DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Two Patient Suicides, a Patient Self-Harm Event, and Mental Health Services Administrative Deficiencies at the Alaska VA Healthcare System Anchorage, Alaska

HEALTHCARE INSPECTION | REPORT #19-00002-16 | NOVEMBER 19, 2019

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review allegations of deficiencies in quality of care and administrative processes that contributed to two patient deaths by suicide and one patient's self-harm behavior at the Alaska VA Healthcare System's (facility) outpatient Social and Behavioral Health Services (Behavioral Health Service).[1]

The OIG team substantiated that facility staff failed to follow Veterans Health Administration (VHA) and facility missing patient policies after Patient 1 left the Same Day Access Clinic without being seen. The OIG team was unable to determine that facility staff's lack of timely search and outreach directly contributed to Patient 1's death by suicide approximately one week later because other potential contributing factors were unknown.

The OIG team substantiated that two additional patients did not have follow-up appointments scheduled as indicated in the providers' order. Although failure to schedule a follow-up appointment can place a patient at risk for adverse outcomes, the OIG team was unable to determine that the unscheduled appointments contributed directly to Patient 2's self-harm behavior and Patient 3's death by suicide. The OIG team substantiated that Patient 2 presented to the Same Day Access Clinic and was evaluated by a registered nurse and three providers (a licensed clinical social worker, a psychologist, and a psychiatrist). However, the OIG team determined that the care provided was adequate and did not find evidence that the Same Day Access Clinic visit resulted in Patient 2's self-harm behavior.

The OIG team substantiated that the Same Day Access Clinic had no triage staff coverage from 7:30 a.m. to 8:00 a.m. and 4:30 p.m. to 5:00 p.m. However, it was unclear whether the clinic operated during these hours due to inconsistencies among building entrance signage, Same Day Access Clinic standard operating procedures, and staff report of Same Day Access Clinic hours of operation. The OIG team did not identify adverse patient outcomes due to confusion about clinic hours; however, the lack of clarity may place patients at risk if they sought care based on an erroneous understanding of the clinic's hours of operation.[2]

[1] The complainants reported three patients died by suicide; however, the OIG team determined through electronic health record reviews that there were two deaths by suicide (Patient 1 and Patient 3) and one instance of self-harm behavior (Patient 2).

[2] Within the context of this report, the OIG considers an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment or a need for higher level care. The OIG recognizes that in addition to the potential for adverse clinical outcomes, avoidable delays and cancellations associated with the deficiencies discussed in this report may impact the convenience and quality of care received by veterans. This report focuses on patient harm in terms of adverse clinical outcomes.

The OIG team substantiated that the Same Day Access Clinic lacked psychiatric coverage from 8:00 a.m. to 12:00 p.m.; however, the OIG did not identify adverse patient outcomes related to lack of psychiatric coverage, and most staff interviewed indicated a psychiatrist was available for assistance when needed. The OIG identified a 2018 Joint Patient Safety Report related to a lack of Same Day Access Clinic psychiatry coverage, which facility leaders attributed to "staffing levels." Three months later, facility managers hired a psychiatrist and a psychiatric nurse practitioner to increase Same Day Access Clinic available psychiatric coverage.

The OIG substantiated that providers were sometimes double booked while providing same day access coverage due to software problems with providers' clinic profiles.[3] Additionally, some providers reportedly double booked to accommodate patient follow-up appointments sooner than would otherwise be possible. The OIG team did not identify adverse patient events related to double booking.

The OIG team substantiated that the facility's medical support assistant staff closed providers' outstanding clinically indicated date and return to clinic orders without contacting patients and completing proper electronic health record documentation.[4] An OIG team review of 103 outstanding clinically indicated date orders indicated that medical support assistants closed 21 (20 percent) without the outreach and documentation required by VHA.[5]

In addition to the original allegations, the OIG learned that, in early 2018, facility leaders identified a backlog of outstanding scheduling orders. In April 2018, facility leaders reported implementing and monitoring measures to mitigate the backlog from reoccurring. However, the Facility Director did not report the non-compliance with VHA scheduling requirements and the outstanding orders to the Veterans Integrated Service Network (VISN). The OIG team learned that the shortage of administrative support staff for the Behavioral Health Service also contributed to the backlog. From January through October 2018, facility managers hired seven administrative support staff that doubled the number of Behavioral Health Service medical support assistants to fourteen.

At the November 8, 2018, exit briefing with facility and VISN leaders, the OIG team requested the facility complete an immediate clinical review of patients identified as having unresolved

[3] Double book is "to make plans (for someone or something) to be in two different places at the same time," Merriam-Webster, https://www.merriam-webster.com/. (The website was accessed on January 29, 2019.) VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016: "Clinic profile is the customized parameters in VistA Scheduling that define outpatient clinic parameters." These parameters "include clinic name, start date/time, provider, location, frequency of the clinic, operating times, stop codes, overbooking allowance., count or non-count clinic, billable or non-billable for first party copays, billable or non-billable for third party billing, appointment lengths, users, etc."

[4] VHA Directive 1230. Clinically indicated date is the date an appointment is deemed clinically appropriate by a health care provider.

[5] Deputy Under Secretary for Health for Operations and Management (10N), *Guidance of Patients Failure to Attend Appointments (No Shows),* August 6, 2013.

clinically indicated date/return to clinic orders to determine status and mental health treatment needs. Facility leaders provided the OIG with the list of 433 outstanding clinically indicated date/return to clinic orders on February 6, 2019, and reported completion of the requested clinical review on March 3, 2019.

The OIG team substantiated that the facility did not have a missed appointment policy as required by VHA. The OIG team did not substantiate that facility leaders failed to implement an electronic wait list or that an unlicensed social worker provided care to a patient. The OIG substantiated that facility leaders did not implement Behavioral Health Interdisciplinary Program teams as required and the facility did not have a primary care mental health integration policy; however, VHA does not require facilities to establish a primary care mental health integration policy.

The OIG substantiated that until February 1, 2019, the facility lacked a Mental Health Treatment Coordinator policy as required by VHA. In November 2018 interviews with the OIG team, facility providers lacked clarity regarding Mental Health Treatment Coordinator assignment and responsibilities. On November 8, 2018, the OIG informed facility and VISN leaders that staff lacked clarity about Mental Health Treatment Coordinator processes and procedures; and requested that the policy be finalized. Effective February 1, 2019, Behavioral Health Service leaders established a Mental Health Treatment Coordinator policy.[6]

The OIG team did not substantiate facility staff expressed concerns about personal safety in the Same Day Access Clinic triage room; however, the facility lacked a behavioral health emergency policy, as required by VHA. The OIG team identified opportunities for improved culture of safety within Behavioral Health Service. In November 2018, an alternative dispute resolution specialist met with Behavioral Health Service staff and provided feedback and recommendations to facility leadership. As of March 2019, facility leaders provided the OIG with an action plan that addressed 10 of the 13 recommendations.

The OIG made 11 recommendations related to Behavioral Health Service's policies and procedures, Same Day Access Clinic coverage, scheduling processes, implementation of the Behavioral Health Interdisciplinary Program and Mental Health Treatment Coordinator, behavioral health emergency plans, and a just culture.

[6] Alaska VA Healthcare System, Policy 116-17, *Mental Health Treatment Coordinator,* February 1, 2019.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided acceptable action plans. (See appendixes A–B, pages 31–39 for the comments.) The OIG considers all recommendations open and will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

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Contents

Abbreviations

EHR	electronic health record
OIG	Office of Inspector General
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review allegations of deficiencies in quality of care and administrative processes that contributed to two patient deaths by suicide and one patient's self-harm behavior at the Alaska VA Healthcare System's (facility) Social and Behavioral Health Services (Behavioral Health Service).[7]

Background

The facility, part of Veterans Integrated Service Network (VISN) 20, consists of the medical center located in Anchorage, and four VA community based clinics located in Fort Wainwright, Kenai, Wasilla, and Juneau, Alaska. The VA classifies the facility as level 3–low complexity.[8] From October 1, 2017, through September 30, 2018, the facility served 22,150 patients and had a total of 74 hospital operating beds, including 50 domiciliary beds, and 24 compensated work therapy transitional resident beds. The facility offers primary, specialty, and mental health outpatient care. The facility provides services through a joint venture with the United States Air Force on nearby Elmendorf Air Force Base, and is affiliated with the University of Alaska Anchorage.

Prior OIG Reports

A search of prior facility healthcare inspections from the last four years identified two OIG reports from the facility with a similar topic. A 2015 OIG report, *Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System*, 14-04077-405, July 7, 2015, reflects issues related to this report. The 2015 report was issued in response to allegations regarding provider availability, workload, access, quality of care, and security at the Mat-Su VA Community Based Outpatient Clinic in Wasilla, Alaska, and scheduling practices at the facility.

The OIG identified issues of culture and employee morale having the potential to compromise patient safety and made nine recommendations. The following recommendation is relevant to the current OIG report:

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[7] The complainants referred to three patients who died by suicide in the allegation; however, the OIG's electronic health record reviews indicated that there were two deaths by suicide (Patients 1 and 3) and one instance of self-harm behavior (Patient 2).

[8] The Veterans Health Administration (VHA) Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most administratively complex. Level 3 facilities are the least complex. VHA Office of Productivity, Efficiency and Staffing, http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. (The website was accessed April 4, 2019, and is an internal VA website not publicly accessible.)

