



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in the
Administration of Emergent
Mental Health Services at
Coatesville VA Medical
Center

Pennsylvania



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Executive Summary

The VA Office of Inspector General (OIG) conducted an inspection to determine the validity of allegations related to a patient’s emergent mental health services, medication management, and emergency procedures at the Coatesville VA Medical Center (facility).¹ The inspection team also identified and reviewed an additional concern related to failure to follow up with patients discharged from 90-day emergent mental health services who were also identified through the Recovery and Engagement and Coordination for Health—Veterans Enhanced Treatment (REACH VET) program.²

The patient was a former service member in their 30s with a history of mood, anxiety, and substance use disorders.³ In winter 2019, the patient was admitted to the Corporal Michael J. Crescenz VA Medical Center, Philadelphia, Pennsylvania, due to depressed mood, suicidal ideation, multiple substance use, homelessness, and a recent suicide attempt via overdose. The patient was granted 90 days of Veterans Health Administration (VHA) emergent mental health services due to other than honorable discharge status.

Ten days after completing inpatient treatment, the patient was transferred to the facility Substance Abuse Residential Rehabilitation Treatment Program. The Substance Abuse Residential Rehabilitation Treatment Program psychiatrist continued to prescribe medications for anxiety and depression, and another physician prescribed Suboxone® for opioid use disorder.⁴ After 27 days in the Substance Abuse Residential Rehabilitation Treatment Program, the staff

¹ In 2017, the Veterans Health Administration (VHA) established that former servicemembers with other than honorable (OTH) administrative discharges are eligible for 90 days of emergent mental health services for stabilization. VHA Directive 1601A.02, *Eligibility Determination*, June 7, 2017. “Other than Honorable (OTH) former service members are former servicemembers with Other than Honorable (OTH) discharges, whose eligibility for health care and benefits under title 38, United States Code, has not yet been finally adjudicated by the agency of original jurisdiction.”

² VHA’s Office of Mental Health and Suicide Prevention generates the REACH VET report. Using national electronic health record data including demographics, use of VA services, and medications, the REACH VET report utilizes a predictive statistical method to identify patients who utilize VHA care and are at statistically higher risk for suicide. Acting Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, *REACH VET: Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment*, August 10, 2016, Office of Research & Development, *Crisis Prevention*, September 20, 2018, <https://www.research.va.gov/currents/0918-Study-evaluates-VA-program-that-identifies-Vets-at-highest-risk-for-suicide.cfm>. (The website was accessed on December 29, 2019.)

³ The OIG uses the singular form of their (they or them) to protect the patient’s privacy.

⁴ Opioid use disorder is the illicit or misuse of opioid drugs, including prescription opioids like oxycodone, or street drugs like heroin. Diagnostic and Statistical Manual of Mental Disorders, <https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm16>. (The website was accessed on May 2, 2019.)

discharged the patient to Grant and Per Diem Program housing with ongoing outpatient treatment, including Suboxone®.

On May 6, 2019, the outpatient psychiatrist documented a request to extend the patient's eligibility for mental health services beyond 90 days. On May 10, 2019, the facility's Chief of Staff received the extension request via email. The Chief of Staff documented in an email that the patient had Medicaid and could transfer care and suggested putting the transfer into effect as soon as possible.⁵ The Chief of Staff allowed one "bridge" appointment before the patient's eligibility ended. A nurse informed the patient during an unscheduled visit on May 23, 2019, that the extension request was denied. The Chief of Staff told the OIG that the extension was denied because the patient had received inpatient and intensive outpatient mental health services and was ready to transition to non-VA care. The patient's eligibility ended on May 25, 2019.

The OIG found that facility staff notified the patient of the extension request denial two days prior to the patient's eligibility ending. VHA did not provide written guidance on expected timeframes and patient notification processes regarding extension requests.⁶ Further, the OIG found that the Chief of Staff failed to review treatment notes and failed to submit the patient's extension request to the Veterans Integrated Service Network Chief Medical Officer, as required by VHA. This was because the Chief of Staff incorrectly thought that extension requests were only submitted to the Veterans Integrated Service Network Chief Medical Officer if approved at the facility level.⁷ The Chief of Staff was unaware of the patient's REACH VET status and acknowledged that REACH VET status would be an important factor to consider in the extension request decision. The failure to thoroughly consider a patient's treatment notes that include treatment status and response, emotional and psychosocial factors, and mental health services needs to determine an emergent mental health services extension could result in an inappropriate termination of services critical to the patient's emotional stability. A patient's transition to non-VA care without patient and treatment team understanding of the patient's stability and needs as well as patient preparation for transfer may increase a patient's risk of adverse outcomes.

