/14/2016 | 15-03713-288 |

Healthcare Inspection – Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California
3/30/2016 | 14-04897-221 |

Healthcare Inspection – Alleged Delayed Mental Health Treatment and Other Care Issues, Kansas City VA Medical Center, Kansas City, MO
9/2/2015 | 14-03531-402 |

Healthcare Inspection – Alleged Poor Mental Health Care Resulting in a Patient Death, VA Central Iowa Health Care System, Des Moines, Iowa
6/10/2015 | 15-02627-386 |

Healthcare Inspection – Evaluation of a Patient's Care and Disclosure of Protected Information, Atlanta VA Medical Center, Decatur, Georgia
6/23/2015 | 15-02276-391 |

Healthcare Inspection – Suicide Risk and Alleged Medical Management Issues, Hampton VA Medical Center, Hampton, Virginia
3/30/2015 | 14-02139-156 |

OIG reports can be found at www.va.gov/oig.

Appendix B

VISN Director Comments

Department of Veterans Affairs

Memorandum

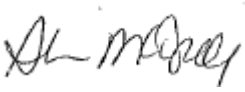
Date: October 26, 2017

From: Director, South Central VA Health Care Network (10N16)

Subj: Healthcare Inspection—Patient Mental Health Care Issues at a VISN 16 Facility

To: Director, Bay Pines Regional Office of Healthcare Inspections (54SP)
Director, Management Review Service (VHA 10E1D MRS Action)

The South Central VA Health Care Network has reviewed and concurs with the findings, recommendations and action plans submitted by the Facility Director, in response to the draft Health Inspection Report.



Skye McDougall, PhD
Director, South Central VA Health Care Network

Appendix C

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: October 24, 2017

From: Facility Director

Subj: Healthcare Inspection—Patient Mental Health Care Issues at a VISN 16 Facility

To: Director, South Central VA Health Care Network (10N16)

1. I have reviewed and concur with the Health Inspection report submitted by the Office of Inspector General.
2. As a health care team, we are committed to providing safe, quality care to Veterans throughout our catchment area. The results of this inquiry have been shared with my leadership team and key service groups such as Behavioral Health, Patient Safety, Risk Management, Suicide Prevention, Quality and Performance Management, and Non-VA Care Coordination. Through our combined efforts, we will ensure all recommendations are successfully addressed and that the services provided to our Veterans are of the highest quality.

Signed by Facility Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director ensure usage of only approved policies regarding use of benzodiazepines and facility managers monitor compliance.

Concur

Target date for completion: January 31, 2018

Facility response: A review of informal practice standards related to the prescribing of benzodiazepines has been initiated by Behavioral Health Service Line to ensure quality and safe care for our Veterans. On October 4, 2017, the Associate Chief of Staff for Behavioral Health Service reminded prescribing providers and program managers that the use of non-standardized practices in the prescribing of benzodiazepines are not endorsed at the Facility. To ensure prescribing practices are in line with national guidelines and standards of practice, a random sample of patients who are prescribed benzodiazepines will be audited every month for appropriateness with a goal of 90 percent compliance or greater for 3 consecutive months.

Recommendation 2. We recommended that the Facility Director ensure facility managers revise the patient complaint policy to include the VHA requirement for a clinical appeals process and to educate clinicians about the VHA requirement for clinical appeals and monitor compliance.

Concur

Target date for completion: February 28, 2018

Facility response: To ensure Veterans rights are protected, the local patient complaint station memorandum will be revised to outline how the facility's clinical appeals process is to be implemented and managed in accordance with VHA Directive 1041, Appeal of VHA Clinical Decisions. Identified clinicians at the Facility will receive education on the revised station memorandum and the appeal process when published. To ensure the appeals process is being utilized in accordance with newly developed policy, a random sample of clinical appeals will be audited every month with a goal of 90 percent compliance or greater for 3 consecutive months.

Recommendation 3. We recommended that the Facility Director ensure that the Psychosocial Residential Rehabilitation Treatment Program committee admission

screening process is appropriate and timely and that facility managers monitor compliance.