- The OIG recommended that the VISN Director ensure that the Facility Director assess the culture, morale, and leadership issues identified in this report, and take appropriate action as necessary.[9]

A 2017 OIG report, *Follow-Up of Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System, Anchorage, Alaska*, 15-05249-162, March 9, 2017, determined that the nine recommendations were acted upon and considered closed as of May 2016.[10]

Allegations

On August 24, 2018, two confidential complainants submitted allegations to the OIG that were accepted as a hotline inspection shortly thereafter. The inspection addressed the following allegations:

1) Behavioral Health Service Access and Scheduling Oversight
    - A patient (Patient 1) died by suicide due to a lack of Same Day Access Clinic policies and staff's failure to respond timely to a patient's leaving before being seen.
    - A patient (Patient 2) engaged in self-harm behavior after being seen by three different providers in the Same Day Access Clinic.
    - Same Day Access Clinic has no triage staff coverage from 7:30 a.m. to 8:00 a.m. and 4:30 p.m. to 5:00 p.m.
    - Same Day Access Clinic lacks psychiatric coverage from 8:00 a.m. to 12:00 p.m.
    - Providers are double booked during assigned Same Day Access Clinic coverage.
    - There are deficits in Behavioral Health Service scheduling processes and patient follow-up.
        - Patient 2 engaged in self-harm behavior due to an inadequate return to clinic response.
        - A patient (Patient 3) died by suicide due to an inadequate return to clinic response.
    - Medical support assistant staff closed outstanding clinically indicated date orders without contacting patients and completing proper electronic health record (EHR) documentation.[11]
    - The facility does not have a missed appointment policy.

[9] VA Office of Inspector General, *Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System, Anchorage, Alaska, Report No. 14-04077-405*, July 7, 2015.

[10] VA Office of Inspector General, *Follow-Up of Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System, Anchorage, Alaska, Report No. 15-05249-162*, March 9, 2017.

[11] VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016. "Clinically indicated date is the date an appointment is deemed clinically appropriate by a VA health care provider."

- Staff are not using the electronic wait list for patients requesting VA mental health treatment.

2) Behavioral Health Service Administrative Processes
    - Patient 1 died by suicide following case management assessment by an unlicensed social worker.
    - Facility leaders did not implement Behavioral Health Interdisciplinary Program teams.
    - The facility lacks policies on primary care mental health integration and a mental health treatment coordinator.
3) Culture of Safety
    - Staff have concerns about personal safety in the Same Day Access Clinic triage rooms.

In addition to the original allegations, the OIG inspection team identified concerns about the establishment of a just culture within the Behavioral Health Service.

Scope and Methodology

The OIG initiated the inspection on September 27, 2018, and conducted a site visit from November 5 through November 8, 2018.

The OIG inspection team reviewed Veterans Health Administration (VHA) and facility policies and standard operating procedures related to the Behavioral Health Service that were effective from October 2016 through October 2018.

OIG staff reviewed All Employee Survey data, applicable meeting minutes, root cause analyses, Joint Patient Safety Reports, patient EHRs, administrative documents, and other relevant documents. The OIG team reviewed electronic wait list and missed appointment data from October 1, 2017, through September 30, 2018, and clinically indicated date/return to clinic data from April 1, 2017, through September 30, 2018.

The OIG team interviewed the complainants, facility leadership, management, and Behavioral Health Service staff, the Patient Safety Manager, Risk Manager, Group Practice Manager, and VHA National Director of Social Work. During the site visit, the OIG team conducted a walk-through of the Same Day Access, Specialty Mental Health, and Primary Care Mental Health Integration clinics.

EHR reviews related to 433 Behavioral Health Service clinically indicated date orders from April 1, 2017, through September 30, 2018, were completed. Of the 433 Behavioral Health Service clinically indicated date orders, the OIG team reviewed a random sample of 103 appointments (from 92 unique patients) to determine if facility medical support assistant staff scheduled an associated appointment and documented required patient outreach. The OIG team also conducted a clinical review of 68 return to clinic orders from October 1, 2017, through

September 30, 2018, and referred 12 cases to the facility for Behavioral Health Service follow-up.

Additionally, to assess the facility's compliance with VHA's missed appointment follow-up procedures, data were obtained on missed Behavioral Health Service individual appointments from the VHA Corporate Data Warehouse from October 1, 2017, through September 30, 2018.[12] The OIG team completed EHR reviews of a random sample of 304 missed appointments. Sixteen of the 304 missed Behavioral Health Service appointments were excluded from analysis based on exclusion criteria and resulted in 288 appointments that required follow-up.[13] The OIG team referred one case to the facility for Behavioral Health Service follow-up.

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

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

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

[12] Deputy Under Secretary for Health for Operations and Management (10N), *Guidance on Patients Failure to Attend Appointments (No Shows)*, August 6, 2013. VHA's Corporate Data Warehouse "is a national repository comprising data from several VHA clinical and administrative systems." The objective of maintaining this database "is to facilitate reporting and data analysis at the enterprise level by incorporating data from multiple data sets throughout the VHA into one standard database structure. Corporate Data Warehouse provides data and tools to support management decision making, performance measurement, and research objectives." http://vaww.vhadataportal.med.va.gov/DataSources/CDW.aspx. (The website was accessed on November 6, 2018.) This website is not accessible to the public.

[13] The OIG excluded 16 of the 304 patients' EHRs from the review based on the following exclusion criteria: the missed appointment was not a Behavioral Health Service appointment (3), appointment already scheduled (6), listed as missed appointment in error (4), engaged in a higher level of care (1), staff unable to reach patient by phone (1), and required outreach completed for previous missed appointments and no further outreach required per VHA policy (1).

Patient Case Summaries

Patient 1

The patient was in their 30s at time of death by suicide in 2017.[14] The patient engaged in regular and recurring medical care at a VA medical center from 2009 until 2013. In 2014, the patient initiated care with the facility's primary care and Behavioral Health Service and reported a history of two suicide attempts, most recently in 2014. The patient's mental health diagnoses included bipolar affective disorder, agoraphobia with panic attacks, obsessive compulsive disorder, and social phobia.

In early 2017, the patient reported increased anxiety, social isolation, and difficulties at work. Throughout mid-2017, the patient complained to the treating psychiatrist and social worker about unstable mood, intense anxiety, and intermittent suicidal ideation. In spring 2017, the patient was admitted to a non-VA hospital inpatient psychiatry unit for depression and thoughts of overdosing on medications. After a week-long admission, the patient denied thoughts of self-harm or suicide and was discharged with improved mood.

Two days after discharge, the Facility Suicide Prevention Coordinator assigned the patient a high risk for suicide patient record flag. Throughout the month, the patient reported ongoing low mood and repeatedly denied active suicidal thoughts or plans. About a week later, the patient requested a referral to a non-VA social worker with whom the patient had a prior therapeutic relationship. The Behavioral Health Service social worker submitted a community referral on that date. The Facility Social Work Executive approved the referral and the patient was scheduled to see the non-VA social worker a week later.

Approximately two weeks later, the patient presented to the facility's Same Day Access Clinic and noted on the triage intake form a concern for high anxiety, depression, and hopelessness but denied suicidal thoughts or a plan. The patient reported "I feel like my mind is deteriorating" to the Licensed Masters Social Worker. At the end of the 45-minute session, the Licensed Masters Social Worker described the patient as "future and goal orientated" and reviewed a suicide safety plan.[15] A clinical Social Worker supervisor reviewed and approved all care provided on the same day.

Two weeks later, the patient attended a scheduled appointment with the treating psychiatrist who documented that the patient's "mood and interest a bit better." The psychiatrist reviewed the

[14] The OIG uses the singular form of they in this instance for privacy purposes.

[15] A suicide safety plan is a brief clinical intervention in which a VA clinician and a patient collaboratively develop a written list of coping strategies and supportive resources to draw upon during a crisis to reduce imminent risk of suicidal behavior.

prescribed medications and noted that the patient denied suicidality or thoughts of self-harm and expressed interest in employment. The psychiatrist also noted that the patient was participating in regular psychotherapy with the non-VA social worker, discussed follow-up in two to three months, and requested the Patient Aligned Care Team social worker assist with employment options.[16]

Approximately two weeks later, at about 11:45 a.m., the patient presented to the Same Day Access Clinic. The triage nurse recorded vital signs and documented that the patient was manic and needed "some additional help." At 12:17 p.m., Medical Support Assistant 1 documented:

> [Psychiatrist] came out to call patient around 1200 looking for the patient. Writer called Veteran using the overhead intercom. Writer also called Veteran phone in attempt to contact Veteran, but only recieved [*sic*] voicemail. Writer left a message for Veteran to call S&BH [Social and Behavioral Health] to see if [the patient] still plans on being seen.

Nine days later, Medical Support Assistant 2 documented in the patient's EHR "Veteran left without being seen…and is flagged as a High Risk for Suicide. This Veteran should be followed up with. Alert to Suicide Prevention Coordinator and Acting Chief, SBHS [Behavioral Health Service]." The Suicide Prevention Coordinator directed the social worker triage team to telephone the patient and offer same day treatment. Two different social workers left voicemail messages for the patient.