The OIG did not substantiate that facility providers discontinued the patient's Suboxone® and other medications without a taper or transition to another program. The patient's psychiatrist prescribed the patient's medications to treat anxiety and mood disorders for over a month beyond the eligibility period. The patient was prescribed Suboxone® for three days beyond the eligibility period, and the patient established care at a non-VA Suboxone® program.

⁵ Patients who are not eligible for VHA care may be transferred to a non-VHA facility that accepts alternate forms of insurance, including Medicaid. VHA Directive 1601A.02.

⁶ The patient approached a nurse on May 23, 2019, and inquired about the status of the extension request. The nurse contacted executive leaders, learned that the extension request was denied, and informed the patient.

⁷ VHA Directive 1601A.02, *Eligibility Determination*, June 7, 2017.

The OIG substantiated that Grant and Per Diem Program staff were instructed to call 911 rather than facility code blue for patients with other than honorable (OTH) discharge status.⁸ However, the Agreement for Use of Department of Veterans Affairs Health Care Resources (Agreement) instructed Grant and Per Diem Program staff to call a facility code blue in case of a patient medical emergency.⁹ Despite the Agreement, facility staff instructed Grant and Per Diem Program staff to call 911 for a medical emergency for patients with OTH discharge status for patients with OTH discharge status.¹⁰ Then in a May 16, 2019, memorandum, the Grant and Per Diem Program Manager instructed staff to call “911 only” specifically for the patient and six other identified residents because they were not eligible for VHA medical care. Variable medical emergency procedures based on eligibility status may result in disparity of care. By denying the facility’s medical emergency response team care to residents not eligible for VHA medical services, staff may be presented with an ethical dilemma due to decision making that may lead to a delay in medical care.

Since June 2017, 16 patients with OTH discharge status received 90-day emergent mental health services at the facility and five of the 16 patients were also identified by the REACH VET program. The OIG found that facility staff met REACH VET coordinator and provider responsibilities for four of the five patients, including the patient discussed above. Facility staff failed to follow up with one of the five patients, who subsequently died by suicide.

The one patient where there was no follow-up was a former servicemember in their 50s with OTH discharge status who initially sought treatment at the facility in fall 2017. The patient was granted eligibility for 90-day emergent mental health services, and during this time, the patient received inpatient, residential, and outpatient mental health services. The patient’s eligibility for VHA services expired on December 27, 2017. On both January 11, 2018, and March 14, 2018, the REACH VET Coordinator documented that the patient was identified as at statistically elevated risk for an adverse outcome and noted that the patient was no longer eligible for VHA services and was receiving non-VA services. The patient’s electronic health record did not contain documentation that staff attempted to contact the patient because the patient was presumed to be receiving non-VA care. In spring 2018, the patient died by suicide. The OIG was

⁸ The Grant and Per Diem program is offered by VHA to fund community agencies to provide supportive housing for homeless veterans. U.S. Department of Veterans Affairs, *Homeless Veterans: Grant and Per Diem Program*, September 5, 2019. <https://www.va.gov/homeless/gpd.asp>. (The website was accessed on October 24, 2019.)

⁹ The facility has an Agreement for Use of Department of Veterans Affairs Health Care Resources to provide transitional housing resources through two Grant and Per Diem Programs, a 95-bed program for male veterans and a 30-bed program for female veterans. The VHA Grant and Per Diem program funds community agencies that provide supportive housing for homeless veterans. U.S. Department of Veterans Affairs, *Homeless Veterans: Grant and Per Diem Program*, <https://www.va.gov/homeless/gpd.asp>. (The website was accessed on October 24, 2019.) Facility Policy PCS-05-16, *Medical Emergency Procedures/Emergency Equipment and Locations*, December 2015.

¹⁰ The OIG obtained documentation indicating that the practice of calling 911 for OTH discharge status residents was in place as early as March 2019 but was unable to obtain evidence that identified the exact initiation date.

unable to determine whether outreach would have prevented the patient's death because of unknown factors related to the patient's death.

The OIG made two recommendations to the Under Secretary for Health related to 90-day emergent mental health services extension timelines and patient notification procedures, and the REACH VET program; and two recommendations to the Facility Director related to compliance with VHA 90-day emergent mental health services extension requirements and Grant and Per Diem Program medical emergency procedures.¹¹

Comments

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



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¹¹ Recommendations directed to the Under Secretary for Health were submitted to the Executive in Charge who has the authority to perform the functions and duties of the Under Secretary for Health.

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Abbreviations

OIG	Office of Inspector General
OTH	Other than Honorable
REACH VET	Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment
VHA	Veterans Health Administration
VISN	Veterans Integrated Healthcare Network



Introduction

The VA Office of Inspector General (OIG) conducted an inspection to determine the validity of allegations related to a patient's emergent mental health services at the Coatesville VA Medical Center (facility), Pennsylvania.

