



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Care, Care
Coordination, and Facility
Response to a Patient Who
Died by Suicide,
Memphis VA Medical Center
in Tennessee



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to determine the validity of an allegation that a patient who sought treatment for insomnia and was out of psychiatric medications did not receive the care needed at the Memphis VA Medical Center (facility) in Tennessee. The patient died by suicide the day following the visit to the facility's Emergency Department.

In conducting its inspection, the OIG identified additional concerns related to

- Lack of written and clear guidance for the patient referral process from Emergency Department physicians to mental health providers who were co-located within the Emergency Department,
- Lack of coordination between Primary Care and Endocrinology Services,¹
- Inadequate facility oversight of the patient's community mental health care,
- Medication reconciliation deficiencies by the Emergency Department physician and primary care provider (PCP 2),²
- Vulnerabilities with the facility's Outpatient Mental Health Clinic check-in process, and
- Deficiencies in the facility's response to the patient's death by suicide.

The patient, in their 30s, received care both at the facility and in the community from the summer of 2015 through 2019.³ In the summer of 2015, the patient was diagnosed with posttraumatic stress disorder (PTSD) and a facility licensed social worker provided mental health counseling through early 2016.⁴ At the patient's last counseling session, sleep was noted to be "good" and there had been a significant improvement in PTSD. Nine months later, the patient contacted the primary care provider (PCP 1) complaining of trouble sleeping and stress. At the time, the patient was referred to a facility psychologist (psychologist 2) who placed a consult for community care mental health treatment. The patient began treatment with a community care

¹ Merriam-Webster, *Definition of endocrinology*. Endocrinology is a branch of medicine concerned with disorders of the endocrine system, including the thyroid. <https://www.merriam-webster.com/dictionary/endocrinology>. (The website was accessed on May 19, 2020.)

² VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011. VHA defines medication reconciliation as a process which identifies, addresses and documents medication discrepancies.

³ The OIG uses the singular form of their (they) in this instance for privacy purposes.

⁴ Department of Veterans Affairs and Department of Defense, *VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder*, Version 3.0–2017. PTSD is a clinically significant condition with symptoms that have persisted for more than one month after exposure to a traumatic event and caused significant distress or impairment in social, occupational, or other important areas of functioning.

nurse practitioner (for medication management) and a community care licensed counselor (for counseling sessions).

The OIG substantiated that the patient presented to the facility's Emergency Department in summer 2019 seeking treatment for insomnia and was out of psychiatric medications. The Emergency Department physician documented evaluating the patient and after a negative screen for suicidal thoughts, the Emergency Department physician discharged the patient with instructions to go to the facility's Outpatient Mental Health Clinic immediately for assistance with medication management. However, the OIG found no documentation in the electronic health record (EHR) that the patient registered or received treatment in the clinic.

The OIG found the patient did not receive the care needed as the facility did not have a clear referral process for patients discharged from the Emergency Department who needed to be seen the same day in the Outpatient Mental Health Clinic for psychiatric medication management. The Emergency Department physician stated that the department's practice was to direct patients to the Outpatient Mental Health Clinic during business hours for medication refills, and that a formal written consult was not required. The Emergency Department physician relied on this informal process and did not order a consult for the patient's referral to the clinic.

Facility policy states that Emergency Department physicians "must involve MH [mental health] staff present in the ER [Emergency Department]...in the assessment of all patients with behavioral health issues."⁵ The facility has a mental health provider in the Emergency Department 24 hours a day to be the liaison for patients in the Emergency Department and the facility's mental health programs.⁶ However, the facility did not have written or clear guidance on the process for Emergency Department physicians to refer patients to Emergency Department mental health providers for a mental health assessment. The OIG was unable to determine whether the Emergency Department physician referred the patient to the Emergency Department mental health provider prior to discharge due to a lack of a documented patient referral. Without a clear referral process, patients are at risk for receiving inadequate care.