The next day, the Suicide Prevention Coordinator requested that medical support assistants contact the patient to schedule an appointment with the treating psychiatrist. Medical Support Assistant 3 documented telephoning the patient at 11:48 a.m. to schedule an appointment but did not reach the patient and left a voicemail. At 12:36 p.m., Medical Support Assistant 4 documented that the patient's mother called and reported that the patient was "deceased by suicide." At 1:27 p.m., the Suicide Prevention Coordinator documented "Veteran died by suicide …Veteran died by overdose. Veteran was reportedly last known alive [date four days before] when [the patient] texted a friend." The non-VA social worker last met with the patient four days before the patient's death. At that appointment, the patient's mood state was self-described as "anxious, slightly less depressed." The non-VA social worker did not document a suicide risk assessment in the medical record and planned a follow-up appointment for the patient one week

[16] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook,* February 5, 2014, and amended on May 26, 2017. This handbook was scheduled for recertification on or before the last working day of February 2019 and had not been recertified. VHA defines Patient Aligned Care Team as a team of health care professionals that provides comprehensive primary care in partnership with the patient (and the patient's personal support person(s)) and manages and coordinates comprehensive health care services consistent with agreed upon goals of care.

later.[17] At 3:20 p.m. the Suicide Prevention Coordinator documented a contact with the non-VA social worker who reportedly said that the patient "was not endorsing acute suicidality, intent or plan" at the recent appointment.

Five months later, the Chief of Staff completed an institutional disclosure with the patient's father.[18] The Chief of Staff noted that a welfare check should have been completed for the patient. The Chief of Staff documented in the patient's EHR that the disclosure was completed because "[p]atient died by suicide and review process recommended institutional disclosure." The disclosure included a summary of the patient's mental health care in the month prior to the patient's death and "[c]oncerns regarding additional outreach to patient after leaving without being seen."

Patient 2

The patient established care with the facility in early 2003. In late 2003, the patient sought help through the mental health clinic for "feelings of depression and anxiety over the past several years." The patient's participation in mental health treatment was intermittent until 2011 when the patient began regular psychiatric medication management and psychotherapy for posttraumatic stress disorder, generalized anxiety disorder, and major depressive disorder. The patient canceled a 2014 psychotherapy appointment and two months later, the patient informed the psychotherapist that care was requested only for psychiatric mental health medication management. Subsequent attempts by facility staff at scheduling the patient for an appointment with a psychiatrist were unsuccessful. In spring 2015, the patient was admitted to a non-VA hospital for suicidal ideation and re-established psychiatric medication management treatment at the facility upon discharge. In fall 2017, the patient resumed psychotherapy with a facility psychologist.

At a late 2017, psychotherapy appointment, the patient was irritable and described diminished interest in daily activities. The patient noted that "I get worse if I don't come into the VA and stay active." The patient missed the next scheduled psychotherapy appointment about two weeks later. The psychologist contacted the patient and submitted an early 2018, clinically indicated

[17] A standard clinical social worker assessment of veterans should include a suicide risk assessment. The National Association of Social Workers Standards for Social Work Practice, *Service Members, Veterans and their Families,* September 2012. https://www.socialworkers.org/LinkClick.aspx?fileticket=fg817fIDop0%3d&portalid=0. (The website was accessed on February 8, 2019.)

[18] VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients,* October 2, 2012. This handbook was in effect during the timeframe of the disclosures discussed in this report. This VHA handbook was rescinded and replaced by VHA Directive 1004.08, *Disclosure of Adverse Events to Patients,* October 31, 2018. The 2012 handbook and the 2018 directive contain the same or similar language to define clinical disclosures. VHA defines institutional disclosure as a formal process of notification to a patient or patient's personal representative that an adverse event has happened during the patient's care that has or is expected to result in death or serious injury. System leaders, in conjunction with clinicians and other appropriate individuals, are to initiate the institutional disclosure as soon as reasonably possible and this type of disclosure is to occur regardless of whether it was a result of an error.

date order for the patient's next appointment. A medical support assistant made one attempt to reach the patient, left a voicemail message, and no appointment was scheduled.

The patient missed a scheduled psychiatric appointment and sent the psychologist a secure message expressing concern about missing a psychotherapy appointment. The psychologist informed the patient that the missed appointment was with the psychiatrist and noted that a follow-up psychotherapy appointment needed to be scheduled as well. The clinic registered nurse (RN) sent an electronic alert to the medical support assistant requesting contact be made to "aid rescheduling" and added the psychiatrist to the alert requesting that the psychiatrist "place new CID [clinically indicated date] if appropriate." The EHR does not reflect medical support assistant outreach or scheduled appointments.

Approximately two and a half months later, the patient presented to the Same Day Access Clinic and reported heightened anxiety, poor sleep, low mood, recurrent symptoms of posttraumatic stress disorder, and thoughts of self-harm. Throughout the day, the patient was evaluated by an RN, a licensed clinical social worker, a psychologist, and the treating psychiatrist. Before seeing the psychiatrist, the patient and the Same Day Access Clinic licensed clinical social worker completed a suicide safety plan. The patient told the psychiatrist about feeling "a lot better now." The psychiatrist documented that the patient "manifested no evidence of a desire to harm himself or anyone else." The patient declined the psychiatrist's offer for an inpatient mental health unit admission. The psychiatrist determined that the patient did not meet criteria for involuntary hospitalization and submitted a return to clinic order that was subsequently scheduled.

Three days after the Same Day Access Clinic visit, the psychologist telephoned, and the patient reported, "I felt so much better after going in. It was good to talk to other people." The patient denied active thoughts of self-harm. The patient agreed to an appointment with the psychologist two days later. The next day, a utilization review nurse informed the psychologist and psychiatrist that the patient was in a non-VA emergency department for a self-inflicted but nonlife-threatening gunshot wound to the chest. That day, the psychologist contacted the patient's spouse who reported that prior to the incident, the patient stated that the Same Day Access Clinic visit was helpful and calls from providers "welcome." Two weeks later, the patient was discharged from the non-VA facility in stable condition. Two days later, the patient met with both the treating psychologist and psychiatrist. As of early 2019, the patient remained in active mental health treatment and was followed by the mental health intensive case management team through which the patient received regular and on-going recovery-oriented support.

Patient 3

At the time of death, the patient was a combat veteran in their 30s with a mental health diagnostic history including posttraumatic stress disorder, attention deficit/hyperactivity disorder, alcohol use disorder, and medication for posttraumatic stress disorder, and was placed on 23-hour observation twice for suicidal ideations. In 2013, the patient separated from the military

and sought mental health services at the facility where the patient was followed for over four years on an outpatient basis. Behavioral Health Service provided mainly medication management services and the patient repeatedly declined psychotherapy.

In early 2018, the patient's psychiatrist documented medication management for posttraumatic stress disorder and attention deficit/hyperactivity disorder. During this visit, the patient reported poor sleep, low appetite, poor concentration, mood "up and down- spikes of energy followed by a crash," and auditory hallucinations (a new symptom). The patient denied suicidal ideation and alcohol use. The psychiatrist adjusted the patient's medication regimen and placed a return to clinic order for follow-up in one month. Medical support assistant staff did not contact the patient to complete the return to clinic order and no follow-up appointment was scheduled. The patient died by suicide two months later.

Inspection Results

1. Behavioral Health Service Access and Scheduling Oversight

Same Day Access

In 2016, VHA launched the My VA Access initiative to ensure same day access to VA mental health services from any entry point. The initiative required facilities to ensure that, for new and established patients who present in person, a clinician sees the patient the same day to address immediate care needs. The initiative required facility schedulers to schedule new patients for an initial mental health evaluation and ask all patients who call by telephone if they need to speak to a provider immediately. VHA also required facilities to review standard processes for provision of immediate care for veterans expressing suicidality, initial mental health screening evaluations, and the monitoring of progress towards same day access using standardized metrics.[19] Additionally, VHA emphasized a focused effort on improving the same day access primary care mental health integration.[20]

Missing Patient Policy

VHA defines a missing patient as "an at-risk patient who disappears from the patient care areas (on VA property)."[21] An at-risk patient is a patient identified as "dangerous to self or others."[22]

[19] Deputy Under Secretary for Health for Operations and Management (10N), *My VA Access: Mental Health Breakthrough Initiative.* April 22, 2016.

[20] Deputy Under Secretary for Health for Operations and Management (10N), *My VA Access: Mental Health Breakthrough Initiative.*

[21] VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.

[22] VHA Directive 2010-052.

VHA and facility policies require prompt detection of missing patients, an employee announcement of a missing patient, and initiation of search procedures.[23] Facility policy designates the chief of police as responsible for timely and thorough search procedures.[24] A preliminary search includes a search of nearby clinics, offices, and adjacent areas and if the patient is not found, the facility initiates a full search to include all areas of the facility.[25]

Patient 1

The OIG team substantiated that Same Day Access Clinic staff failed to adhere to VHA and facility missing patient policies after the patient left without being seen.[26] However, the OIG team was unable to determine that facility staff's lack of timely search and outreach directly contributed to the patient's death by suicide approximately one week later because other potential contributing factors were unknown. The OIG team found that the facility had a Same Day Access Clinic policy in effect at the time of the patient's check-in at the Same Day Access Clinic although it did not reference the missing patients policy.[27]

The patient, who was assigned a high risk for suicide patient record flag, checked into the Same Day Access Clinic but left prior to being seen. Facility staff failed to follow VHA and facility policies for missing patients designated as at-risk including determination of the patient as an at-risk missing patient, announcement to employees, and initiation of search procedures.[28]

In a 2018 institutional disclosure with the patient's family member, the Chief of Staff acknowledged "[c]oncerns regarding additional outreach to [the patient] after leaving without being seen." Facility managers, clinicians, and medical support assistants described an awareness of a need to outreach to patients who might leave the Same Day Access Clinic without being seen but identified inconsistent follow-up processes including alerting the provider, overhead paging to request the patient return to the clinic, and alerting the VA police to complete a health and welfare check.