Background

The facility, part of Veterans Integrated Service Network (VISN) 4, includes two community based outpatient clinics located in Spring City and Springfield, Pennsylvania. From October 1, 2017, through September 30, 2018, the facility served 19,250 patients and had a total of 302 hospital operating beds, including 28 inpatient beds, 126 community living center beds, and 148 domiciliary beds. The facility has an Agreement for Use of Department of Veterans Affairs Health Care Resources (Agreement) to provide transitional housing resources through two Grant and Per Diem Programs, a 95-bed program for male veterans and a 30-bed program for female veterans.¹

90-Day Emergent Mental Health Services Eligibility

In 2017, the Veterans Health Administration (VHA) established that former servicemembers with other than honorable (OTH) administrative discharges are eligible for 90 days of emergent mental health services for stabilization.² VHA policy emphasizes that eligibility is for emergent mental health services only. The 90-day episode of mental health services can include inpatient, residential, and outpatient mental health services. VHA requires that a request for a second 90-day episode of mental health services be based on a review of the treatment team's request, treatment notes, and annotation of treating notes in the electronic health record. The request must be submitted to the VISN Chief Medical Officer for approval.³

¹ The VHA Grant and Per Diem program funds community agencies that provide supportive housing for homeless veterans. U.S. Department of Veterans Affairs, *Homeless Veterans: Grant and Per Diem Program*, <https://www.va.gov/homeless/gpd.asp>, September 5, 2019. (The website was accessed on October 24, 2019.)

² VHA Directive 1601A.02, *Eligibility Determination*, June 7, 2017. "Other than Honorable (OTH) former service members are former servicemembers with Other than Honorable (OTH) discharges, whose eligibility for health care and benefits under title 38, United States Code, has not yet been finally adjudicated by the agency of original jurisdiction."

³ VHA Directive 1601A.02.

Recovery and Engagement and Coordination for Health—Veterans Enhanced Treatment

In September 2016, VHA implemented the Recovery and Engagement and Coordination for Health—Veterans Enhanced Treatment (REACH VET) program and required each medical center to assign a coordinator who receives a monthly report of patients utilizing medical center care who are identified in the top 0.1 percent of patients at elevated statistical risk for suicide or other adverse outcomes.⁴ The REACH VET coordinator is responsible for integrating identified patients into the REACH VET program and assigning a REACH VET provider for each patient. The REACH VET provider is responsible for “reevaluating diagnoses and treatment plans, and for enhancing access and care when appropriate.”⁵ The Deputy Director, Office of Mental Health and Suicide Prevention told the OIG team that REACH VET was developed for enrolled veterans and that the type of discharge was not a considered factor.

Allegations and Related Concern

On May 24, 2019, the OIG received a complaint related to the provision of 90-day emergent mental health services, medication management, and emergency procedures.

The purpose of the inspection was to determine the validity of the following allegations:

1. A patient with OTH discharge status was denied an extension of the 90-day eligibility for VA emergent mental health services.
2. Facility providers discontinued the patient’s Suboxone® and other medications without a taper or transition to another program.⁶

⁴ VHA’s Office of Mental Health and Suicide Prevention generates the REACH VET report. Using national electronic health record data including demographics, use of VA services, and medications, the REACH VET report utilizes a predictive statistical method to identify patients who utilize VHA care and are at statistically higher risk for suicide. Acting Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, *REACH VET: Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment*, August 10, 2016, Office of Research & Development, *Crisis prevention*, September 20, 2018, <https://www.research.va.gov/currents/0918-Study-evaluates-VA-program-that-identifies-Vets-at-highest-risk-for-suicide.cfm>. (The website was accessed on December 29, 2019.)

⁵ Mental Illness Research, Education and Clinical Centers (MIRECC), *Team REACH VET*, updated May 17, 2017. (The website was accessed on July 31, 2019; it is an internal VA website that is not publicly accessible.)

⁶ Suboxone® is a medication used in the treatment of opioid use disorder. National Institute on Mental Health, *Treatment approaches for mental health*. <https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction>. (The website was accessed on September 11, 2019.) Prescribers’ Digital Reference, *Suboxone Drug Summary*, 2019. <https://www.pdr.net/drug-summary/Suboxone-buprenorphine-naloxone-1292.8207>. (The website was accessed on October 21, 2019.)

3. Grant and Per Diem Program staff were instructed to call 911 rather than facility code blue for patients with OTH discharge status.⁷

The inspection team identified and reviewed a related concern: failure to follow up with patients discharged from 90-day emergent mental health services who were also identified through the REACH VET program.

