



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Evaluation,
Documentation, and Care
Coordination for a Bariatric
Surgery Patient at the VA
Pittsburgh Healthcare
System in Pennsylvania



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations that the VA Pittsburgh Healthcare System (facility) inadequately managed preoperative and postoperative care for a patient approved for bariatric surgery.¹

The patient was in their mid-20s with a history of obesity, childhood trauma, and mental health diagnoses to include major depressive disorder (depression) and a suicide attempt in summer 2016.² In spring 2018, the patient asked the primary care provider (provider) about bariatric surgery and a consult was entered.

The patient was not fully evaluated for bariatric surgery because there was no documented evidence of coagulation studies, vitamin B12 and folate levels, and the patient's initial electrocardiogram.³ Despite not being fully evaluated, the OIG did not substantiate that the patient was inappropriately approved for bariatric surgery, as the omissions did not impact the clinical indication for surgery or the surgical outcome. Prior to surgery the patient underwent the preoperative evaluation process outlined in the bariatric surgery consult. Although listed in the consult, the preoperative evaluation did not include coagulation studies and vitamin B12 or folate levels. The patient underwent bariatric surgery in 2019 and was discharged home two days later.

Because of the lack of Veterans Health Administration (VHA) and facility requirements regarding mental health evaluations and bariatric surgery, the OIG did not substantiate that the

¹ VHA Directive 1120.01(1), *Core Requirements for MOVE!® Weight Management Program for Veterans (MOVE!)*, June 5, 2017, amended September 20, 2019. (For the purposes of this report, other than when referring to the directive, the OIG refers to the Weight Management Program for Veterans as MOVE.) Bariatric surgery is available to patients who are unable to achieve their weight loss goals through lifestyle interventions alone. According to Oregon Health and Science University, the most common bariatric surgery is sleeve gastrectomy, a restrictive procedure that removes a portion of the patient's stomach but leaves the rest of the gastrointestinal tract intact.

² The OIG uses the singular form of they (their) in this instance for patient privacy. Mayo Clinic Patient Care and Health Information, *Major Depressive Disorder*. "Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. Also called major depressive disorder or clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems." <https://www.mayoclinic.org/diseases-conditions/depression/symptoms-causes/syc-20356007>. (The website was accessed on January 8, 2020.)

³ Mayo Clinic, *Prothrombin Time Test*. Coagulation studies include international normalized ratio (INR), prothrombin time (PT), and partial thromboplastin time (PTT). These tests assess the body's ability to clot. <https://www.mayoclinic.org/tests-procedures/prothrombin-time/about/pac-20384661>. (The website was accessed on February 4, 2020.) Mayo Clinic, *Vitamin B-12*. Vitamin B-12 is essential in the formation of red blood cells, metabolism of cells, and nerve function. <https://www.mayoclinic.org/drugs-supplements-vitamin-b12/art-20363663?p=1>. (The website was accessed on February 4, 2020.) Mayo Clinic, *Folate (folic acid)*. Folate (vitamin B-9) is important in the formation of red blood cells and their healthy growth and function. Mayo Clinic, *Patient Care and Health Information, Electrocardiogram (ECG or EKG)*. An electrocardiogram is a test used to detect heart problems and monitor heart rhythms. <https://www.mayoclinic.org/tests-procedures/ekg/about/pac-20384983>. (The website was accessed on January 21, 2020.)

patient was inadequately evaluated by mental health providers prior to approval for bariatric surgery. The OIG found that the Bariatric Surgery Program team considered the patient's complex mental health history prior to approving the patient for bariatric surgery.

The OIG substantiated that the electronic health record (EHR) contained a documentation error by the Managing Overweight and/or Obesity for Veterans Everywhere (MOVE) coordinator, whose chart entry overstated the extent of the patient's ongoing preoperative mental health treatment. The MOVE coordinator documented that "the patient is closely followed by Behavioral Health Services, being seen by psychiatry and involved in individual therapy 2-4 times per month." The MOVE coordinator recognized the documentation error in a 2018 note but did not comply with facility policy to correct the error. The MOVE coordinator reported calling the psychologist to discuss the error and that the psychologist clarified the information by adding a note. Despite the inaccurate documentation, frequent communication between members of the treatment team permitted healthcare providers to make decisions based on an accurate understanding of the patient's ongoing mental health treatment and appropriateness for surgery. By not complying with facility policy, the documentation error could have led providers to base treatment decisions on that misinformation.

Although the patient was appropriately approved for bariatric surgery, the OIG noted several concerns related to the approval process including the lack of a laboratory and studies checklist, reliance on informal communication, and the use of additional signers to alert team members on progress notes instead of documented interdisciplinary team discussions. The OIG concluded that these concerns did not impact the patient's appropriateness for bariatric surgery, but with an improved process, the risk of an incomplete preoperative evaluation for future patients should be diminished.

The OIG did not substantiate that the patient was insufficiently monitored either medically or for mental health status following bariatric surgery and weight loss. The patient met with the Bariatric Surgery Program nurse practitioner, a nutritionist, a neurologist, and a psychiatry provider, and was seen in the Emergency Department twice following discharge. During these visits, the patient consistently received medication management and weight loss monitoring. The patient was also monitored for symptoms of depression, side effects of medications, thoughts of suicide, and adherence to the treatment plan. In late spring 2019, the patient was seen in the Emergency Department for a skin rash. During the triage process, an Emergency Department nurse asked the patient "Over the past two weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?" The patient responded, "Not At All."