Patient 2

The OIG team substantiated that an RN and three providers (a licensed clinical social worker, a psychologist, and a psychiatrist) evaluated the patient in 2018 in the Same Day Access Clinic.

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[23] VHA Directive 2010-052; Alaska VA Healthcare System Memorandum 07-04, *Management of "At-Risk" Missing Patients,* June 10, 2017.

[24] Alaska VA Healthcare System Memorandum 07-04.

[25] Alaska VA Healthcare System Memorandum 07-04.

[26] VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010; Alaska VA Healthcare System Memorandum 07-04, *Management of "At-Risk" Missing Patients*, June 10, 2017.

[27] Alaska Veterans Healthcare System Standard Operating Procedure 001-16, *Same Day Mental Health Access Standard Operating Procedure*, June 15, 2016.

[28] VHA Directive 2010-052; Alaska VA Healthcare System Memorandum 07-04.

The patient and the Same Day Access Clinic licensed clinical social worker completed a suicide safety plan and subsequently, the patient told the psychiatrist about feeling "a lot better now." The psychiatrist documented that the patient "manifested no evidence of a desire to harm [him/her] self or anyone else" and declined the psychiatrist's offer for an inpatient mental health unit admission. In a telephone call with the psychologist three days later, the patient described feeling better, denied active thoughts of self-harm, and agreed to an appointment two days later. The day after the phone call, a utilization review nurse informed the psychologist and psychiatrist that the patient was in a non-VA emergency department for a self-inflicted but nonlife-threatening gunshot wound to the chest. The OIG team determined the care provided in the Same Day Access Clinic was adequate given the patient's documented presenting symptomology. The OIG team did not find evidence that the Same Day Access Clinic visit resulted in the patient's self-harm behavior.

Same Day Access Clinic Triage Staff

The OIG substantiated that the Same Day Access Clinic had no coverage of triage staff from 7:30 a.m. to 8:00 a.m. and 4:30 p.m. to 5:00 p.m. However, it was unclear if the Same Day Access Clinic operated during those times. The OIG team found that staff understanding, building entrance signage, and one standard operating procedure provided different information about Same Day Access Clinic operating hours. Behavioral Health Service staff and managers consistently reported the Same Day Access Clinic hours of operation as 8:00 a.m. to 4:30 p.m., Monday through Friday. The facility building entrance signage listed the hours as 7:15 a.m. to 4:30 p.m. Two of the three standard operating procedures did not list Same Day Access Clinic hours of operation and one listed 7:30 a.m. to 5:30 p.m.[29] The OIG team's review of patient safety reports from November 1, 2017, through October 28, 2018, did not identify adverse patient outcomes due to confusion about clinic hours; however, the lack of clarity may have placed patients at risk if they sought care based on an erroneous understanding of the clinic's hours of operation.[30]

[29] Alaska Veterans Healthcare System Memorandum 001-16, *Same Day Mental Health Access*, June 15, 2016; Alaska Veterans Healthcare System, *Primary Care Same Day Access with MH Additions,* November 26, 2018; Alaska VA Healthcare System, *Social and Behavioral Health Services RN Same Day Access,* Standard Operating Procedure, November 28, 2018.

[30] Within the context of this report, the OIG considers an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for higher level care. The OIG recognizes that in addition to the potential for adverse clinical outcomes, avoidable delays and cancellations associated with the deficiencies discussed in this report may impact the convenience and quality of care received by veterans. This report focuses on patient harm in terms of adverse clinical outcomes.

Same Day Access Clinic Psychiatric Coverage

The OIG team substantiated that the Same Day Access Clinic lacked psychiatric coverage from 8:00 a.m. to 12:00 p.m.; however, for the review period of November 1, 2017, through October 28, 2018, the lack of psychiatric coverage did not result in adverse patient outcomes. The OIG team found that managers assigned a social worker or a psychologist to cover the Same Day Access Clinic Monday through Friday during all hours of operation.

Additionally, a Behavioral Health Service psychiatrist covered the Same Day Access Clinic for four-hour blocks in the afternoon. Staff told the OIG that Same Day Access Clinic staff called a psychiatrist as needed in the morning hours. Most staff interviewed indicated a psychiatrist was available for assistance when needed.

The OIG identified a 2018 Joint Patient Safety Report related to a lack of Same Day Access Clinic psychiatry coverage. A patient with suicidal and homicidal ideation required an evaluation for potential involuntary psychiatric admission; however, a Same Day Access Clinic social worker was unable to reach a psychiatrist and the patient left. Staff initiated a health and welfare check and the patient was deemed safe. In response to the Joint Patient Safety Report, facility leaders stated that "staffing levels" was the reason for the absence of all-day Same Day Access Clinic psychiatry coverage. Three months later, facility managers hired a psychiatrist and a psychiatric nurse practitioner to increase Same Day Access Clinic available psychiatric coverage.

The OIG determined the facility's Same Day Access Clinic standard operating procedures did not include a protocol for staff to access psychiatry consultation services when there was not an assigned psychiatrist, increasing risk for failures in care delivery, coordination, and adverse patient outcomes.

Double Booking

The OIG substantiated that providers were sometimes double booked while providing same day access coverage due to software problems with providers' clinic profiles.[31] Additionally, some providers reportedly double booked to accommodate patient follow-up appointments sooner than would otherwise be possible. The OIG team did not identify adverse patient events related to double booking.

[31] Double book is "to make plans (for someone or something) to be in two different places at the same time," Merriam-Webster, https://www.merriam-webster.com/. (The website was accessed on January 29, 2019.) VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016: "[c]linic profile is the customized parameters in VistA Scheduling that define outpatient clinic parameters." These parameters "include clinic name, start date/time, provider, location, frequency of the clinic, operating times, stop codes, overbooking allowance, count or non-count clinic, billable or non-billable for first party copays, billable or non-billable for third party billing, appointment lengths, users, etc."

Deficiencies in Behavioral Health Service Scheduling Processes and Patient Follow-up

VHA requires timely and accurate appointment scheduling within 30 days of the clinically indicated date, which is the date deemed appropriate by the ordering provider.[32] Further, appointments are to be scheduled "immediately, but no later than three calendar days after the request."[33] If a patient chooses to schedule when checking out from an appointment, the facility medical support assistant completes the clinically indicated date order and there is no required EHR documentation. If the patient chooses to schedule the appointment later, staff must document two contact attempts (one phone call and one letter) on separate dates.[34] Facility directors must ensure appropriate resources for scheduling, ongoing staff training, continuous auditing and improvement processes, compliance monitoring, and reporting of non-compliance with the scheduling directive to the VISN.[35]

In June 2017, VHA designated a single term—"patient indicated date"—to replace both clinically indicated date and preferred date.[36] In December 2017, VHA established a standardized national "return to clinic" process.[37]

Patient 2 and Patient 3

The OIG team substantiated that Patients 2 and 3 did not have appointments scheduled as indicated in the providers' clinically indicated date, and return to clinic orders, respectively. Although failure to schedule a follow-up appointment with a patient having active psychiatric symptoms can place a patient at risk for adverse outcomes, the OIG team was unable to determine that the unscheduled appointments contributed directly to Patient 2's self-harm behavior and Patient 3's death by suicide.

Clinically Indicated Date and Return to Clinic

The OIG team substantiated that the facility's medical support assistant staff closed providers' outstanding clinically indicated date and return to clinic orders without contacting patients and

[32] VHA Directive 1230.

[33] VHA Directive 1230.

[34] VHA Directive 1230.

[35] VHA Directive 1230.

[36] Deputy Under Secretary for Health for Operations and Management (10N), *Scheduling and Consult Policy Updates,* June 5, 2017; VHA Directive 1230. VHA defines preferred date as "the date the patient communicates they would like to be seen."

[37] VHA Directive 1230. Prior to January 2018, the facility used the term clinically indicated date and then used the term return to clinic in adherence to the Deputy Under Secretary for Health for Operations and Management (10N), *Deployment of National Return To Clinic Order*, December 7, 2017 guidance.

completing proper EHR documentation. Facility medical support assistant staff told the OIG team that they closed outstanding clinically indicated date and return to clinic orders with proper patient follow-up or provider consultation. However, an OIG team review of 103 outstanding clinically indicated date orders indicated that medical support assistants closed 21 (20 percent) without the outreach and documentation required by VHA.[38]

In addition to the original allegation regarding outstanding clinically indicated date and return to clinic orders, the OIG inspection team identified an additional backlog of outstanding Behavioral Health Service clinically indicated date and return to clinic orders. In November 2018, facility leaders told the OIG team that in early 2018, approximately 200 outstanding Behavioral Health Service clinically indicated date and return to clinic orders did not have patient appointments scheduled as ordered. In April 2018, facility leaders reported implementing and monitoring measures to mitigate the backlog from reoccurring. Facility leaders identified an issue with the VistA Scheduling Enhancement system, which did not readily print the entire list of return to clinic orders on the return to clinic report. Facility leaders identified the VistA Scheduling Enhancement system report formatting issues as a factor that contributed to a failure to schedule appointments.[39]

On May 31, 2018, the Facility Director informed the VISN about the VistA Scheduling Enhancement program problems and received guidance on how to proceed. However, the Facility Director did not report the consequent non-compliance with VHA scheduling requirements and the approximately 200 outstanding clinically indicated date and return to clinic orders. Following receipt of VISN guidance, facility leaders implemented a daily review of the open return to clinic orders.