The OIG determined that the Emergency Department physician did not adequately reconcile the patient's medications during the patient's summer 2019 Emergency Department visit. The OIG team reviewed the patient's EHR and the state prescription drug monitoring program report and found that the medication list documented in the Emergency Department note included two current medications (bupropion and buspirone) that had been discontinued by the community

⁵ Facility Policy 116A-12, *Management of Patients at Risk for Suicide*, February 26, 2018.

⁶ Facility Handbook, *Emergency Department Mental Health Handbook*, March 5, 2019.

care nurse practitioner and a discrepancy in the dosage in another medication (clonazepam).⁷ The OIG found that the Emergency Department physician did not identify, address, or document the medication discrepancies. When asked about completing medication reconciliation during the patient's visit, the Emergency Department physician reported "we talked about all...meds [medications]" and the patient had been out of medications for a few days, was getting some medications refilled from the Veterans Health Administration (VHA) and others from community pharmacies.

The OIG was unable to determine from the EHR whether the patient presented to or was treated in the Outpatient Mental Health Clinic because there was no documentation of staff contact with the patient, or that the patient attended an unscheduled appointment. The current check-in process for patients presenting to the Outpatient Mental Health Clinic without an appointment did not include registering patients into the facility's scheduling system upon arrival. Program support staff in the Outpatient Mental Health Clinic described different methods to communicate to nursing staff that an unscheduled patient presented to the clinic and was requesting to be seen. At the conclusion of the site visit, the OIG expressed concern to the Executive Leadership Team that unscheduled patients presenting to the Outpatient Mental Health Clinic may not get registered, which may result in a patient not being triaged or receiving mental health care. In January 2020 facility leaders implemented changes in the Outpatient Mental Health Clinic to include posting temporary signs in the clinic indicating that unscheduled appointments are available and directing patients to register with the program support staff.⁸ In addition, facility leaders were developing a patient registration standard operating procedure.

In conducting the inspection, the OIG identified a number of other issues related to the patient's care. The patient established care with a new PCP (PCP 2) in fall 2017. After routine laboratory tests suggested hyperthyroidism in fall 2017 and late summer 2018, PCP 2 placed an electronic consult to the endocrinologist who recommended additional laboratory tests, a thyroid

⁷ Bupropion is an antidepressant medication. <https://www.pdr.net/drug-summary/Wellbutrin-bupropion-hydrochloride-237.5886?mode=preview>. (The website was accessed on January 2, 2020.) Buspirone is an anti-anxiety medication. <https://www.pdr.net/drug-summary/Buspirone-Hydrochloride-Tablets--USP--5-mg--10-mg--15-mg--30-mg--buspirone-hydrochloride-1524.2496>. (The website was accessed on January 2, 2020.) The prescription drug monitoring program (PDMP) is an electronic database used by healthcare providers to review and track controlled substance prescriptions, which can aid in identifying patients that may be at risk for overdose or misuse of certain medications. <https://www.cdc.gov/drugoverdose/pdmp/providers.html>. (The website was accessed on January 28, 2020.)

⁸ Facility leaders used temporary signage until permanent signage could be completed.

ultrasound, and an office visit with Endocrinology Service.⁹ In fall 2018, the facility's Endocrinology Clinic and radiology program support staff attempted to schedule the patient for an Endocrinology Clinic appointment and an ultrasound. After being unable to contact the patient, Endocrinology Clinic staff referred the consult to the endocrinology nurse practitioner who discontinued the consult after speaking with the patient, indicating that the patient declined to see endocrinology. While eligible for community care treatment, the facility endocrinology nurse practitioner did not offer the patient a community care endocrinology consult. The endocrinology nurse practitioner told the OIG of having called the patient to schedule an endocrinology appointment prior to discontinuing the consult, but did not recall speaking with the patient about offering community care endocrinology services and explained that the program support staff usually speak with patients about community care.