Despite the patient receiving consistent medical and mental health care, the patient completed suicide five days following the Emergency Department visit.

The OIG made six recommendations to the Facility Director related to developing a facility policy for bariatric surgery; ensuring bariatric patients receive all preoperative medical and

mental health evaluations and monitoring compliance; reviewing, correcting, and educating staff on documentation errors and the requirement to follow facility policy; documenting preoperative bariatric interdisciplinary team discussions; and reviewing the Bariatric Surgery Program.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes B and C). The OIG considers Recommendation 3 closed and will follow up on the planned actions for the remaining recommendations until they are completed.



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Abbreviations

CTAD	Center for Treatment of Addictive Disorders
DoD	Department of Defense
EHR	electronic health record
EKG	Electrocardiogram
MOVE	Managing Overweight and/or Obesity for Veterans Everywhere
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations that the VA Pittsburgh Healthcare System (facility) inadequately managed preoperative and postoperative care for a patient who underwent bariatric surgery.¹

Facility Background

The facility is part of Veterans Integrated Service Network (VISN) 4 and includes two medical centers located in Pittsburgh, Pennsylvania, and five community-based outpatient clinics located in nearby counties. The facility provides inpatient medical, surgical, and psychiatric care; operates a community living center; and offers residential rehabilitation programs in posttraumatic stress disorder, substance use disorder, and homelessness. From October 1, 2018, through September 30, 2019, the facility served 78,934 patients and had a total of 549 hospital operating beds, including 146 medical, surgical, and intensive care beds; 78 psychiatry inpatient beds; 225 community living center beds; and 100 residential beds.

Managing Overweight and/or Obesity for Veterans Everywhere Program

The Managing Overweight and/or Obesity for Veterans Everywhere (MOVE) program was developed by the VA National Center for Health Promotion and Disease Prevention in 2006.² In 2018, the National Center for Health Promotion and Disease Prevention reported that 75 percent of patients receiving care at Veterans Health Administration (VHA) facilities were considered overweight or obese.³ The MOVE program's core tenets include encouraging healthy eating, increasing physical activity, promoting healthy weight loss, and improving the lives of patients. The goals of the MOVE program are to screen patients annually for obesity and provide referrals

¹ VHA Directive 1120.01(1), *Core Requirements for MOVE![®] Weight Management Program for Veterans (MOVE!)*, June 5, 2017, amended September 20, 2019. (For the purposes of this report, other than when referring to the directive, the OIG refers to the Weight Management Program for Veterans as MOVE.) Bariatric surgery is available to patients who are unable to achieve their weight-loss goals through lifestyle interventions alone. According to Oregon Health and Science University, the most common bariatric surgery is sleeve gastrectomy, a restrictive procedure that removes a portion of the patient's stomach but leaves the rest of the gastrointestinal tract intact.

² VHA Directive 1120.01(1).

³ VHA Directive 1120.01(1). VHA defines body mass index, obesity, and overweight in the following terms. Body mass index is a measure of stored fat that adjusts for weight and height. A patient is considered obese if they have an excessively high amount of body fat relative to lean body mass and a body mass index of 30 or more. A patient is considered overweight if they have increased body weight in relation to height, when compared to a standard of acceptable or desirable weight, and a body mass index of 25–29.9. National Center for Health Promotion and Disease Prevention, <https://www.prevention.va.gov/MOVE.asp>. (The website was accessed on March 16, 2020.)

to those interested in weight management treatment interventions. One intervention is bariatric surgery.

Bariatric Surgery

Patients unable to achieve their weight loss goals through lifestyle interventions alone may be considered for bariatric surgery. Bariatric surgical options can be categorized into two types: restrictive and malabsorptive.⁴ The most common bariatric surgery is a sleeve gastrectomy, a restrictive procedure that removes a portion of the patient's stomach but leaves the rest of the gastrointestinal tract intact.

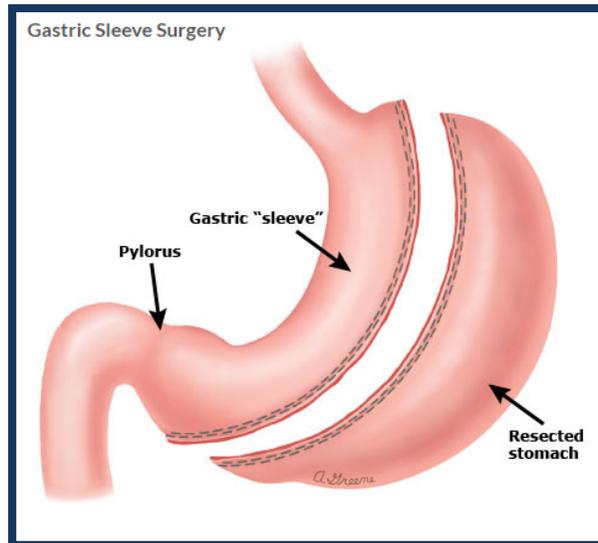


Figure 1. Picture of sleeve gastrectomy

Source: Oregon Health and Science University (OHSU),

<https://www.ohsu.edu/bariatric-services/gastric-sleeve-surgery-weight-loss>,

January 9, 2020.