Concur

Target date for completion: January 31, 2018

Facility response: Our philosophy is to provide a Veteran centric individualized approach to care for the patients in our Psychosocial Residential Rehabilitation Treatment Program. To ensure that Veterans who receive care in the Psychosocial Residential Rehabilitation Treatment Program do so in a safe, therapeutic environment, a screening criteria must be utilized, but that criteria must not serve as a barrier to accessing treatment. Clinical decisions that are made based on the established criteria must be timely and sound (as outlined in VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program). With that, we have taken steps to improve our processes. For example, the Psychosocial Residential Rehabilitation Treatment Program Screening Committee strives to complete consults for Facility inpatients within 1 business day of the request. To ensure compliance, screening outcomes will be audited for timeliness of responses and to confirm the process is being accomplished in accordance with local and national guidelines. A 90 percent or greater compliance standard for 3 consecutive months will be used to determine success.

Recommendation 4. We recommended that the Facility Director ensure that mental health clinicians administer tuberculosis tests (purified protein derivative) when needed for Psychosocial Residential Rehabilitation Treatment Program admission and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2017

Facility response: We are committed to patient-centered care. Recognizing that requiring a Purified Protein Derivative test prior to program admission may serve as a barrier to accessing treatment for our Veterans, changes have been made to no longer require a Purified Protein Derivative test prior to admission. If necessary, this can be accomplished after admission. To ensure compliance, screening outcomes will be audited to ensure Purified Protein Derivative testing is not a barrier to care using a standard of 90 percent compliance or greater for 3 consecutive months.

Recommendation 5. We recommended that the Facility Director ensure that Mental Health services are provided timely for patients designated as high risk for suicide that have been recently discharged from community hospitals.

Concur

Target date for completion: January 31, 2018

Facility response: Behavioral Health will partner with Non-VA Care Coordination to ensure all Veterans who have been designated as high risk for suicide and have been recently discharged from a community hospital, receive and complete an outpatient appointment or telephone visit. In accordance with VA/Department of Defense Clinical Practice Guidelines for Assessment and Management of Patients at Risk for Suicide, high risk patients will be seen within 7 days of their discharge. Non-VA Care Coordination will provide Behavioral Health with a list of patients being discharged from the community hospital. Behavioral Health will in turn schedule the patients to complete an outpatient or telephone visit within 7 days of their discharge. Compliance will be determined based on an audit of the electronic medical record to compare the number of high risk patients recently discharged from a community hospital against those discharged (high risk) from a community hospital who complete a mental health appointment or telephone visit within 7 days of their discharge. The threshold for compliance will be 90 percent or greater for 3 consecutive months.

Recommendation 6. We recommended that the Facility Director ensure that non-VA care for psychiatric services is offered to patients who need to be seen sooner than VA appointment availability permits.

Concur

Target date for completion: January 31, 2018

Facility response: We recognize that on occasion, psychiatric services may be required by our patients sooner than our availability allows. While we have taken steps to ensure same-day access for psychiatric services is available throughout the Facility, we want to ensure our Veterans have multiple means of prompt access without excessive wait when care is needed. In those instances, when the needs of our patients exceed our availability, Veterans are to be offered non-VA care. Using an established auditing process of scheduling practices, we will identify Behavioral Health patients who were scheduled greater than 30 days of their Patient Indicated Date. Those who fall into this category (30 days beyond Patient Indicated Date) will be offered non-VA care in accordance with Veterans Health Administration scheduling guidelines. Compliance will be determined by the number of patients at 30 days or beyond who were offered non-VA care as required. The threshold for compliance will be 90 percent or greater for 3 consecutive months.

Recommendation 7. We recommended that the Facility Director ensure that the VISN Mental Health Program Manager evaluate facility Mental Health Services and programs for opportunities for improvement.

Concur

Target date for completion: Completed

Facility response: Since August 2016, the Associate Chief of Staff, Behavioral Health Service has met with the Office of Mental Health Operations and the VISN 16 Mental Health Program Managers on a biweekly basis to discuss program concerns, quality

metrics and outcomes, as well as opportunities for improvement. This is an ongoing activity which will continue as a means of ensuring Veterans are receiving safe, quality care at the Facility.

Recommendation 8. We recommended that the Facility Director ensure that a Mental Health Treatment Coordinator policy is implemented as required by VHA and that all patients receiving mental health services are assigned a Mental Health Treatment Coordinator.