PCP 2 did not follow up with or clinically reassess the patient when the endocrinology consult and ultrasound order were discontinued. PCP 2 acknowledged forgetting about the patient's endocrinology consult and did not recall receiving a view alert for the discontinued consult. The EHR did not contain evidence that the patient completed the recommended thyroid ultrasound or was ever seen by an endocrinologist.¹⁰

On two occasions, PCP 2 did not document a higher dose of clonazepam on the patient's non-VA medication list, which resulted in an incorrect EHR medication list.¹¹ When the OIG asked PCP 2 about medication reconciliation completion, PCP 2 indicated that nursing staff were usually tasked with completing medication reconciliation. Accurate medication information is necessary especially when multiple providers are providing treatment and patients are receiving multiple medications.

The patient did not receive several community care counseling sessions due to deficiencies in coordination of care between the facility's community care staff, community care providers, and

⁹ Hyperthyroidism is a condition caused by an overactive thyroid. Laboratory values in hyperthyroidism are characterized by elevated T4 and/or T3 and low TSH levels. https://www.thyroid.org/wp-content/uploads/patients/brochures/Hyper_brochure.pdf. (The website was accessed on May 18, 2020.) Hyperthyroidism is associated with psychiatric symptoms including anxiety, insomnia, and confusion. VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016. An electronic consult (e-consult) allows consult questions to be answered without face-to-face examination of the patient; Merriam-Webster, *Definition of ultrasound*. An ultrasound is a diagnostic test that uses vibration to form an image of internal body structures to detect abnormalities. <https://www.merriam-webster.com/dictionary/ultrasound>. (The website was accessed on February 10, 2020.)

¹⁰ View alerts are EHR notifications that provide information to staff about clinical or administrative events to review and determine whether further action is needed.

¹¹ Clonazepam is a benzodiazepine medication used to treat anxiety. <https://www.pdr.net/drug-summary/Klonopin-clonazepam-3064>. (The website was accessed on December 18, 2019.)

the third party administrator (TPA).¹² The OIG identified a three-month delay between fall 2017 and early 2018 in the patient's community mental health treatment, but was unable to find documentation to explain why the delay occurred. The change in VHA community care eligibility rules, which gave the TPA scheduling responsibilities, may have contributed to the delay.

In fall 2018, the community care licensed counselor terminated the patient's counseling sessions but did not document terminating the sessions, submit documentation to the facility, or refer the patient to another mental health counselor. When asked about making recommendations for another therapist to continue with treatment, the community care licensed counselor reported having encouraged the patient to stay on the medications and to promptly address issues if they arose. The OIG did not find that the community care licensed counselor advised the patient on how to obtain assistance should issues arise.

The OIG determined that facility community care staff did not obtain medical record documentation for treatment the patient received from community care providers after fall 2017. During interviews, the facility community care nurse manager and staff stated they were aware of the requirement to obtain medical record documentation, but because the patient was receiving care under Choice 40 eligibility criteria, they were not required and did not make attempts to obtain the medical records. The OIG could not find documentation to support the facility community care staff's statements that they were not required to obtain medical records for the patient receiving care under Choice 40 criteria. Without the medical record documentation, facility staff were unable to review the care provided, impacting the ability to coordinate the patient's mental health care.

The OIG further determined the community care nurse practitioner and facility community care staff did not ensure care authorizations were current; without current authorizations the patient was unable to refill several medications at the facility pharmacy.¹³

In fall 2017 and summer 2018, the community care nurse practitioner's office faxed the patient's prescriptions to the facility pharmacy to be filled. A facility pharmacist identified that the authorization was expired and notified the community care nurse practitioner that the prescriptions could not be refilled due to the expired authorization, and provided instructions on

¹² VHA Publication, *Veterans Access, Choice and Accountability Act of 2014 (VACAA)*. The Choice Program and the Choice Card, March 2015. A third party administrator (TPA) is a company that VA has a contract with to manage the CHOICE program. In 2016, Veterans Access, Choice, and Accountability Act of 2014 required hospital care and medical services to be provided to veterans at specified non-VA facilities if the veterans resided more than 40 miles away from a VA medical facility or an appointment could not be scheduled at a VA medical facility within the VA's wait time goals.