Depression is common after bariatric surgery, and the VA/ Department of Defense (DoD) Clinical Practice Guideline For Screening and Management of Overweight and Obesity recommends increased vigilance for suicidal ideation and other risk factors for suicide such as

⁴ American Society for Metabolic and Bariatric Surgery, *Bariatric Surgical Procedures*. When a gastric bypass involves rerouting the intestines, it is a malabsorptive bariatric procedure. A significant portion of the upper part of the small intestines, where fat, protein, vitamins, and medications are absorbed, is bypassed from the route that food normally takes. Because nutrients and medications pass through a shortened intestine, less opportunity exists for absorption. <https://asmbs.org/patients/bariatric-surgery-procedures>. (The website was accessed on October 17, 2019.)

substance use disorders.⁵ Although studies have been conducted, there is no clear guidance for medication adjustments following a sleeve gastrectomy. VHA and the facility do not have policies defining prescription of medication dose or route following bariatric surgery.⁶

Allegations

In summer 2019, the OIG received a forwarded complaint from the VHA's Office of the Medical Inspector regarding concerns with the bariatric surgery evaluation process and the follow-up care received by a patient who completed suicide.⁷ The complaint noted conflicting information about the patient's surgical readiness in the electronic health record (EHR), and that following surgery, the facility failed to provide adequate mental health monitoring and medication management.

Scope and Methodology

The OIG initiated an inspection and conducted a site visit in late 2019.

The OIG team interviewed the complainant; Chief of Staff, Assistant Chief of Surgery, Associate Chief of Mental Health Service, and Chief of Quality Management; the bariatric surgeon and nurse practitioner; the MOVE coordinator; primary care and mental health providers; other relevant staff; and VISN leaders. OIG staff reviewed applicable VHA directives, relevant facility policies, clinical practice guidelines, Joint Commission standards, issue briefs, peer reviews, patient advocate reports, relevant meeting minutes from October 2018 to October 2019, staff trainings and competencies from October 1, 2017, through September 30, 2019, congressional correspondence, and the identified patient's EHR.

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

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take

⁵ VA/DoD, Clinical Practice Guideline For Screening And Management Of Overweight and Obesity, Version 2.0 – 2014.

⁶ Merriam-Webster, *Definition of dose*. The dose of a medication is the measured quantity of a therapeutic agent to be taken at one time. <https://www.merriam-webster.com/dictionary/dosing>. (The website was accessed on January 2, 2020.) Merriam-Webster, *Definition of route*. A method or route of administering a remedy. <https://www.merriam-webster.com/dictionary/route#medical>. (The website was accessed on January 2, 2020.)

⁷ VHA's Office of the Medical Inspector Mission states it "independently investigates health care issues raised by Veterans and other stakeholders to monitor and improve the quality of care provided by VHA." Staff within the Office of Medical Inspectors review issues through local and national data and makes recommendations for changes at the local and national level. <https://www.va.gov/health/medicalinspector/>. (The website was accessed on February 4, 2020.)

place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leadership on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Patient Case Summary

The patient was in their mid-20s with a history of obesity, migraine headaches, sleep apnea, childhood trauma, and mental health diagnoses to include major depressive disorder (depression).⁸ In summer 2016, the patient attempted suicide by overdose and was admitted to the facility's inpatient psychiatry unit for several days followed by an additional extended stay on a residential rehabilitation unit. Following discharge from the residential rehabilitation unit, the patient received periodic outpatient mental health care. In spring 2018, a psychiatrist documented that the patient reported doing well, with a stable mood, had no suicidal thoughts, and that the patient's depression was "in remission."

In spring 2018, the patient asked the primary care provider (provider) about bariatric surgery and a consult was entered. The Bariatric Surgery Program required preoperative laboratory testing, attendance at a bariatric surgery class, and consultation with the MOVE program staff, which included psychological testing and participation in educational sessions.

The MOVE coordinator assessed the patient and discussed the MOVE program and bariatric surgery. The patient then completed psychological testing with a psychology technician and self-reported no significant psychiatric symptoms or depression. The MOVE coordinator documented that "there appear[ed] to be no psychological contraindications to [the patient] undergoing bariatric surgery."

⁸ The OIG uses the singular form of they (their) for the purpose of patient privacy. Merriam-Webster, *Definition of sleep apnea*. Sleep apnea is an obstruction of a person's airway during sleep. <https://www.merriam-webster.com/dictionary/sleep%20apnea>. (The website was accessed on February 8, 2020.) Mayo Clinic, *Patient Care and Health Information, Major Depressive Disorder*. "Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. Also called major depressive disorder or clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems." <https://www.mayoclinic.org/diseases-conditions/depression/symptoms-causes/syc-20356007>. (The website was accessed on January 8, 2020.)

A psychologist interpreting the psychological tests documented that the patient's results indicated "a marked tendency for problematic compliance, either inadvertently or intentionally not following medical recommendations," and a "marginal ability and/or coping skills to maintain changes." The psychologist noted, "per records, veteran was last seen by [the] CTAD [Center for Treatment of Addictive Disorders] psychologist [in spring 2017] and [the patient] is not involved in CTAD groups or any other therapy at this time." The psychologist recommended that, "given [the patient's] significant substance use history and history of depression, if symptoms or urges recur, [the patient] should reengage in CTAD groups and/or resume therapy." The psychologist also recommended that urine drug screens be conducted as part of the patient's workup for bariatric surgery.

In late spring 2018, the patient met with the CTAD psychologist, but the patient declined to schedule further appointments with the CTAD. In fall 2018, the patient had a negative urine drug screen.

Medication management of the patient's depression included fluoxetine 60 milligrams daily.⁹ However, pharmacy records indicated that fluoxetine refills were not requested and filled consistently or timely enough to maintain this dosage.