Scope and Methodology

The OIG reviewed the patient's electronic health record for the period of February 24, 2019, through May 25, 2019, the patient's emergent mental health services eligibility, and follow-up documentation through August 20, 2019. Electronic health records for an additional four patients who received emergent mental health services were also reviewed.

The OIG conducted interviews with the complainant, facility leaders and staff, facility staff familiar with the Grant and Per Diem Program, Grant and Per Diem Program leaders and staff, a Health Enrollment Center leader, and Office of Mental Health and Suicide Prevention leaders.

The OIG team reviewed VHA directives, handbooks, and memoranda, facility policies and procedures related to eligibility, mental health services, suicide prevention, and emergency procedures that were in effect in May 2019. The OIG also reviewed OTH emergent mental health services eligibility training materials, an Agreement, and a Grant and Per Diem Program annual inspection report.

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.

⁷ A code blue is called in the event of acute medical emergency such as chest pain, shortness of breath, seizures, falls, or acute changes in heart rate or blood pressure. A medical response team including a physician, physician assistant or certified registered nurse practitioner, nurse, and respiratory therapist respond to the emergency.

Patient Case Summary

The patient was a former service member in their 30s with a history of mood, anxiety, and substance use disorders.⁸ In winter 2019, the patient presented to the Corporal Michael J. Crescenz VA Medical Center, Philadelphia, Pennsylvania, Emergency Department and reported depressed mood, suicidal ideation, multiple substance use, homelessness, and a recent suicide attempt via overdose, which required the administration of rescue medication. The patient was admitted and granted 90 days of VHA emergent mental health services.

Ten days after completing inpatient care treatment for substance withdrawal, mood, anxiety, and substance use disorders, the patient was transferred to the facility's Substance Abuse Residential Rehabilitation Treatment Program for further treatment. During the patient's Substance Abuse Residential Rehabilitation Treatment Program admission, the psychiatrist continued to prescribe medications for anxiety and mood disorders, and another physician continued the patient's Suboxone® for opioid use disorder.⁹ Six days after being transferred, a psychologist assessed the patient as at an intermediate risk of suicide. One week later, another psychologist documented a REACH VET provider note that stated the patient denied suicidal ideation and was receiving appropriate care. The facility's Substance Abuse Residential Rehabilitation Treatment Program staff discharged the patient two weeks later to Grant and Per Diem Program housing with ongoing treatment in the facility's substance use disorder intensive outpatient treatment program.

While in the intensive outpatient treatment program, the patient continued to receive medication management, including Suboxone®. On April 11, 2019, a psychiatrist documented a REACH VET provider note that stated the patient was receiving appropriate care, the patient was engaged in treatment and responding well, and that no changes to the treatment plan were needed. On May 6, 2019, the psychiatrist prescribed enough medication to treat the patient's anxiety and mood disorders to last until June 4, 2019. The psychiatrist also documented a request to extend the patient's eligibility for mental health services beyond 90 days. On May 21, 2019, the patient was prescribed a seven-day Suboxone® supply. On May 23, 2019, a nurse informed the patient at a walk-in visit that the extension request was denied, and a social worker documented that the patient had medical coverage and knew where to obtain services.

The patient's eligibility ended on May 25, 2019. On May 28, 2019, the patient did not present to a scheduled outpatient psychiatry appointment and a nurse left a telephone voicemail message

⁸ The OIG uses the singular form of their (they or them) to protect the patient's privacy.

⁹ Opioid use disorder is the illicit or misuse of opioid drugs, including prescription opioids like oxycodone, or street drugs like heroin. Diagnostic and Statistical Manual of Mental Disorders, <https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm16> (The website was accessed on May 2, 2019.)

and requested a call back to reschedule. On June 4, 2019, the psychiatrist renewed the prescriptions for another 30 days of the patient's medications for anxiety and mood disorders.

Inspection Results

1. Emergent Mental Healthcare Eligibility Extension

The OIG substantiated that a patient was denied an extension of the 90-day eligibility for VA emergent mental healthcare. The OIG found that facility staff notified the patient of the extension request denial two days prior to the patient's eligibility ending. Further, the OIG found that the Chief of Staff failed to review treatment notes and failed to submit the patient's extension request to the VISN Chief Medical Officer.

VHA requires that a request for a second 90-day episode of mental health services be based on a review of the treatment team's request, treatment notes, and annotation of treating notes in the electronic health record. The request must be submitted to the VISN Chief Medical Officer for approval.¹⁰ The OIG found that VHA did not provide written guidance on expected timeframes and patient notification processes regarding requests for extension of 90-day emergent mental health services.