The OIG team learned that a shortage of administrative support staff for the Behavioral Health Service also contributed to the backlog. However, from January through October 2018, facility managers hired seven administrative support staff thereby doubling the number of Behavioral Health Service medical support assistants to fourteen.

Staff members told the OIG team that when a provider placed a return to clinic order for a Behavioral Health Service patient, the patient was supposed to schedule the next appointment with the medical support assistant prior to leaving the clinic. If the patient left without scheduling

[38] Deputy Under Secretary for Health for Operations and Management (10N), *Guidance of Patients Failure to Attend Appointments (No Shows),* August 6, 2013.

[39] VHA Directive 1230. "VistA is an integrated EHR information technology system created and used by VHA with approximately 200 application/modules. The VistA Scheduling module is designed to assist in the set-up of outpatient clinics, scheduling of patients for clinic appointments, and the collection of related workload data for reporting purposes." Deputy Under Secretary for Health for Operations and Management, *Veterans Health Information Systems and Technology Architecture (VistA) Scheduling Enhancements Leadership Update II: Return to Clinic Orders,* March 30, 2018. "The Vista Scheduling Graphic User Interface, also known as VistA Scheduling Enhancement, should be used to schedule all appointments."

the return to clinic appointment, the medical support assistant staff did not receive a computer system alert; however, a staff member told the OIG that the medical support assistant supervisor queried return to clinic orders every other day for follow-up.

At the November 8, 2018, exit briefing with facility and VISN leaders, the OIG team requested the facility complete an immediate clinical review of patients identified as having unresolved clinically indicated date/return to clinic orders to determine status and mental health treatment needs. Facility leaders provided the OIG with the list of 433 outstanding clinically indicated date/return to clinic orders on February 6, 2019. On March 3, 2019, facility leaders reported completion of the requested clinical review.

In January 2018, the facility conducted an internal review related to outstanding clinically indicated date orders that resulted in two action items: (1) developing a standardized medical support assistant process for implementing the clinically indicated date scheduling process in accordance with national guidance, and (2) creating a process to monitor and ensure service lines are in compliance. In February 2019, facility leaders provided the OIG with information regarding the action items follow-up that included a guide on how to complete a return to clinic order electronically. However, this guide did not include relevant process elements such as, required timeframes and monitoring pending orders. The OIG team determined that facility leaders did not establish a standardized medical support assistant protocol and failed to monitor Behavioral Health Service compliance.

Missed Appointments

VHA requires staff to contact patients who miss scheduled mental health or substance use disorder appointments. Staff should attempt to contact the patient at least three times and must document the attempts in the patient's EHR.[40] Medical support assistants may contact patients; however, a qualified mental health provider must contact patients with a high risk for suicide patient record flag in the EHR.[41] If unable to contact a high risk for suicide patient, the provider should contact local law enforcement to perform a health and welfare check.[42] The facility's Suicide Prevention Coordinator must ensure that staff provide outreach to high risk for suicide

[40] Deputy Under Secretary for Health for Operations and Management (10N), *Guidance on Patients Failure to Attend Appointments (No Shows)*, August 6, 2013; VHA Directive 1230.

[41] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. A patient record flag is used to alert VHA employees to patients whose behavior, medical status, or other characteristics may pose a safety threat to that patient's, other patients, VHA employees, or may compromise safe health care delivery. Deputy Under Secretary for Health for Operations and Management (10N), *Guidance on Patients Failure to Attend Appointments (No Shows)*, June 25, 2013.

[42] Deputy Under Secretary for Health for Operations and Management (10N), *Guidance on Patients Failure to attend Appointments (No Shows)*, June 25, 2013.

patients who miss mental health and substance abuse appointments.[43] VHA requires facility leaders to establish a policy consistent with national requirements regarding mental health patients missed appointment follow-up, including a compliance audit of EHRs.[44]

The OIG substantiated that the facility did not have a missed appointment policy as required by VHA. Facility staff stated that they followed national guidance procedures for missed appointments. However, in interviews with the OIG, facility staff were inconsistent in their understanding of who was responsible for making missed appointment follow-up calls, how many calls were required, and how attempted contacts were documented.

From October 1, 2017, through September 30, 2018, the OIG identified a total of 2,261 missed Behavioral Health Service appointments by 1,137 unique facility patients. The OIG reviewed a random sample of 288 EHRs of patients who missed Behavioral Health Service individual appointments that required follow-up.[45] The OIG found that facility staff documented initial follow-up telephone calls in 237 of the 288 (82 percent) missed appointments reviewed. The OIG found no documentation that facility staff followed up with contact attempts as required for 30 of the 288 (10 percent) patients with missed appointments. Of the 30 patients, 15 patients subsequently re-engaged in Behavioral Health Service treatment.

Eight of the 288 patients' EHRs reviewed were assigned high risk for suicide patient record flags that required physicians or other qualified mental health providers to make outreach attempts. A provider reached five of the eight patients on the first or second telephone call.[46] The three patients not reached all continued in Behavioral Health Service treatment. One patient had an appointment 15 days after the missed appointment; however, facility staff did not complete the required missed appointment outreach for this patient.[47]

[43] VHA Directive 2008-036, *Use of PRF to Identify Patients at High Risk for Suicide*, July 18, 2008, expired July 31, 2013 and has not been replaced. The Suicide Prevention Coordinator is a position funded at each medical center as part of VHA's national suicide prevention strategy.

[44] Deputy Under Secretary for Health for Operations and Management (10N), *Guidance on Patients Failure to attend Appointments (No Shows)*, June 25, 2013.

[45] The OIG excluded 16 of the 304 patients' EHRs from the review based on the following exclusion criteria: the missed appointment was not a Behavioral Health Service appointment (3), appointment already scheduled (6), listed as missed appointment in error (4), engaged in a higher level of care (1), staff unable to reach patient by phone (1), and required outreach completed for previous missed appointments and no further outreach required per VHA policy (1).

[46] A provider reached a caregiver for one of the five patients. The caregiver informed the provider that the patient died of medical complications.

[47] On February 8, 2019, the OIG team informed the Facility Director of this patient case and requested clinical review.

Electronic Wait List

The OIG team did not substantiate that facility staff were non-compliant with use of an electronic wait list for patients requesting mental health treatment.[48] Through data review and staff interviews, the team determined that facility staff utilized the electronic wait list as needed. When a new patient or patient with a new clinical issue in Behavioral Health Service requested an appointment, scheduling occurred within 90 days of the clinically indicated date, as required. Further, facility Behavioral Health Service leaders stated that if a Behavioral Health Service patient waited longer than 90 days for a scheduled appointment, the patient was placed on an electronic wait list; however, this did not routinely occur.

2. Deficiencies in Behavioral Health Service Administrative Processes

Social Worker Supervision

VHA requires that newly hired or reassigned social workers in the General Schedule–185 series receive state licensure or certification to independently practice social work at the master's level. VHA social workers must become licensed or certified at the independent, master's level within three years of their appointment.[49] The employee's supervisor or social worker executive will inform any unlicensed social workers of this requirement upon appointment. Social workers who fail to become licensed within the defined timeframe will be removed from the position and may be terminated.[50]

A social worker's level of licensure defined for independent (unsupervised) practice varies across states. In Alaska, licensed masters social workers are allowed to provide counseling independently while licensed clinical social workers can provide both counseling and psychotherapy at an independent billing level.[51]

The OIG team did not substantiate that an unlicensed social worker provided care to Patient 1 in the Same Day Access Clinic prior to a completed suicide. The OIG found that Patient 1 saw a Licensed Masters Social Worker in the Same Day Access Clinic with appropriate case management and counseling provided. The OIG team reviewed the personnel records of

[48] VHA Directive 1230. Electronic wait list is defined as "VHA's official list to track patients who have been waiting for more than 90 calendar days for an appointment."

[49] VHA Directive 1027, *Supervision of Psychologist, Social Workers, Professional Mental Health Counselors and Marriage and Family Therapists Preparing for Licensure*, October 23, 2013. Supervision is defined as "clinical consultation between the independent practitioner serving as supervisor and the psychologist, social worker, professional mental health counselor or marriage and family therapist; who is not licensed for the purpose of monitoring, informing, and guiding provision of services."

[50] VA Handbook 5005/23, *Staffing*, February 13, 2009.

[51] Social Work Guide, "Alaska Social Work License Requirements," 2019. https://www.socialworkguide.org/licensure/alaska/. (The website was accessed on July 22, 2019.)

58 social workers employed at the facility from October 1, 2017, through September 30, 2018. During that time period, social workers included 48 licensed clinical social workers or equivalent, eight licensed masters social workers, and three unlicensed social workers. The 48 licensed clinical social workers were advanced practice level providers. The eight licensed masters social workers performed duties within a scope of practice, including case management and counseling, but not psychotherapy. The three unlicensed social workers were within the three-year timeframe in which they could practice supervised while working toward licensure. The OIG team found that the facility was in compliance with social workers supervision requirements within the timeframe reviewed.