During a routine follow-up visit in fall 2018, a psychiatric provider documented the patient's depression to be "in full remission."¹⁰ In early 2019, a psychiatric provider documented the patient's depression to be in "partial remission."

Approximately three months after the appointment with the psychiatric provider, the patient underwent bariatric surgery without complications and was discharged home two days later on medications including fluoxetine 60 milligrams daily for depression and oxycodone 10 milligrams, to be used every four hours as needed for pain.¹¹ The following day, the patient was contacted in a discharge follow-up telephone call and reported "feeling good."

Seven days later a pharmacist placed an EHR entry titled "Data Based Opioid Risk Review." The pharmacist's assessment was intended to help determine the patient's "risk of suicide-related event[s] or overdose in the next year" utilizing VHA's Stratified Tool for Opioid Risk

⁹ Merriam-Webster, *Definition of fluoxetine*. Fluoxetine is a type of antidepressant medication that enhances serotonin activity. <https://www.merriam-webster.com/dictionary/fluoxetine>. (The website was accessed on February 8, 2020.)

¹⁰ Merriam-Webster, *Definition of remission*. Remission refers to when symptoms of a disease stop. <https://www.merriam-webster.com/dictionary/remission>. (The website was accessed on January 2, 2020.)

¹¹ Mayo Clinic, *Oxycodone*. Oxycodone is an opioid drug that may be used in treating surgical and severe pain. <https://www.mayoclinic.org/drugs-supplements/oxycodone-oral-route/description/drg-20074193>. (The website was accessed on February 5, 2020.)

Mitigation.¹² The patient's risk estimate for a suicide-related event, or overdose, with active opioid therapy in the next year was assessed as 7.9 percent ("very high"). The patient's supply of oxycodone consisted of a single disbursement of 36-five milligram tablets upon discharge from the facility.

Fourteen days after surgery, the patient was seen for a planned follow-up visit by Bariatric Surgery Program staff. It was noted that the patient was treated in the Emergency Department for palpitations and lightheadedness several days earlier and that these symptoms resolved with greater fluid intake. One week later, the patient, seen for a routine mental health appointment, was described as cooperative, alert, and fully oriented, and was continued on fluoxetine 60 milligrams per day. The patient was reminded of the emergency and non-emergency contacts for mental health and the availability of the walk-in clinic.

In the month following surgery, the patient was seen by the Bariatric Surgery Program nutritionist and reported "doing well," and with "no complaints." In the subsequent month the patient was seen by a neurologist for a routine follow-up visit for headaches, which the patient described as "non-existent." The neurologist noted the patient to be "well dressed, alert, and attentive" and revealing "no gross disorder of thought content."

In late spring 2019, the patient presented to the facility's Emergency Department with a skin rash involving the neck and right upper extremity and was prescribed a seven-day course of valacyclovir.¹³ The Emergency Department physician observed the patient to be alert, cooperative, and appropriate with responses. During the triage process, an Emergency Department nurse asked the patient, "Over the past two weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?" The patient responded, "Not At All."

Five days after the Emergency Department visit, the patient completed suicide.

¹² VHA Notice, *Conduct of Data-Based Case Reviews of Patients with Opioid-Related Risk Factors*, March 8, 2018. VHA's Stratified Tool for Opioid Risk Mitigation is a tool developed in VHA as part of its Opioid Safety Initiative to help mitigate risks associated with opioid prescribing taking into consideration both risk factors (such as substance use disorders) and risk mitigation interventions (such as urine drug screening, psychosocial treatment) as needed. The Stratified Tool for Opioid Risk Mitigation prioritizes patients for review and intervention according to their modeled risk for overdose or suicide-related events and displays risk factors and risk mitigation interventions from VHA and the EHR.

¹³ Mayo Clinic, *Valacyclovir*. Valacyclovir is a medication used to treat herpes virus infections, such as shingles, and reduces associated pain and discomfort. <https://www.mayoclinic.org/drugs-supplements/valacyclovir-oral-route/description/drg-20066635>. (The website was accessed on January 23, 2020.)

Inspection Results

1. Preoperative Evaluation

Medical

The OIG substantiated that the patient was inadequately evaluated for bariatric surgery by medical providers. Despite not being fully evaluated, the OIG did not substantiate that the patient was inappropriately approved for bariatric surgery, as the omissions did not impact the clinical indication for surgery or the surgical outcome.

VHA and the facility did not have written policies regarding the preoperative evaluation for bariatric surgery. However, the facility's bariatric surgery consult required laboratory, radiology, and specialty testing; participation in the MOVE program; and a bariatric surgery class prior to scheduling surgery.

In spring 2018, the provider ordered all required laboratory tests outlined in the bariatric surgery consult. The Bariatric Surgery Program nurse practitioner told the OIG team that the patient had completed all required laboratory work. However, the OIG team found no documented results in the EHR for the coagulation studies, or vitamin B12 and folate levels, which were listed on the bariatric surgery consult.¹⁴

An electrocardiogram (EKG) and chest x-ray were ordered in spring 2018.¹⁵ A chest x-ray was completed as well as an ultrasound required by the bariatric surgery consult in 2018, but the OIG

¹⁴ Mayo Clinic, *Prothrombin Time Test*. Coagulation studies include international normalized ratio (INR), prothrombin time (PT), and partial thromboplastin time (PTT). These tests assess the body's ability to clot. <https://www.mayoclinic.org/tests-procedures/prothrombin-time/about/pac-20384661>. (The website was accessed on February 4, 2020.) Mayo Clinic, *Vitamin B-12*. Vitamin B-12 is essential in the formation of red blood cells, metabolism of cells, and nerve function. <https://www.mayoclinic.org/drugs-supplements-vitamin-b12/art-20363663?p=1>. (The website was accessed on February 4, 2020.) Mayo Clinic, *Folate (folic acid)*. Folate (vitamin B-9) is important in the formation of red blood cells and their healthy growth and function. <https://www.mayoclinic.org/drugs-supplements-folate/art-20364625?p=1>. (The website was accessed on February 4, 2020.)