VISN 4 leaders developed a process and extension waiver form to facilitate extension requests. The VISN 4 Mental Health Officer provided information and offered several implementation sessions with facility leaders to disseminate this information. In July 2017, the facility established a standard operating procedure related to 90-day emergent mental health service eligibility.

On May 6, 2019, the patient's psychiatrist completed the extension waiver form for a second 90-day episode of emergent mental health services. On May 10, 2019, the facility's Chief of Psychiatry signed the extension waiver form, and the Chief of Staff received a copy via email. The Chief of Staff documented in an email that the patient had Medicaid and could transfer care and suggested putting the transfer into effect as soon as possible.¹¹ The Chief of Staff allowed one "bridge" appointment before the patient's eligibility ended. The patient approached a nurse on May 23, 2019, and inquired about the status of the extension request. The nurse contacted executive leaders, learned that the extension request was denied, and informed the patient. The patient's eligibility ended on May 25, 2019.

The OIG concluded that the absence of VHA guidance to inform the patient of the extension request status, the burden on the patient to pursue the information, and the notification within two days of discontinuation of VHA mental health services may have caused emotional distress

¹⁰ VHA Directive 1601A.02.

¹¹ Patients who are not eligible for VHA care may be transferred to a non-VHA facility that accepts alternate forms of insurance, including Medicaid. VHA Directive 1601A.02.

for the patient. Of particular concern is that the absence of explicit timeframes and notification processes may impose stress on a vulnerable population for whom additional stress may contribute to increased risk of adverse outcomes.

In an OIG interview, the Chief of Staff acknowledged conducting “less than a careful review” of the patient’s electronic health record. The Chief of Staff told the OIG that the extension was denied because the patient had received inpatient and intensive outpatient mental health services and was ready to transition to non-VA care. The Chief of Staff acknowledged not being aware of the patient’s REACH VET status and that REACH VET status would be an important factor to consider in the extension request decision. The failure to thoroughly consider a patient’s treatment notes that include treatment status and response, emotional and psychosocial factors, and mental health services needs to determine an emergent mental health services extension could result in an inappropriate termination of services critical to a patient’s emotional stability. A patient’s transition to non-VA care without patient and treatment team understanding of the patient’s stability and needs as well as patient preparation for transfer may increase a patient’s risk of adverse outcomes.

The OIG found that the Chief of Staff did not submit the extension request to the VISN Chief Medical Officer, as required by VHA. This was because the Chief of Staff incorrectly thought that extension requests were only submitted to the VISN Chief Medical Officer if approved at the facility level.¹² The Deputy Director, Office of Mental Health and Suicide Prevention, told the OIG that a discussion between the VISN Chief Medical Officer, Chief of Staff, and the provider would be expected as part of the decision-making process. Further, the Deputy Director, Office of Mental Health and Suicide Prevention, noted that approval at the level of the VISN Chief Medical Officer is important to maintain a higher level of decision making.

2. Medication Management and Transition to Non-VA Care

The OIG did not substantiate that facility providers discontinued the patient’s Suboxone® and other medications without a taper or transition to another program. The patient’s psychiatrist prescribed the patient’s medications to treat anxiety and mood disorders for over a month beyond the eligibility period. The patient was prescribed Suboxone® for three days beyond the eligibility period, and the patient established care at a non-VA Suboxone® program.

In March 2019, the patient started Suboxone® treatment and had ongoing medication management appointments through April 2019 and the first weeks of May. On May 21, 2019, the patient was prescribed a final seven-day Suboxone® supply. The patient’s 90-day emergent mental health services eligibility ended on May 25, 2019. On June 4, 2019, a case manager documented that the patient was receiving care at a non-VA clinic that prescribed Suboxone®.

¹² VHA Directive 1601A.02.

3. Emergency Procedures

The OIG substantiated that Grant and Per Diem Program staff were instructed to call 911 rather than a facility code blue for patients with OTH discharge status.¹³ However, the Agreement instructed Grant and Per Diem Program staff to call a facility code blue in case of a patient medical emergency. In a May 16, 2019, memorandum, the Grant and Per Diem Program Manager instructed staff to call “911 only” specifically for the patient and six other identified residents because they were not eligible for VA medical care.¹⁴ Grant and Per Diem Program staff reported that facility staff advised them to call 911 for patients with OTH discharge status. The Chief of Staff confirmed that the Grant and Per Diem Program staff would call 911 for a medical emergency for patients with OTH discharge status.

Grant and Per Diem Program staff noted that when a code blue is called, a medical emergency response team from the facility arrives prior to the ambulance and initiates medical care. Two Grant and Per Diem Program staff reported that calling an ambulance from either code blue or 911 resulted in similar ambulance response times.