Concur

Target date for completion: February 28, 2018

Facility response: A Mental Health Treatment Coordinator Station Memorandum has been developed and is being reviewed by the facility Policy Group for approval. Our adoption of the Behavioral Health Interdisciplinary Program model will ensure facilitation of this policy and the assignment of a Mental Health Treatment Coordinator to each patient receiving mental health services. To ensure compliance, random audits of the patient assignment list will be completed to determine if Veterans are being assigned a Mental Health Treatment Coordinator as required using a standard of 90 percent compliance or greater for 3 consecutive months.

Recommendation 9. We recommended that the Facility Director ensure compliance with medication reconciliation as required by facility policies.

Concur

Target date for completion: Completed

Facility response: Medication reconciliation compliance is being tracked on a regular basis through our Patient Safety Committee. Service performance is reviewed and opportunities for improvement are addressed as identified. The Patient Safety Manager then provides a report to the executive-level quality committee which meets quarterly and is co-chaired by the Facility Director. In addition, this has been added to the Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluations.

Recommendation 10. We recommended that the Facility Director ensures that Suicide Behavior Reports are completed for all patient suicide attempts and that the Patient Safety Manager is added as an additional signer as required by facility policy.

Concur

Target date for completion: December 31, 2017

Facility response: Behavioral Health and the Suicide Prevention Program managers have revisited their processes and have implemented actions (e.g., shared e-mails, medical record notes, and enhanced Suicide Prevention Reports) to ensure that suicide behavior reports are completed for all patients who commit a suicide attempt as outlined

in local station policy. Also, in accordance with local station policy, the Patient Safety Manager is now being added as an additional signer on the completed reports. To ensure compliance, the local Suicide Prevention Activity Reporting tracker (which is maintained by the local Suicide Prevention Team) will be enhanced to include this information. Also, the tracker will be audited to confirm that the Suicide Behavior Reports are completed as required. In addition, the Suicide Behavior Reports will be audited to ensure the Patient Safety Manager has been included as an additional co-signer.

Recommendation 11. We recommended that the Facility Director ensure that a peer review screening is completed for patients who have attempted suicide within 30 days of seeing a health care professional as required by facility policy.

Concur

Target date for completion: December 31, 2017

Facility response: Behavioral Health and the Suicide Prevention Program managers have revisited their processes in relation to peer review screening. Processes have been put in place to ensure the Suicide Prevention Coordinator notifies the facility Risk Manager of patients who have exhibited parasuicidal behavior and were seen by a provider within 30 days of exhibiting such behavior. These cases are to have a peer review screening completed. To ensure compliance, the local Suicide Prevention Activity Reporting tracker (which is maintained by the local Suicide Prevention Team) will be enhanced to include this information. The activity report and the actual peer review screenings will be audited to confirm completion.

Recommendation 12. We recommended that the Facility Director initiate an external peer review to determine whether the mental health staff appropriately managed the patient's bipolar illness. Based on the results of that peer review, the Facility Director should consult with the Office of Chief Counsel regarding an institutional disclosure, if appropriate.

Concur

Target date for completion: December 31, 2017

Facility response: As recommended, the Risk Manager has initiated an external peer review and based on the findings of that review, a determination will be made regarding an institutional disclosure.

Appendix D

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Lauren Olstad, LCSW, MSW, Team Leader Darlene Conde-Nadeau, ARNP, MSN Martha Kearns, MSN, FNP Alan Mallinger, MD April Terenzi, BA, BS Carol Torczon, MSN, ACNP Julie Watrous, RN, MS Michelle Wilt, BSN, MBA

Appendix E

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, South Central VA Health Care Network (10N16)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Roy Blunt, John Boozman, Bill Cassidy, Thad Cochran, John Cornyn, Tom Cotton, Ted Cruz, James M. Inhofe, Doug Jones, John Kennedy, James Lankford, Claire McCaskill, Bill Nelson, Marco Rubio, Richard C. Shelby, Roger Wicker
U.S. House of Representatives: John Abney, Ralph Abraham, Kevin Brady, Bradley Byrne, Rick Crawford, Neal P. Dunn, Matt Gaetz, Louie Gohmert, Garret Graves, Al Green, Greg Harper, Vicky Hartzler, Jeb Hensarling, French Hill, Clay Higgins, Sheila Jackson, Mike Johnson, Trent Kelly, Billy Long, Michael T. McCaul, Markwayne Mullin, Pete Olson, Steven Palazzo, Ted Poe, John Ratcliffe, Cedric Richmond, Steve Scalise, Bennie G. Thompson, Randy K. Weber Sr., Bruce Westerman, Steve Womack

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