¹³ TriWest Healthcare Alliance, *Behavioral Health Authorization Forms*, 2019. A secondary authorization request (authorization) is required when the initial authorization expires but the community care provider wishes to extend treatment. After the initial authorization for community care services expired, the community care providers were required to submit an authorization to the TPA for review and approval of continued care.

how to submit an authorization request to the TPA. The community care nurse practitioner's office provided documentation to the OIG that indicated authorization was faxed to the TPA. However, the OIG did not find that the TPA submitted the authorization to the shared internet site, or that facility community care staff approved the authorization.¹⁴ Facility community care staff reported not approving authorizations timely because the TPA did not submit the authorizations to the shared internet site for the staff to view and approve.

A facility community care nurse approved authorizations for the patient's community care mental health services in early 2018 and spring 2019, but did not ensure a facility designated staff member conducted a review of the authorizations. The OIG found that community care nursing staff lacked a clear understanding of the requirement for a facility clinical review prior to approval of a community care authorization. A clinical review would have afforded the opportunity for the facility to evaluate and identify gaps in the patient's community care mental health treatment.

The patient's family member sent an email to the facility's transition patient advocate 11 days after the patient's death by suicide.¹⁵ The email described concerns of inadequate care the patient received from the facility Emergency Department and Outpatient Mental Health Clinic staff and included information about the patient's death by suicide. The transition patient advocate forwarded the email to the Transition and Care Management Program Manager (program manager), and requested assistance. However, the transition patient advocate did not enter the complaint into the Patient Advocate Tracking System.¹⁶ This would have afforded the opportunity to monitor that the complaint was addressed and resolved. The transition patient advocate reported having been trained on the Patient Advocate Tracking System and having access to the system to enter complaints but could not recall having entered the complaint into the system. The program manager confirmed that the transition patient advocate had responsibility to input complaints into the Patient Advocate Tracking System but had not thought to have the transition patient advocate input the complaint into the system.

The family member's email was shared with several facility leaders, but no facility staff member assumed responsibility to contact the family to address or resolve the complaint. During interviews, facility leaders told the OIG of having thought someone from either service recovery,

¹⁴ The TPA established an internet site to for VHA, TPA, and community care providers to access medical record documentation and authorizations.

¹⁵ VHA Directive 1010, *Transition and Care Management of Ill or Injured Servicemembers and New Veterans*, November 21, 2016. The transition care management team includes the program manager, nurse and social worker case managers and transition patient advocates. The transition patient advocate has a primary role to assist patients in accessing services needed at the facility and in the community.

¹⁶ VHA Directive 1010; Facility Policy 00-73, *Customer Service Program-Putting Veterans First*, February 22, 2016. Patient Advocate Tracking system is a computerized program used to document complaints, facility responses and resolution to complaints.

mental health, executive leadership, or the Suicide Prevention Program supervisor followed up on the complaint or contacted the family.

Facility leaders approached the initial gathering of facts inconsistent with VHA policy. Four days after the patient's death, the Chief, Mental Health requested that a fact finding be completed. Only two staff members, the Emergency Department mental health provider and the Emergency Department mental health provider's supervisor, were interviewed during the fact finding. Facility leaders relied on a statement from the Emergency Department physician outside of a fact finding that the Emergency Department mental health provider did not assess the patient. In addition, facility leaders should have considered conducting further review to address the differing accounts by the Emergency Department physician and Emergency Department mental health provider regarding the patient referral to ascertain whether the Emergency Department mental health provider failed to follow facility policy.