Variable medical emergency procedures based on eligibility status may result in disparity of care. This potential disparity of care raised ethical concerns. VHA staff instructed Grant and Per Diem Program staff to initiate different medical emergency procedures based on the patient’s eligibility status, which might result in a delay in emergent medical care. By denying the facility’s medical emergency response team care to residents not eligible for VHA medical services, staff may be presented with an ethical dilemma due to decision making that may lead to a delay in medical care. The OIG found that facility staff did not consider the potential ethical conflict because OTH emergent mental health services eligibility only permits mental health treatment, and therefore medical care is not included in the eligibility.¹⁵

4. Related Concern: REACH VET Program Follow-Up

Since June 2017, 16 patients with OTH discharge status received 90-day emergent mental health services at the facility. Five of the 16 patients were identified by the REACH VET program. The

¹³ The Grant and Per Diem program is offered by VHA to fund community agencies to provide supportive housing for homeless veterans. U.S. Department of Veterans Affairs, *Homeless Veterans: Grant and Per Diem Program*, September 5, 2019. (The website was accessed on October 24, 2019.)

¹⁴ The OIG obtained documentation indicating that the practice of calling 911 for OTH discharge status residents was in place as early as March 2019 but was unable to obtain evidence that identified the exact initiation date.

¹⁵ Ethics quality in health care refers to organizational practices that are consistent with widely accepted ethics standards, norms, or expectations for the staff. VHA established the IntegratedEthics® program to establish a national, systematic, integrated approach to ethics in health care. Each medical center must establish an IntegratedEthics® program that provides ethics consultation to resolve health care related ethical concerns. VHA Directive 1004.06, *IntegratedEthics®*, October 24, 2018. This VHA directive is scheduled for recertification on or before the last working day of October 2023.

OIG found that facility staff met REACH VET coordinator and provider responsibilities for four of the five patients, including the patient discussed in sections 1 and 2. The OIG found that staff accurately documented the patient's REACH VET status and followed up with the patient per VHA guidance. However, staff failed to follow up with another REACH VET patient who died by suicide three months after being identified by REACH VET and five months after transitioning from the facility to non-VA mental health services.

REACH VET Outreach to Patient

The patient was identified to be at elevated risk for suicide or other adverse outcomes by the REACH VET program in March 2019 and April 2019. Facility staff completed REACH VET coordinator and provider documentation, as required by VHA.¹⁶

The patient's 90-day eligibility for emergent mental health services ended on May 25, 2019. During interviews with facility leaders and staff conducted July 29, 2019, through August 13, 2019, the OIG team informed facility leaders and staff about concerns regarding REACH VET outreach for patients receiving OTH 90-day emergent mental health services. On August 19, 2019, the patient was again identified as a patient at elevated risk and who might benefit from enhanced treatment. On August 20, 2019, the facility suicide prevention coordinator contacted the patient by telephone, documented that the patient did not have suicidal ideation and was engaged with non-VA services, and sent a follow-up letter with contact information and additional resources.

Deficient REACH VET Outreach

One of the five patients who received OTH discharge status 90-day emergent mental health services and was identified by REACH VET died by suicide about five months after transfer to non-VA care. This patient's electronic health record did not include documentation of outreach to the patient or non-VA care providers despite being identified as a REACH VET twice within the five months prior to the patient's death. The OIG was unable to determine whether outreach would have prevented the patient's death because of unknown factors related to the patient's death.

The one patient where there was no follow-up was a patient who was a former servicemember in their 50s with OTH discharge status who initially sought treatment at the facility in fall 2017. The patient was granted eligibility for 90-day emergent mental health services, and during this time, the patient received inpatient and residential mental health services. In October 2017, the

¹⁶ Acting Deputy Under Secretary for Health and Operations and Management (10N), *REACH VET: Recovery and Engagement and Coordination for Health – Veterans Enhanced Treatment*, August 10, 2016. Mental Illness Research, Education and Clinical Centers, *Team REACH VET*, updated May 17, 2017. (The website was accessed on July 31, 2019; it is an internal VA website that is not publicly accessible.)

REACH VET Coordinator identified the patient as at elevated risk of suicide or adverse outcome and assigned a REACH VET provider.

Throughout November 2017, the REACH VET Coordinator and providers documented required status reviews and care needs. In December 2017, the REACH VET Coordinator noted the patient's continued high-risk status, and the REACH VET provider documented that the patient was receiving non-VA case management services. For five days in late fall 2017, the patient was admitted to a VHA inpatient mental health unit to address substance abuse. Throughout the month, the patient's VHA case manager coordinated with non-VA providers to ensure transition to non-VA care. The patient's eligibility for VHA services expired on December 27, 2017.