Primary Care Mental Health Integration and Behavioral Health Interdisciplinary Program Implementation

In 2008, VHA required that facilities integrate mental health services into primary care clinics.[52] In 2013, VHA required every facility to create at least one Behavioral Health Interdisciplinary Program team by October 5, 2013.[53] The Behavioral Health Interdisciplinary Program is composed of interdisciplinary teams to provide recovery-oriented, evidence-based mental health care. The goals of the Behavioral Health Interdisciplinary Program are increased collaboration and continuity of care, improved access, well-defined treatment goals for veteran-centric care, defined panel-size and predictable workload, coverage for team members, and the ability to draw on the strengths of all team members. In 2014, VHA required each facility to enter the Behavioral Health Interdisciplinary Program team name, staff membership, patients assigned, and associated Mental Health Treatment Coordinator into the Primary Care Management Model.[54] In April 2014, VHA notified each VISN that every facility must have at least one Behavioral Health Interdisciplinary Program team established by July 1, 2014.[55]

[52] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008. This handbook was scheduled for recertification on or before the last working day of September 2013 and has not been recertified.

[53] Deputy Under Secretary for Health for Operations and Management, *General Mental Health Staffing Model Team Development: Behavioral Health Interdisciplinary Program (BHIP) Team-Based Care*, August 5, 2013.

[54] VHA Handbook 1101.02, *Primary Care Management Module*, April 21, 2009. This handbook was replaced by VHA Directive 1406, *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017. In Directive 1406, the name of Primary Care Management Module was changed to Patient Centered Management Module. Primary Care Management Model is a software program that allows "users to set up and define a health care team, assign staff to positions within the team, assign patients to the team, and assign patients to practitioners" and "allows national roll up of this data for tracking, case finding, and comparison purposes."

[55] Assistant Deputy Under Secretary for Health for Clinical Operations Memorandum, *Entry of Behavioral Health Interdisciplinary Program (BHIP) Teams in the Primary Care Management Module (PCMM)*, April 17, 2014.

Primary Care Mental Health Integration

The OIG substantiated that the facility lacked a primary care mental health integration policy; however, VHA does not require facilities to establish a primary care mental health integration policy. A 2013 VHA survey found that the facility implemented primary care mental health integration. Facility staff confirmed implementation of primary care mental health integration and the OIG team toured the primary care mental health integration clinical area. As of October 2018, facility leaders established a primary care and mental health service agreement.

Behavioral Health Interdisciplinary Program Implementation

The OIG team substantiated that as of December 2018, facility leaders had not implemented Behavioral Health Interdisciplinary Program teams as required by VHA. Facility leaders told the OIG that the Behavioral Health Service established partial Behavioral Health Interdisciplinary Program teams that included psychiatrists and nurses but not all disciplines. Facility staff told the OIG team that some providers had Behavioral Health Interdisciplinary Program titles; however, there was not a Behavioral Health Interdisciplinary Program structure or team meetings. As of June 2019, Behavioral Health Service leaders reported planning to develop Behavioral Health Interdisciplinary Program teams. The Associate Chief of Staff of Mental Health reported that the Behavioral Health Interdisciplinary Program was not operational and partially implemented due to difficulty in recruiting social workers and psychologists.

Mental Health Treatment Coordinator

In 2008, VHA required that every patient receiving mental health services be assigned a principal mental health provider to ensure continuity of care in mental health treatment and transitions in care.[56] In 2012, the Office of Mental Health Services replaced the requirement of a principal mental health provider with the requirement of a Mental Health Treatment Coordinator. The Mental Health Treatment Coordinator must be clearly identified in the EHR and changes to the Mental Health Treatment Coordinator should be minimal. Any change in the Mental Health Treatment Coordinator should be part of a clinical plan with collaborative input from the patient and must be documented in the EHR, including the rationale for the change and confirmation that the patient was involved and informed.[57] The Mental Health Treatment Coordinator was, generally, a member of a patient's assigned Behavioral Health Interdisciplinary Program team.[58]

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

[57] Deputy Under Secretary for Health for Clinical Operations Memorandum, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012.

[58] Assistant Deputy Under Secretary for Health for Clinical Operations Memorandum, *Entry of Behavioral Health Interdisciplinary Program (BHIP) Teams in the Primary Care Management Module (PCMM),* April 17, 2014.

VHA required facility leaders to develop policies outlining the Mental Health Treatment Coordinator assignment process.[59]

The OIG substantiated that until February 1, 2019, the facility lacked a Mental Health Treatment Coordinator policy as required by VHA. In November 2018 interviews with the OIG team, facility providers lacked clarity regarding Mental Health Treatment Coordinator assignment and responsibilities. On November 8, 2018, the OIG informed facility and VISN leaders that staff lacked clarity about Mental Health Treatment Coordinator processes and procedures and requested that the policy be finalized. Effective February 1, 2019, Behavioral Health Service leaders established a Mental Health Treatment Coordinator policy.[60]

3. Culture of Safety

Employee and Public Safety

VHA requires facility leaders to establish policy regarding the management of disruptive behaviors and other occurrences that threaten public safety.[61] The facility director is responsible for implementation of a written policy that is consistent with the VHA directive.[62]

The OIG team did not substantiate that facility staff expressed concerns about personal safety in the Same Day Access Clinic triage rooms. Through interviews, the OIG team found that facility staff knew how to request additional assistance from staff or facility police if concerned about their personal safety. However, the facility lacked a policy for a behavioral health emergency, as per VHA requirement. Without a behavioral health emergency policy, there is not a standardized response to disruptive behavior that may pose a public threat and disrupt the delivery of healthcare.[63]

Joint Patient Safety Reporting

To ensure patient safety and prevent patient harm, facility staff should report all identified patient safety concerns, close calls, and adverse events to the Patient Safety Manager using the

[59] Deputy Under Secretary for Health for Operations and Management Memorandum, *Assignment of the Mental Health Coordinator,* March 26, 2012.

[60] Alaska VA Healthcare System, Policy 116-17, *Mental Health Treatment Coordinator,* February 1, 2019.

[61] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in VHA Facilities*, September 27, 2012. This directive expired February 28, 2015, and has not been updated.

[62] VHA Directive 2012-026.

[63] VHA Directive 2012-026.

designated national reporting system.[64] The Patient Safety Manager is responsible for maintaining the reporting system, tracking and analyzing trends, and following up with actions to address patient safety events.[65]

In 2017, VA and the Department of Defense collaborated to standardize patient safety event reporting using the Joint Patient Safety Reporting System.[66] The Joint Patient Safety Reporting System is a secure, web-based application that can be used by any active VA employee.[67] The implementation of the Joint Patient Safety Reporting System was to increase collaboration between VA and the Department of Defense, identify vulnerabilities, and plan interventions. VHA expected full implementation at each VA medical center by April 1, 2018. VHA discontinued all other event reporting systems as of July 1, 2018.[68]

Facility leaders explained to the OIG team that the national Joint Patient Safety Report template allows an employee to enter the term "FEAR" rather than the employee's name if the employee does not feel safe or comfortable to report a patient safety incident. The OIG team found that, from November 1, 2017, through October 28, 2018, 37 (35 percent) of the facility's 107 Behavioral Health Service-related Joint Patient Safety Reports were entered under "FEAR," indicating that the submitting facility employees did not feel safe when reporting a patient safety concern.

Just Culture

In a 1999 healthcare system review, the Institute of Medicine determined that most medical errors are related to faulty systems or processes rather than individual recklessness. The Institute

[64] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This handbook was scheduled for recertification on or before the last working date of March 2016; it has not been recertified. VHA defines a *close call* as "an event or situation that could have resulted in an adverse event, but did not, either by chance or through timely intervention." VHA defines *adverse events* as "untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical facility, outpatient clinic, or other VHA facility."

[65] Alaska VA Healthcare System Memorandum 00QM-06, *Patient Safety Reporting Program,* April 12, 2017.

[66] VHA Chief Patient Safety and Risk Awareness Officer, *Transition to Joint Patient Safety Reporting System (JPSR) for Adverse Event Reporting,* August 2, 2017.

[67] Principal Deputy Under Secretary for Health Memorandum, *Joint Patient Safety Reporting System,* January 30, 2018.

[68] Principle Under Secretary for Health Memorandum, *Transition to Joint Patient Safety Reporting (JPSR) for Adverse Event Reporting*, August 2, 2017.

of Medicine recommended designing safer healthcare systems to prevent individual errors. The safety culture of the organization is one key element in safer healthcare systems.[69]

The Joint Commission identified that intimidation, including "overtly hostile actions, as well as subtle or passive-aggressive behaviors" and employees' fears of retaliation decrease willingness to report issues.[70]

The OIG team identified areas in need of improvement in the Behavioral Health Service culture of safety. The facility's Patient Safety Manager reported that just culture training was provided to Behavioral Health Service in late 2017. During the OIG team's site visit in November 2018, staff expressed frustration about leaders perceived lack of response to their concerns and potential retaliation in response to voicing concerns. Some facility staff acknowledged that the Behavioral Health Service manager hired in October 2017 was more responsive than other managers.

The facility's October 1, 2017, through September 30, 2018, All Employee Survey results identified Behavioral Health Service staff's top priority concerns as workload, communication, and coworker relationships. The Behavioral Health Service All Employee Survey ratings decreased from 2017 to 2018 in ratings of senior leadership, information sharing, workgroup psychological safety, and perceptions that supervisors address concerns that are raised. Behavioral Health Service's All Employee Survey action plan included improving leadership accessibility to staff, "genuine and appropriate accountability, giving positive feedback, proactively addressing known systems issues, and including staff in policy development." Behavioral Health Service managers responded with a plan for a team building presentation. In November 2018, an alternative dispute resolution specialist met with Behavioral Health Service staff. The specialist provided feedback and recommendations to facility leaders in areas related to level of trust in and respect from upper management, communication regarding policies and standard operating procedures, and Behavioral Health Service leader's management style. Recommendations to facility leadership were designed to address the feedback received from staff. As of March 2019, facility leaders provided the OIG with an action plan that addressed 10 of 13 recommendations.