In December 2012, VHA implemented the Behavioral Health Autopsy Program, a VHA quality improvement program "that seeks to understand the context of Veterans' lives prior to their suicides."¹⁷ Following a patient's death by suicide, suicide prevention coordinators are to call the next of kin to offer condolences, explain the family interview program to the next of kin, and complete a behavioral health autopsy report. The Acting Supervisor, Suicide Prevention Program (acting supervisor) completed an insufficient behavioral health autopsy report by failing to contact the next of kin after the death of the patient due to a lack of training and having been told by the Section Chief, Mental Health Social Work not to communicate with the patient's family members.¹⁸ The Section Chief, Mental Health Social Work and the acting supervisor's lack of knowledge of the Behavioral Health Autopsy Program requirements and absence of training, contributed to the omission of contacting the next of kin after the patient's death.¹⁹ The facility and VHA missed an opportunity to gain knowledge about the deceased patient's life and barriers

¹⁷ Deputy Under Secretary for Health for Operations and Management (10N), *Behavioral Autopsy Program Implementation*, December 11, 2012; VA VISN 2 Center of Excellence Newsletter, *Suicide Prevention News, Understanding Veteran Suicides- VA's Behavioral Health Autopsy Program*, May 2015. https://www.mirecc.va.gov/suicideprevention/News/Newsdocs/1505_CoE_News_May.pdf. (The website was accessed on November 18, 2019.) The family interview program is part of the VA Behavioral Health Autopsy Program which allows the next of kin of a patient who died by suicide the opportunity to share information about the patient's life, awareness of resources and potential barriers to seeking assistance during times of distress. VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care *Suicide Prevention Coordinator Guide*, January 5, 2018.

¹⁸ Department of Veterans Affairs Data.Gov. <https://catalog.data.gov/dataset/behavioral-health-autopsy-program-bhap>. (The website was accessed on November 18, 2019.) Department of Veterans Affairs defines a behavioral health autopsy report as a document that VHA suicide prevention coordinators complete which includes behavioral data about a veteran prior to death by suicide.

¹⁹ Deputy Under Secretary for Health for Operations and Management (10N), *Behavioral Autopsy Program Implementation*, December 11, 2012; VHA defines Behavioral Autopsy Program as a VHA quality improvement program "that seeks to understand the context of Veterans' lives prior to their suicides."

to seeking assistance when in distress, implementing changes to reduce any identified barriers, and strengthening suicide prevention initiatives.

The Chief, Mental Health and social work leaders were aware of the patient's death by suicide within three days of the patient's death. The OIG could not find evidence, however, that facility leaders notified the Executive Leadership Team of the patient's death. During interviews with the OIG, the Chief of Staff and other facility leaders reported being notified about the patient's death by suicide after receipt of the family member's email complaint sent to the facility 11 days after the patient's death. However, the OIG found documentation that two days after the patient's death, the suicide prevention coordinator from another VA medical center (in Jackson, Mississippi) sent an email to the facility's suicide prevention team with information about the patient's death by suicide. The OIG found that facility leaders reported differing accounts of when they were informed and who provided the information of the patient's death. This resulted in an untimely submission of a Heads Up Message to the Veterans Integrated Service Network.²⁰

VHA requires individuals directly involved with an adverse event "be interviewed as part of the root cause analysis process and asked for suggestions about how to prevent the same or similar situations from happening again."²¹ The OIG found that the root cause analysis team failed to conduct a sufficient review by not interviewing individuals vital to the Emergency Department patient assessment and referral processes.²² Root cause analysis team members reported inconsistent statements about which staff from the Emergency Department were questioned during the analysis and also reported that staff from the Outpatient Mental Health Clinic were not interviewed.

The OIG made 16 recommendations to the Facility Director related to Emergency Department processes for patients needing psychiatric medication management, referral to the Outpatient Mental Health Clinic and Emergency Department mental health provider, medication reconciliation, the Outpatient Mental Health Clinic check-in process, Community Care consults, coordination and medical record documentation retrieval, complaint response, fact finding, behavioral health autopsy, and root cause analysis.