On both January 11, 2018, and March 14, 2018, the REACH VET Coordinator documented that the patient was identified as at statistically elevated risk for an adverse outcome and noted that the patient was no longer eligible for VHA services and was receiving non-VA services. The patient's electronic health record did not contain documentation that staff attempted to contact the patient because the patient was not engaged in VA care and presumed to be receiving non-VA care. In spring 2018, the patient died by suicide.

Despite the patient's continued identification as at elevated risk for suicide or other adverse outcomes, facility staff did not reach out to the patient following discontinuation of eligibility and transfer to non-VA care. Although VHA provides suggested actions, there is no written policy regarding outreach to patients identified as REACH VET who no longer receive VHA care, including patients who received 90-day emergent mental health services.

VHA leaders told the OIG that there was not a policy regarding patients no longer eligible for VA care but still identified by REACH VET. In an internal website, VHA suggests that REACH VET coordinators "do their best to help the individual engage in other community care" for REACH VET patients who are ineligible for VA services. For patients receiving non-VA care, VHA suggests staff contact the patient to discuss the REACH VET program and obtain a release of information from the patient to inform non-VA providers about the program. If the REACH VET coordinator is unable to connect the patient to non-VA care, VHA suggests that the coordinator documents the attempts in the patient's electronic health record to ensure a record of actions taken on behalf of the patient.¹⁷

Although an internal website provides guidance, the absence of written policy to clearly direct staff actions when a REACH VET patient is no longer receiving VHA care may result in a failure to outreach, assess risk, and offer resources to patients identified as at statistically elevated risk for suicide and other adverse outcomes.

¹⁷ Mental Illness Research Education Clinical, *Common Questions REACH VET*, updated May 13, 2019. (The website was accessed on October 3, 2019; it is an internal VA website that is not publicly accessible.)

Conclusion

The OIG substantiated that a patient was denied an extension of the 90-day eligibility for VA emergent mental health services. Facility staff notified the patient of the extension request denial two days prior to the patient's eligibility ending, and VHA did not provide guidance related to timeframes and patient notification processes. The absence of a process to inform the patient of the extension request status, the burden on the patient to pursue the information, and the notification within two days of discontinuation of VHA mental health services may have caused emotional distress for the patient. Of particular concern is that the absence of explicit timeframes and notification processes may impose stress on a vulnerable population for whom additional stress may contribute to increased risk of adverse outcomes.

Additionally, the Chief of Staff failed to review treatment notes and failed to submit the patient's extension request to the VISN Chief Medical Officer, as required by VHA. Failure to thoroughly consider a patient's treatment notes that include treatment status and response, emotional and psychosocial factors, and mental health services needs to determine an emergent mental health services extension could result in an inappropriate termination of services critical to the patient's emotional stability.

The OIG did not substantiate that facility providers discontinued the patient's Suboxone® and other medications without a taper or transition to another program. The psychiatrist prescribed the patient's medications to treat anxiety and mood disorders for over a month beyond the eligibility period, the patient was prescribed Suboxone® for three days beyond the eligibility period, and the patient established care at a non-VA Suboxone® program.

The OIG substantiated that Grant and Per Diem Program staff were instructed to call 911 rather than facility code blue for patients with OTH discharge status. Variable medical emergency procedures based on eligibility status may result in disparity of care. This potential disparity of care raised ethical concerns.

The OIG found that staff accurately documented the patient's REACH VET status and followed up with the patient per VHA guidance. However, staff failed to follow up with another REACH VET patient who died by suicide three months after having been identified by REACH VET and five months after transitioning from the facility to non-VA mental health services. Although an internal website provides guidance, the absence of written policy to clearly direct staff actions when a REACH VET patient is no longer receiving VHA care may result in a failure to outreach, assess risk, and offer resources to patients identified as at statistically elevated risk for suicide and other adverse outcomes.

Recommendations 1–4

1. The Under Secretary for Health ensures the clarification of policy regarding emergent mental health services extension request procedures including expected timeframes and patient notification processes.¹⁸
2. The Under Secretary for Health expedites the establishment of policy regarding follow-up of patients identified by the Recovery Engagement and Coordination for Health –Veterans Enhanced Treatment program and no longer receiving Veterans Health Administration services.
3. The Coatesville VA Medical Center Director ensures compliance with the 90-day emergent mental health services extension request policies and procedures, as required by the Veterans Health Administration.
4. The Coatesville VA Medical Center Director evaluates the Grant and Per Diem Program medical emergency procedures, seeks consultation with relevant subject matter experts including IntegratedEthics®, and takes action as appropriate.

¹⁸ Recommendations directed to the Under Secretary for Health were submitted to the Executive in Charge who has the authority to perform the functions and duties of the Under Secretary for Health.