[69] Safety culture is "the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety." 11 Tenets of a Safety Culture. https://www.jointcommission.org/assets/1/6/SEA_57_infographic_11_tenets_safety_culture.pdf. (The website was accessed on February 21, 2019.); Institute of Medicine, *To Err is Human: Building a Safer Health System*, 1999.

[70] Subtle retaliation may include behaviors such as failing to return phone calls or respond to messages, excluding individuals from team or committee activities, and use of condescending language or demeaning comments. The Joint Commission, Sentinel Event Alert, *The Essential Role of Leadership in Developing a Safety Culture*, Issue 57, March 1, 2017.

Conclusion

The OIG team substantiated that Same Day Access Clinic staff failed to adhere to VHA and facility missing patient policies after Patient 1 left without being seen. However, the OIG team was unable to determine that the facility staff's lack of timely search and outreach directly contributed to Patient 1's death by suicide a week later because other contributing factors were unknown. The OIG team substantiated that Patient 2 presented to the Same Day Access Clinic and saw an RN and three providers. However, the OIG team did not substantiate that the care provided to Patient 2 resulted in self-harm behavior.

The OIG substantiated that the Same Day Access Clinic had no coverage of triage staff from 7:30 a.m. to 8:00 a.m. and 4:30 p.m. to 5:00 p.m. However, it was unclear if the Same Day Access Clinic operated during those times. The Same Day Access Clinic lacked psychiatric coverage from 8:00 a.m. to 12:00 p.m.; however, for the review period of November 1, 2017, through October 28, 2018, the lack of psychiatric coverage did not result in adverse patient outcomes.

The OIG substantiated that providers were sometimes double booked while providing same day access coverage due to software problems with the providers' clinic scheduling profiles and some providers double booked to accommodate timely patient follow-up appointments. The OIG team did not identify adverse patient events related to double booking.

The OIG team substantiated that Patient 2 and Patient 3 did not have follow-up appointments scheduled as ordered; however, the OIG team was unable to substantiate that the unscheduled appointments resulted in Patient 2's self-harm behavior and Patient 3's death by suicide.

The OIG team substantiated that facility staff closed providers' outstanding clinically indicated date and return to clinic orders without contacting patients. Medical support assistants closed 21 of 103 (20 percent) of outstanding clinically indicated date scheduling orders, without outreach and documentation, as required by VHA.

In addition to the original allegations, the OIG learned that in early 2018, facility managers identified a backlog of approximately 433 outstanding scheduling orders. However, facility leaders did not report non-compliance with scheduling requirements to the VISN and failed to complete action items associated with an internal review.

The OIG team substantiated that the facility did not have a missed appointment policy. The OIG team did not substantiate that the facility failed to implement an electronic wait list or that care was provided by an unlicensed social worker.

The OIG substantiated that the facility did not implement Behavioral Health Interdisciplinary Program teams as required by VHA and lacked a primary care mental health integration policy. However, VHA does not require facilities to establish a primary care mental health integration

policy. The OIG substantiated that until February 1, 2019, the facility lacked a Mental Health Treatment Coordinator policy as required by VHA.

The OIG team did not substantiate facility staff concerns about personal safety in the same day access triage room; however, the facility lacked a behavioral health emergencies policy, as required by VHA. The OIG team identified opportunities for improved culture of safety within Behavioral Health Service.

Recommendations 1–11

1. The Alaska VA Healthcare System Director ensures that staff are educated and trained on missing patient policies and procedures, and monitors compliance.
2. The Alaska VA Healthcare System Director makes certain that managers establish a unified Same Day Access Clinic policy, educates staff on the policy, and monitors compliance.
3. The Alaska VA Healthcare System Director ensures a psychiatric coverage plan for the Same Day Access Clinic for all hours of operation that includes a contingency plan for psychiatric providers' unavailability.
4. The Alaska VA Healthcare System Director establishes clearly defined Same Day Access Clinic hours that are consistent with the Same Day Access Clinic policy and signage.
5. The Northwest Network Director strengthens the Alaska VA Healthcare System leaders' adherence to the scheduling directive reporting structure as required by the Veterans Health Administration.
6. The Alaska VA Healthcare System Director implements standardized clinically indicated date and return to clinic order procedures, and staff training, and monitors for compliance.
7. The Alaska VA Healthcare System Director establishes a missed appointment policy, ensures that staff are educated on the policy, and monitors compliance.
8. The Alaska VA Healthcare System Director facilitates the full implementation of a Behavioral Health Interdisciplinary Program, as required by the Veterans Health Administration.
9. The Alaska VA Healthcare System Director ensures staff training on the Mental Health Treatment Coordinator policy established on February 1, 2019, and monitors compliance.
10. The Alaska VA Healthcare System Director establishes a behavioral health emergency policy, ensures that staff are educated on the policy, and monitors compliance.
11. The Northwest Network Director ensures that the Alaska VA Healthcare System Director evaluates the culture, morale, and leadership issues identified by the alternative dispute resolution specialist in this report and takes appropriate action as necessary.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 9, 2019

From: Director, Northwest Network (VISN 20)

Subj: Healthcare Inspection—Two Patient Suicides, a Patient Self-Harm Event, and Alleged Mental Health Services Administrative Deficiencies at the Alaska VA Health Care System, Anchorage, Alaska

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

1. Thank you for the opportunity to review the report of the Office of Inspector General Healthcare Inspection of Care for Two Patient Suicides, a Patient Self-Harm Event, and Alleged Mental Health Services Administrative Deficiencies at the Alaska VA Health Care System

2. Attached please find the VISN's concurrence and response to the findings from review.

3. If you have additional questions or need further information, please contact Terisa Sjue-Loring, Chief Nurse Officer/Quality Management Officer, VISN 20 at (360) 619-5930.

(Original signed by:)

Terisa Sjue-Loring, VISN 20 Chief Nursing Officer/Quality Management Officer *for*:
Michael J. Murphy VISN 20 Network Director

VISN Director Response

Recommendation 5

The Northwest Network Director strengthens the Alaska VA Healthcare System leaders' adherence to the scheduling directive reporting structure as required by the Veteran Health Administration.

Concur.

Target date for completion: January 30, 2020

Director Comments

The VISN 20 Northwest Network Director has implemented the following actions as outlined by the Veteran Health Administration. There are two audit cycles per year with two levels of review required. The Level 1 Audit runs from October 1st to March 31st and from April 1st to September 30th. The Level 2 Audit runs from November 1st to April 30th and May 1st to October 31st. The Network Director ensures Level 1 Audits are completed by each facility and assigned the Level 2 Audits to one of the other facilities within the VISN to prevent a conflict of interest and improve the validity of the audits.

Level 1 Audits for VISN20 were 100% complete on March 31st and September 30th. and Level 2 Audits were 100% completed on April 30th. Progress in completion to the biannual audits are reviewed weekly and reported daily toward the end of an audit cycle to ensure completion.

Recommendation 11

The Northwest Network Director ensures that the Alaska VA Healthcare System Director evaluates the culture, morale, and leadership issues identified by the alternative dispute resolution specialist in this report and takes appropriate action as necessary.

Concur.

Target date for completion: February 29, 2020

Director Comments

VISN 20 Northwest Network Director will have the Alaska VA Healthcare System Director submit their current action plan addressing the recommendations submitted by the alternative dispute resolution specialist. VISN 20 Human Resources staff in consultation with the Mental Health Lead at the VISN Network Office has been tasked with reviewing the approved action plan on a monthly basis until all items are closed. The status, concerns and /or assistance

requested by the facility will be reported each month at the Network Director's VISN 20 Chief Officers meeting.

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 9, 2019

From: Director, Alaska VA Health Care System (463)

Subj: Healthcare Inspection— Two Patient Suicides, a Patient Self-Harm Event, and Alleged Mental Health Services Administrative Deficiencies at the Alaska VA Health Care System, Anchorage, Alaska

To: Director, Northwest Network (VISN 20)

1. Thank you for the opportunity to review the report of the Office of Inspector General Healthcare Inspection of Care for Two Patient Suicides, a Patient Self-Harm Event, and Alleged Mental Health Services Administrative Deficiencies at the Alaska VA Health Care System. We concur with the findings and recommendations and will ensure that actions to correct them are completed as described.

2. If you have any additional questions or need further information, please contact Sheryl Leary, Chief of Quality Management at 907-257-5455.

Respectfully submitted by,

(Original signed by:)

Timothy D. Ballard, MS, MD
Director

Facility Director Response

Recommendation 1

The Alaska VA Healthcare System Director ensures that staff are educated and trained on missing patient policies and procedures, and monitors compliance.

Concur.

Target date for completion: January 30, 2020

Director Comments

All Mental Health and Primary Care staff will be educated on the Missing Patient Policy. Documentation of training will be maintained within the employee 6-part Competency Folders and reported to the Quality Board in December 2019 demonstrating 100% compliance.

Numerator = # of relevant staff that have completed the Missing Patient Policy education.

Denominator = # of relevant staff required to complete the Missing Patient Policy education.

Alaska VA Police will conduct a Missing Patient Drill quarterly to monitor compliance with the policy. Results of the drills will be reported on a quarterly basis to the Quality Board to monitor compliance starting December 2019.

Recommendation 2

The Alaska VA Healthcare System Director makes certain that managers establish a unified Same Day Access Clinic policy, educates staff on the policy, and monitors compliance.

Concur.