¹⁵ Mayo Clinic, *Patient Care and Health Information, Electrocardiogram (ECG or EKG)*. An electrocardiogram is a test used to detect heart problems and monitor heart rhythms. <https://www.mayoclinic.org/tests-procedures/ekg/about/pac-20384983>. (The website was accessed on January 21, 2020.) Mayo Clinic, *Patient Care and Health Information, Chest x-rays*. Chest x-rays produce images of the bones, heart, lungs, blood vessels, and airways. They can also reveal air or fluid in or around lungs. <https://www.mayoclinic.org/tests-procedures/chest-x-rays/about/pac-20393494>. (The website was accessed on January 21, 2020.)

found no documentation of an EKG or EKG results in 2018.¹⁶ An EKG that showed sinus rhythm was completed in 2019 a few weeks before surgery.¹⁷

The patient met with the MOVE coordinator in spring 2018, who completed a psychosocial assessment. During that meeting, the patient enrolled in the three-month MOVE program telephone clinic.

The patient attended the two-hour bariatric surgery class in spring 2018. This class reviewed the required preoperative workup, education, and nutritional components.

The Bariatric Surgery Program nurse practitioner told the OIG team that because the facility did not have a checklist, the practice was to search each patient's EHR for the laboratory tests or studies listed on the bariatric consult. The Bariatric Surgery Program nurse practitioner discussed with the OIG team being unaware that some of the patient's consult items were missing.

The OIG concluded that the preoperative evaluation consult requirements for bariatric surgery were completed and documented, except for the coagulation studies, vitamin B12 and folate levels, and the patient's initial EKG. Despite the absence of testing results, the OIG found that the omissions did not impact the clinical indication for surgery or the surgical outcome.

Mental Health

The OIG did not substantiate that the patient was inappropriately evaluated for bariatric surgery by mental health providers.

The VHA Preoperative Bariatric Surgery Psychological Evaluation recommends, but does not require, a formal psychological evaluation due to evidence of increased risk for suicide and substance use after bariatric surgery. The factors to be considered should include any active psychosis, suicide attempts, and mental health diagnoses.¹⁸ However, the VA/DoD Clinical Practice Guideline for Screening and Management of Overweight and Obesity states routine

¹⁶ Merriam-Webster, *Definition of ultrasound*. An ultrasound is a diagnostic or therapeutic noninvasive technique involving images to detect and measure bodily abnormalities. <https://www.merriam-webster.com/dictionary/ultrasound>. (The website was accessed on February 8, 2020.)

¹⁷ Practical Clinical Skills, *Sinus Rhythm*. Sinus rhythm also means normal heart beat (rate and rhythm). <https://www.practicalclinicalskills.com/sinus-rhythm>. (The website was accessed on February 5, 2020.)

¹⁸ National Institute of Mental Health, *What is psychosis*. Psychosis describes a condition where a person loses contact with reality. Symptoms can include delusions, hallucinations, mood disturbance, difficulty functioning overall, and other related symptoms. <https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-psychosis.shtml>. (The website was accessed on December 30, 2019.)

preoperative assessments by mental health are not supported by current evidence.¹⁹ At the time of the site visit, the Bariatric Surgery Program nurse practitioner informed the OIG that the facility did not have a policy for the coordination of care between mental health and bariatric surgery. Instead, bariatric surgery patients received a preoperative medical evaluation and referral to the MOVE coordinator for psychological testing and participation in educational sessions.²⁰

In spring 2018, the MOVE coordinator completed a psychosocial assessment, including a review of the patient's medical, psychological, and social histories. The MOVE coordinator and the psychologist reported to the OIG team that they had a discussion and agreed that the patient did not have psychological contraindications for surgery. The MOVE coordinator documented that the patient had "no psychological contraindications" for bariatric surgery, but did not document the discussion with the psychologist. The MOVE coordinator referred the patient to a psychology technician to complete psychological testing and the results were interpreted by the psychologist three days later. The results showed that the patient reported no problematic psychological symptoms but that the patient may have responded in a more positive light for surgery approval. The psychologist documented the results were valid, meaning the results were within acceptable score ranges and did not indicate cause for concern.

The psychologist made recommendations for the patient to complete urine drug screens and to follow-up with CTAD groups and therapy, or both if psychiatric symptoms return. The patient completed one urine drug screen in fall 2018, and the test results were negative. The psychologist also recommended that the patient meet with the last assigned mental health provider, a CTAD psychologist, due to a significant history of substance use and depression. The CTAD psychologist addressed previous addictive behaviors, lack of follow-through on lasting behavior changes, and poor eating habits. The patient was offered, but declined, a future appointment. The CTAD psychologist documented that the patient appeared to have a clear understanding of the mental health challenges following bariatric surgery and was "strongly encouraged" to contact the psychologist if symptoms returned.

The OIG concluded that although there are no specific requirements for psychological testing prior to bariatric surgery, the Bariatric Surgery Program team did consider the patient's complex mental health history prior to approving the patient for bariatric surgery.