Appendix A: Executive in Charge Memorandum

Department of Veterans Affairs Memorandum

Date: February 19, 2020

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: Healthcare Inspection—Deficiencies in Administration of Emergent Mental Health Services at the Coatesville VA Medical Center, Pennsylvania

To: Assistant Inspector General for of Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Deficiencies in Administration of Emergent Mental Health Services at the Coatesville VA Medical Center, Pennsylvania.
2. The Veterans Health Administration (VHA) agrees with the need to ensure clarification of, and compliance with VHA policy regarding emergent mental health extension services. There are four recommendations, two to the Under Secretary for Health and two to the Medical Center Director. Action plans have been developed to address all four of OIG's recommendations.
3. If you have any questions, please email Karen Rasmussen, M.D., Director, GAO-OIG Accountability Liaison at VHA10EGGOALAction@va.gov.

(Original signed by:)

Roger A. Stone, M.D.
Executive in Charge, Office of the Under Secretary for Health

Executive in Charge Response

Recommendation 1

The Under Secretary for Health ensures the clarification of policy regarding emergent mental health services extension request procedures including expected timeframes and patient notification processes.

Concur.

Target date for completion: July 2020

Comments

The Veterans Health Administration (VHA) Office of Mental Health and Suicide Prevention will be meeting with the national VHA Chief of Staff group in February 2020 to review existing policy and processes. The VHA Office of Mental Health and Suicide Prevention will also be providing training and guidance to facility mental health leads on processes for care extension requests and care transition.

Recommendation 2

The Under Secretary for Health expedites the establishment of policy regarding follow up of patients identified by the Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment program and no longer receiving Veterans Health Administration services.

Concur in principle.

Target date for completion: July 2020

Comments

The Veterans Health Administration (VHA) concurs in principle with the Inspector General's and seeks to avoid developing potentially prescriptive additional policy on what is considered standard clinical practices already addressed by existing Directives. To address the inconsistency in follow-up processes for Recovery Engagement and Coordination for Health –Veterans Enhanced Treatment (REACH VET), the VHA Office of Mental Health and Suicide Prevention has updated field information (Frequently Asked Questions: “Other Than Honorable Access to Care”, “Coordinator Note Template Guide” and the “Other Than Honorable” memo) which specifically describes the processes to be followed when a Veteran or Service Member identified is not eligible for Department of Veterans Affairs care. The VHA Office of Mental Health and Suicide Prevention will also be providing education to field REACH VET Coordinators/Community of Practice as well as mental health leadership.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: February 20, 2020

From: Director, VA Healthcare (10N4)

Subj: Healthcare Inspection—Deficiencies in Administration of Emergent Mental Health Services at the Coatesville VA Medical Center, Pennsylvania

To: Executive in Charge, Office of the Under Secretary for Health (10)

I have reviewed the responses provided by the Coatesville VA Medical Center, Coatesville, PA, and I am submitting to your office as requested. I concur with their responses.

(Original signed by:)

Timothy W. Liezert
Network Director, VISN 4

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: January 24, 2020

From: Director, Coatesville VA Medical Center (542)

Subj: Healthcare Inspection—Deficiencies in Administration of Emergent Mental Health Services at the Coatesville VA Medical Center, Pennsylvania

To: Director, VA Healthcare (10N4)

1. Thank you to the OIG HealthCare Inspection Team for the professional review of the organization that was completed. I have reviewed the draft report and concur with the findings and recommendations.
2. Attached are the facility responses to the recommendations, including the actions in progress to correct the identified opportunities for improvement.

(Original signed by:)

Carla A. Sivek
Director, Coatesville VA Medical Center

Facility Director Response

Recommendation 3

The Coatesville Veterans Affairs Medical Center Director ensures compliance with 90-day emergent mental health services extension request policies and procedures, as required by Veterans Health Administration.

Concur.

Target date for completion: June 2020

Director Comments

The Coatesville Medical Center Director will ensure a work group is formed to delineate procedures to ensure that there is appropriate follow-up with patients discharged from 90-day emergent mental health services, as well as compliance with Veterans Health Administration policies and procedures for mental health services extension requests. The procedure will be defined in a local policy. Involved staff will be trained on the defined procedure.

Recommendation 4

The Coatesville Veterans Affairs Medical Center Director evaluates the Grant and Per Diem Program medical emergency procedures, seeks consultation with relevant subject matter experts including IntegratedEthics®, and takes action as appropriate.

Concur.

Target date for completion: June 2020

Director Comments

The Coatesville Medical Center Director will ensure a work group is formed to delineate procedures to ensure that there are defined emergency medical procedures, in consultation with IntegratedEthics®, within the Grant and Per Diem Program.

The procedure will be defined in a local policy. Involved staff will be trained on the defined procedure.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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