Target date for completion: December 30, 2019

Director Comments

The facility will combine the established Anchorage Primary Care and Mental Health clinic Same Day Access policy to include education of staff. The education will be completed by October 30, 2019. Documentation of education will be maintained within the employee 6-part Competency Folders. Results of policy completion and staff education will be reported to the Quality Board in November 2019.

Numerator = # of relevant clinical staff that have completed the Same Day Access Clinic policy education.

Denominator = # of relevant staff that are required to complete the Same Day Access Clinic policy education.

Recommendation 3

The Alaska VA Healthcare System Director ensures a psychiatric coverage plan for the Same Day Access Clinic for all hours of operation that include a contingency plan for psychiatric providers' unavailability.

Concur.

Target date for completion: February 29, 2020

Director Comments

A SharePoint link has been created that contains Same Day Access psychiatric coverage. The link will be sent electronically by October 4, 2019 by the Chief of Social Behavioral Health to all Same Day Access staff. The Quality Management Department will conduct 10 audits a month to ensure staff can access and verbalize psychiatric coverage availability. Monthly Audits will be conducted to ensure 100% compliance and reported monthly to the Quality Board until 3 consecutive months of sustainment.

Recommendation 4

The Alaska VA Healthcare System Director establishes clearly defined Same Day Access Clinic hours that are consistent with the Same Day Access Clinic policy and signage.

Concur.

Target date for completion: Completed on September 26, 2019

Director Comments

The Anchorage Same Day Access Hours are 0800-1630. Signage was posted on the front exterior entrance on September 26, 2019 and will be in congruence with the Same Day Access Policy.

OIG Comment

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

Recommendation 6

The Alaska VA Healthcare System Director implements standardized clinically indicated date and return to clinic order procedures, and staff training, and monitors for compliance.

Concur.

Target date for completion: December 30, 2019

Director Comments

Mental Health leaders have provided overall return to clinic data at the Director's daily morning huddle since July 2018. Additionally, Return to Clinic data is reported at the Mental Health Executive Committee on a monthly basis since February 2019.

All staff who have the ability to schedule have received standardized education on Clinically Indicated Date and Return to Clinic procedures. Documentation of education is maintained within the employee's 6-part Competency Folder. Education compliance will be reported to the Quality Board in November 2019.

Numerator = # of relevant staff that have completed the education for standardized clinically indicated date and return to clinic order procedures.

Denominator = # of relevant staff that are required to complete the education for standardized clinically indicated date and return to clinic order procedures.

Recommendation 7

The Alaska VA Healthcare System Director establishes a missed appointment policy, ensures that staff are educated on the policy, and monitors compliance.

Concur.

Target date for completion: January 30, 2020

Director Comments

A local Missed Appointment (no show) policy will be created and disseminated to staff. The education will be completed by November 30, 2019. Documentation of education is maintained within the employee's 6-part Competency Folder. Education compliance will be reported to the Quality Board in December 2019.

Numerator = # of relevant staff that have completed the Missed Appointment policy education.

Denominator = # of relevant staff that are required to complete the Missed Appointment policy education.

Recommendation 8

The Alaska VA Healthcare System Director facilitates the full implementation of a Behavioral Health Interdisciplinary Program, as required by the Veterans Health Administration.

Concur.

Target date for completion: March 30, 2020

Director Comments

Updates on the implementation of the Behavioral Health Interdisciplinary Program will be provided by the Chief of Social Behavioral Health to the Mental Health Executive Committee on a monthly basis starting October 2019 until full implementation is completed.

Recommendation 9

The Alaska VA Healthcare System Director ensures staff training on the Mental Health Treatment Coordinator policy established on February 1, 2019, and monitors compliance.

Concur.

Target date for completion: December 30, 2019

Director Comments

A revised Mental Health Treatment Coordinator policy will be completed and disseminated to staff by October 30, 2019. The education will be completed by November 30, 2019. Documentation of education is maintained within the employee 6-part Competency Folders. Education compliance will be reported to the Quality Board in December 2019.

Numerator = # of relevant staff that have completed the Mental Health Treatment Coordinator policy education.

Denominator = # of relevant staff that are required to complete the Missed Mental Health Treatment Coordinator policy education.

Recommendation 10

The Alaska VA Healthcare System Director establishes a behavioral health emergency policy, ensures that staff are educated on the policy, and monitors compliance.

Concur.

Target date for completion: January 30, 2020

Director Comments

The Alaska VA Healthcare System policy 00-23 Workplace Violent Prevention and Response Programs dated July 31, 2017, will be revised. All Behavioral Health and Primary Care staff will be educated on the policy. Documentation of training will be maintained within the employee 6-part Competency Folders and reported to the Quality Board in December 2019 demonstrating 100% compliance.

Numerator = # of relevant staff that have completed the Behavioral Health Emergency policy education.

Denominator = # of relevant staff required to complete the Behavioral Health Emergency policy education.

Glossary of Terms

agoraphobia. An anxiety disorder characterized by "marked, or intense, fear or anxiety triggered by the real or anticipated exposure to a wide range of situations." The disorder can be accompanied by "panic-like symptoms" such as "dizziness, faintness, and fear of dying."[71]

alcohol use disorder. An addictive disorder that involves problematic use of alcohol that causes significant impairment or distress.[72]

attention deficit/hyperactivity disorder. A neurocognitive disorder with a childhood onset that is characterized with a pattern of inattention and/or hyperactivity/impulsivity. Inattention is a behavioral pattern of difficulty with sustained focus, distractibility, and disorganization. Hyperactivity is characterized by excessive motor activity and talkativeness and impulsivity is characterized by actions that lack forethought and may place an individual in dangerous situations. Symptoms of attention deficit/hyperactivity disorder must be present and cause impairment in two different settings, such as home and school.[73]

bipolar affective disorder or bipolar disorder. An episodic mood disorder that causes periods of depression and periods of abnormally elevated mood called mania.[74]

generalized anxiety disorder. A disorder characterized by disproportionate and excessive worry about a variety of events or activities, often everyday life experiences. Generalized anxiety is different from normative anxiety and worry in that it is excessive and interferes with psychosocial functioning, is pervasive, and is accompanied by physical symptoms such as restlessness, fatigue, and/or muscle tension.[75]

major depressive disorder. A disorder characterized by a period of at least two weeks with depressed mood and/or loss of pleasure or interest in activities. Symptoms must be present much

[71] Diagnostic and Statistical Manual of Mental Disorders, https://doi.org/10.1176/appi.books.9780890425596.dsm05. (The website was accessed on November 30, 2018.)

[72] Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, American Psychiatric Association, May 22, 2013 (print); September 24, 2014 (online). https://doi.org/10.1176/appi.books.9780890425596.dsm16. (The website was accessed on April 30, 2019.)

[73] Diagnostic and Statistical Manual of Mental Disorders, https://doi.org/10.1176/appi.books.9780890425596.dsm01. (The website was accessed on April 30, 2019.)

[74] Diagnostic and Statistical Manual of Mental Disorders, https://doi.org/10.1176/appi.books.9780890425596.dsm05. (The website was accessed on November 30, 2018.)

[75] Diagnostic and Statistical Manual of Mental Disorders, https://doi.org/10.1176/appi.books.9780890425596.dsm05. (The website was accessed on April 30, 2019.)

of the day nearly every day during the two-week period. Symptoms must be a marked change from one's prior functioning and not better explained by a medical condition.[76]

obsessive compulsive disorder. A disorder characterized by the presence of obsessions (recurrent and persistent thoughts, urges or images) and/or compulsions (repetitive behaviors or mental acts).[77]

panic attacks. May occur as a symptom of an anxiety disorder or another mental disorder and some medical conditions. A panic attack is characterized by an abrupt and intense fear or discomfort and at least four of the following symptoms:palpitations, accelerated heart rate, sweating, trembling or shaking, sensations of shortness of breath or smothering, feelings of choking, chest pain or discomfort, nausea or abdominal distress, feeling dizzy, unsteady, light-headed, or faint, chills or heat sensations, numbness or tingling sensations, derealization, depersonalization, fear of losing control, and fear of dying.[78]

posttraumatic stress disorder. A disorder defined by exposure to a traumatic event followed by the development of characteristic symptoms. Symptoms of posttraumatic stress disorder may include fear-based emotional and behavioral reactions, loss of pleasure in activities and negative cognitions, heightened arousal and externalizing behavior, and/or dissociative symptoms.[79]

social phobia. An anxiety disorder in which the individual is fearful or anxious about or avoidant of social interactions and situations that involve the possibility of being scrutinized.[80]

[76] Diagnostic and Statistical Manual of Mental Disorders, https://doi.org/10.1176/appi.books.9780890425596.dsm04. (The website was accessed on April 30, 2019.)

[77] Diagnostic and Statistical Manual of Mental Disorders, https://doi.org/10.1176/appi.books.9780890425596.dsm05. (The website was accessed on November 30, 2018.)

[78] Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, American Psychiatric Association, May 22, 2013 (print); September 25, 2014 (online). https://doi.org/10.1176/appi.books.9780890425596.dsm05. (The website was accessed on April 30, 2019.)

[79] Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, American Psychiatric Association, May 22, 2013 (print); September 25, 2014 (online). https://doi.org/10.1176/appi.books.9780890425596.dsm07. (The website was accessed on April 30, 2019.)

[80] Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, American Psychiatric Association, May 22, 2013 (print); September 24, 2014 (online). https://doi.org/10.1176/appi.books.9780890425596.dsm05. (The website was accessed on November 30, 2018.)

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