¹⁹ VA/DoD, *Clinical Practice Guideline For Screening And Management Of Overweight and Obesity*, Version 2.0 – 2014. The VA/DoD Clinical Practice Guideline for Screening and Management of Overweight and Obesity provides information and assists with decision-making in creating a framework for evaluation of individual needs and preferences of overweight and obese patients. The Guideline includes evidence-based information and best practices for the management of related conditions, weight loss, care delivery, and pharmaceutical approaches. <https://www.healthquality.va.gov/guidelines/CD/obesity/> (The website was accessed on January 3, 2020.)

²⁰ American Psychological Association, *Understanding psychological testing and assessment*. Psychological testing is to "measure and observe a client's behavior to arrive at a diagnosis and guide treatment." <https://www.apa.org/helpcenter/assessment>. (The website was accessed on January 17, 2020.)

Documentation Error

The OIG substantiated that the EHR contained a documentation error, which could have caused confusion amongst the Bariatric Surgery Program team related to the patient's involvement in mental health treatment. However, it was determined that the documentation error did not change the outcome of the evaluation for bariatric surgery.

The OIG identified a documentation error in the MOVE coordinator's note from spring 2018, when it was written that "the patient is closely followed by behavioral health, being seen by psychiatry and involved in individual therapy 2–4 times per month." At the time of the documentation, the patient had not engaged in mental health treatment since 2017.²¹ When the OIG team asked about this error, the MOVE coordinator explained that it was a typographical error and that the entry should have indicated the patient "was," not "is," closely followed by behavioral health. The MOVE coordinator reported calling the psychologist to discuss the error. The psychologist clarified in a note dated three days later, that the patient had not been engaged in mental health treatment. Despite the correction in the psychologist's note, the error remained in the MOVE coordinator's note.

Facility policy requires providers to contact the Health Information Management Services' supervisor or designee to correct any errors in clinical documentation. The OIG concluded that although the MOVE coordinator recognized the documentation error and took steps to correct the error by speaking with the psychologist, facility policy for correcting documentation errors was not followed. During an interview with the OIG, the MOVE coordinator acknowledged an awareness of the policy, but did not follow it due to a belief that the entry of a second corrected note in the EHR would be enough. Despite the inaccurate documentation, subsequent events revealed that healthcare providers made decisions based on an accurate understanding of the patient's ongoing mental health treatment and appropriateness for surgery. By not complying with facility policy, the documentation error could have led providers to base treatment decisions on that misinformation.

Additional Finding

The OIG determined that although the patient was appropriately approved for bariatric surgery, there were additional concerns related to the approval process. These concerns included the previously mentioned lack of laboratory and studies checklist, reliance on informal communication, and the use of additional signers to alert team members on progress notes instead of documented interdisciplinary team discussions.

²¹ The patient was seen by psychiatry service in spring 2017 and would not encounter psychiatry staff again until early 2018 for a walk-in psychiatry appointment with a registered nurse. The patient was not seen by a psychiatry provider until spring 2018.

VHA requires EHR documentation to be accurately reflected, clinically relevant, comprehensive, concise, and complete.²² VHA allows for the use of an “additional signer” to be added to progress notes as a communication tool to alert providers about patient information but electronic signatures do not imply “responsibility for the content of, or concurrence with, the note.”²³

The Bariatric Surgery Program team reported to the OIG that they had the following informal discussions to determine if the patient had any medical or mental health barriers for surgery, but did not document those discussions in the EHR:

- The MOVE coordinator and clinical psychologist collaborated weekly to determine the appropriateness of patients for bariatric surgery; the team did not formally meet to discuss patient care or document meeting minutes. Instead of documenting decision-making in the EHR, they regularly used phone conversations and secure messaging to communicate about patient care.
- The Bariatric Surgery Program nurse practitioner reported sending emails or having conference calls with the MOVE coordinator and psychologist to discuss cases, as needed.

A few Bariatric Surgery Program team members utilized additional signers as an alert on progress notes, but the Bariatric Surgery Program team lacked a formalized process to document team discussion and consensus about the patient’s appropriateness and approval for bariatric surgery.

Ultimately, the OIG concluded that these additional concerns did not impact the patient’s appropriateness for bariatric surgery. However, these aspects of documentation could increase the chance of missed or inaccurate information with the reliance on memory.

2. Postoperative Care

Medical

The OIG did not substantiate that the patient was insufficiently monitored by medical staff following bariatric surgery and weight loss.

The facility’s discharge policy requires a comprehensive discharge note, a follow-up appointment, and an adequate supply of medications provided to the patient upon discharge.²⁴

The Bariatric Surgery Program nurse practitioner completed the discharge note with a follow-up appointment scheduled for 14 days after surgery. The Bariatric Surgery Program nurse

²² VHA Handbook 1907.01, Health Information Management and Health Records, March 19, 2015.

²³ VHA Handbook 1907.01.

²⁴ Facility Memorandum TX-088, Discharge Policy, January 3, 2019.

practitioner reviewed the patient's medications and reconciled the list to include the patient's discharge medications with instructions for use.

Three days after surgery, the Primary Care Clinic nurse contacted the patient to review the discharge instructions. During this telephone conversation, the patient stated, "I'm feeling good" and verbalized understanding of postoperative care and medications.

Eleven days after surgery, the patient presented to the Emergency Department with complaints of two episodes of chest palpitations in the last week. The patient was asymptomatic but stated, "it [drinking water] is slightly more uncomfortable since the surgery." The patient agreed to increase water intake and repeat laboratory tests. The Emergency Department physician ordered a heart monitor consult for evaluation and for repeated laboratory tests to be completed prior to the bariatric surgery follow-up appointment scheduled three days later.

The patient was seen in the Bariatric Surgery Clinic by both the nurse practitioner and the nutritionist at the scheduled follow-up appointment. At the visit, the patient was weighed, medications were reconciled, and the patient was provided an updated list of medications.

The Bariatric Surgery Program nutritionist documented that the patient lost 37.9 pounds since surgery, 42 days earlier. The patient stated a plan to return to the gym for weight training and was to follow-up in approximately two months with the Bariatric Surgery Program nutritionist.

During a follow-up neurology appointment, 79 days after surgery, the neurologist documented a review of the patient's medications and noted that the patient reported that headaches were "non-existent." The patient's next neurology appointment was in approximately six months.

The patient presented to the Emergency Department 90 days after surgery with complaints of a rash to the neck and right upper extremity that had developed three days prior. The Emergency Department physician documented that the patient was "clinically well-appearing" and "does not appear to be very uncomfortable now." The patient was prescribed valacyclovir and instructed to follow-up in seven to 10 days if the condition did not improve.

The OIG concluded that the patient received adequate medical postoperative care following bariatric surgery based on medication management, clinical presentation, weight loss monitoring, and follow-up appointments.

Mental Health

The OIG did not substantiate that the facility insufficiently monitored the patient's mental health condition or medications following bariatric surgery and weight loss.

VHA and the facility do not have policies defining how often follow-up appointments for mental health treatment should occur. The VA/DoD Clinical Practice Guideline For The Management of Major Depressive Disorder recommends monthly follow-up when there is a change to mental health medications until the patient reaches remission of their depression and that mental health

providers assess patients individually for ongoing symptoms of depression, side effects, and adherence to treatment plans.²⁵ During interviews with the OIG team, facility leaders and the psychiatric provider reported that anti-depressant medication adjustments were considered and made according to a patient's report of side effects and present mood, rather than weight loss. In addition, the VA/DoD Clinical Practice Guideline For Screening and Management of Overweight and Obesity recommends providers watch for symptoms of suicide and depression following surgery, as patients are at increased risk.²⁶

The patient met with the psychiatric provider 20 days post bariatric surgery. During this appointment, the psychiatric provider documented that the patient did not report symptoms of depression, side effects of the medications, or thoughts of suicide. The psychiatric provider documented the patient's adherence to the treatment plan, including a follow-up appointment in three months, and reviewed how to access urgent mental health treatment between scheduled appointments. The psychiatric provider documented that the patient's depression was in remission.

The patient was seen in the facility's Emergency Department, 90 days post bariatric surgery. During the triage process, the Emergency Department nurse documented that the patient denied thoughts of suicide over the past two weeks.

Despite the patient receiving consistent medical and mental health care, the patient completed suicide 95 days post bariatric surgery.

The OIG concluded that during postoperative follow-up appointments, the patient was monitored for symptoms of depression, side effects of medications, thoughts of suicide, and adherence to treatment plans.

Conclusion

The OIG substantiated that the patient was incompletely evaluated for bariatric surgery by medical providers. The preoperative evaluation did not include coagulation studies, vitamin B12 or folate levels, and the patient's initial EKG results. Despite not being fully evaluated, the OIG did not substantiate that the patient was inappropriately approved for bariatric surgery, as the omissions did not impact the clinical indication for surgery or the surgical outcome.

Because of the lack of VHA and facility requirements regarding mental health evaluations and bariatric surgery, the OIG did not substantiate that the patient was inadequately evaluated by mental health providers prior to approval for bariatric surgery. The OIG found that the Bariatric

²⁵ VA/DoD, Clinical Practice Guideline For The Management Of Major Depressive Disorder, Version 3.0–2016.

²⁶ VA/DoD, Clinical Practice Guideline For Screening And Management Of Overweight and Obesity, Version 2.0–2014.

Surgery Program team considered the patient's complex mental health history prior to approving the patient for bariatric surgery.

The OIG substantiated that the EHR contained a documentation error that could have caused confusion amongst the Bariatric Surgery Program team related to the patient's involvement in mental health treatment; however, the documentation error did not change the outcome of the evaluation for bariatric surgery. The MOVE coordinator recognized the documentation error but did not comply with facility policy to correct the error. Despite the inaccurate documentation, subsequent events revealed that healthcare providers made decisions based on an accurate understanding of the patient's ongoing mental health treatment and appropriateness for surgery.

The patient was appropriately approved for bariatric surgery, but the OIG noted several concerns related to the approval process including lack of a laboratory and preoperative studies checklist, reliance on informal communication, and the use of additional signers to alert team members on progress notes instead of documented interdisciplinary team discussions. The OIG concluded that these concerns did not impact the patient's appropriateness for bariatric surgery.

The OIG did not substantiate that the patient was insufficiently monitored either medically or for mental health changes following bariatric surgery and weight loss.

Recommendations 1–6

1. The VA Pittsburgh Healthcare System Director considers developing a facility policy for bariatric surgery to include preoperative medical and mental health evaluations.
2. The VA Pittsburgh Healthcare System Director ensures that bariatric patients receive all preoperative medical and mental health evaluations and monitors compliance.
3. The VA Pittsburgh Healthcare System Director reviews the documentation error noted in this report and takes action as appropriate.
4. The VA Pittsburgh Healthcare System Director provides education to staff on how to correct documentation errors and the requirement to follow facility policy.
5. The VA Pittsburgh Healthcare System Director ensures interdisciplinary discussions about preoperative bariatric patients are documented in the electronic health record and monitors compliance.
6. The VA Pittsburgh Healthcare System Director considers a programmatic review of the Bariatric Surgery Program to ensure patients receive a comprehensive preoperative evaluation and postoperative follow-up care.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 27, 2020

From: Director, VA Healthcare—VISN 4 (10N04)

Subj: Healthcare Inspection—Deficiencies in Evaluation, Documentation, and Care Coordination for a Bariatric Surgery Patient at VA Pittsburgh Healthcare System in Pennsylvania

To: Director, Office of Healthcare Inspections (54HL08)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. The recommendations from the draft Healthcare Inspection Report - Deficiencies in Evaluation, Documentation and Care Coordination for a Bariatric Surgery Patient conducted at VA Pittsburgh Healthcare System on November 18 through November 21, 2019 have been reviewed.
2. Attached are the facility responses addressing each recommendation, including actions that are in progress and those that have already been completed.
3. I concur with the VA Pittsburgh Healthcare System responses.

(Original signed by:)

Timothy W. Liezert
Network Director, VISN 4

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 20, 2020

From: Director, VA Pittsburgh Healthcare System (646/00)

Subj: Healthcare Inspection—Deficiencies in Evaluation, Documentation, and Care Coordination for a Bariatric Surgery Patient at VA Pittsburgh Healthcare System in Pennsylvania

To: Director, VA Healthcare—VISN 4 (10N04)

1. The recommendations from the draft Healthcare Inspection Report - Deficiencies in Evaluation, Documentation and Care Coordination for a Bariatric Surgery Patient conducted at VA Pittsburgh Healthcare System on November 18 through November 21, 2019 have been reviewed.
2. Attached are the facility responses addressing each recommendation, including actions that are in progress and those that have already been completed.

(Original signed by:)

DONALD E. KOENIG

Director VA Pittsburgh Healthcare System

Facility Director Response

Recommendation 1

The VA Pittsburgh Healthcare System Director considers developing a facility policy for bariatric surgery to include preoperative medical and mental health evaluations.

Concur.

Target date for completion: August 31, 2020

Director Comments

The Medical Center Director has assigned Vice President, Surgery in coordination with the Bariatric Surgeon and Nurse Practitioner to develop, route for approval, and publish a Bariatric Surgery Program Policy to include all required preoperative medical and mental health evaluations.

Recommendation 2

The VA Pittsburgh Healthcare System Director ensures that bariatric patients receive all preoperative medical and mental health evaluations and monitors compliance.

Concur.

Target date for completion: February 28, 2021

Director Comments

The Medical Center Director has directed Vice President, Surgery to conduct a review of all bariatric surgery cases, ensure all required preoperative medical and mental health evaluations were completed. This case review will begin September 1, 2020 and will be completed February 28, 2021. The measure of success will be set at 90%. Results will be reported at the monthly facility Surgery Workgroup Meeting through February 28, 2021.

Recommendation 3

The VA Pittsburgh Healthcare System Director reviews the documentation error noted in this report and takes action as appropriate.

Concur.

Target date for completion: May 18, 2020.

Director Comments

The Medical Center Director has verified that the MOVE Coordinator who entered the referenced note has since retired without addressing the documentation error. The Outpatient Behavioral Health Nurse Manager has documented an addendum to the progress note in the respective electronic medical record addressing the documentation error, in accordance with Medical Center Policy, IM-013, Charting Guidelines. This addendum corrected the error.

OIG Comment

Based on information submitted with the Director's response, the OIG considers this recommendation closed.

Recommendation 4

The VA Pittsburgh Healthcare System Director provides education to staff on how to correct documentation errors and the requirement to follow facility policy.

Concur.

Target date for completion: June 1, 2020

Director Comments

The Medical Center Director has requested the Chief of Healthcare Information Management Systems (HIMS) to use the medical center communication tools to quarterly remind staff of the procedure for correcting electronic medical record documentation errors in accordance with Medical Center Policy, IM-013, Charting Guidelines. The first reminder will be sent the third quarter FY20 by June 1, 2020. The tools used will be New Employee Orientation, The Director's News and Notes, and the Chief of Staff Medical Staff Bulletin.

Recommendation 5

The VA Pittsburgh Healthcare System Director ensures interdisciplinary discussions about preoperative bariatric patients are documented in the electronic health record and monitors compliance.

Concur.

Target date for completion: February 28, 2021

Director Comments

The Medical Center Director has directed the Vice President, Surgery to develop an Interdisciplinary Bariatric Surgery Team (IDT) for the preoperative review of each bariatric surgery case. The Bariatric Program Nurse Practitioner will complete an IDT note in the

electronic medical record for each case discussed. The documentation will include the consensus for surgery. Minutes for the IDT will include the case discussion(s) and verification that an IDT note has been placed in the medical record. A six-month review of the minutes will be completed by the Vice President, Surgery by February 28, 2021. The measure of success will be set at 90%.

Recommendation 6

The VA Pittsburgh Healthcare System Director considers a programmatic review of the Bariatric Surgery Program to ensure patients receive a comprehensive preoperative evaluation and postoperative follow-up care.

Concur.

Target date for completion: September 30, 2020

Director Comments

The Medical Center Director has tasked the Vice President, Surgery, to complete an annual review of the Bariatric Surgical Program. This will be completed to ensure that Veterans are receiving the comprehensive preoperative evaluation and postoperative follow-up care by all involved disciplines. This annual review will occur at the end of each fiscal year.

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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