²⁰ Deputy Secretary for Health for Operations and Management (10N), *10N Guide to VHA Issue Briefs*, March 29, 2018. Issue briefs provide information to VHA leaders regarding an event or issue and allows leadership to determine whether policies surrounding the event were met.

²¹ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. VHA defines adverse events as harmful occurrences directly associated with facility care or services.

²² VHA Handbook 1050.01. Root Cause Analysis "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls." Deputy Under Secretary for Health for Operations and Management (10N), *Behavioral Autopsy Program Implementation*. December 11, 2012.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes B and C). Based on information provided, the OIG considers recommendation 13 closed. For the remaining open recommendations, the OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.



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Abbreviations

EHR	electronic health record
OIG	Office of Inspector General
PCP	primary care provider
PTSD	posttraumatic stress disorder
TPA	third party administrator
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to an allegation that a patient who presented to the Memphis VA Medical Center (facility) Emergency Department who was seeking treatment for insomnia and was out of psychiatric medications did not receive the care needed. The patient died by suicide the day following the visit to the facility's Emergency Department.

Background

The facility, part of the Veterans Integrated Service Network (VISN) 9, includes 13 community-based outpatient clinics located in Mississippi, Tennessee and Arkansas.²³ VA classifies the facility as a Level 1a-high complexity facility.²⁴ From October 1, 2018, through September 30, 2019, the facility served 65,023 patients and had a total of 221 operating beds. The facility offers acute medical, primary and surgical care. Specialty care services include psychiatry, dentistry, neurology, spinal cord injury rehabilitation, and women's care.

The facility has an affiliation with the University of Tennessee, Memphis, Colleges of Medicine, Pharmacy, Nursing, Dentistry, and Allied Health, and further affiliations for related health professions with colleges and universities across the country.

Allegation and Related Concerns

On August 16, 2019, the OIG Office of Investigations submitted a referral to the OIG Office of Healthcare Inspections, which contained an allegation that an individual patient who presented to the facility's Emergency Department, seeking treatment for insomnia and was out of psychiatric medications did not get the care needed. The patient died by suicide the day following the visit to the Emergency Department.

The Office of Healthcare Inspections opened a hotline inspection on September 4, 2019, to further review the allegation.

During the inspection the OIG identified additional concerns: lack of written and clear guidance for the patient referral process from Emergency Department physicians to mental health

²³ A community-based outpatient clinic is a VA operated or funded clinic that is geographically separated from its parent facility; six community-based outpatient clinics are in Mississippi: Smithville, Byhalia, Mt. Pleasant, Houlika, Tremont, and Tupelo; five clinics are in Tennessee: Memphis, Jackson, Bolivar, Dyersburg, and Savannah; and two clinics are in Arkansas: Jonesboro and Helena.

²⁴ The Veterans Health Administration Facility Complexity Model categorizes medical facilities based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3, with Level 1a facilities being the most complex and Level 3 facilities being the least complex.

providers who are co-located within the Emergency Department, lack of coordination between Primary Care and Endocrinology Services, inadequate facility oversight of the patient's community mental health care, and medication reconciliation deficiencies by the Emergency Department physician and primary care provider (PCP 2).²⁵ The OIG also identified vulnerabilities with the facility's Outpatient Mental Health Clinic check-in process, and deficiencies in the facility's response to the patient's death by suicide.

Scope and Methodology

The OIG initiated the inspection on September 4, 2019, and conducted a site visit October 29–31, 2019.

The OIG team interviewed the patient's family members, facility leaders, managers, an Emergency Department physician, Emergency Department nursing staff, community care staff, and other staff with knowledge of identified issues.²⁶

The OIG reviewed the patient's electronic health record (EHR), community care medical records and secondary authorization requests (authorization), relevant medical literature, relevant Veterans Health Administration (VHA) and facility policies, email communication, and administrative and quality management reports.²⁷

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.

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

²⁵ Merriam-Webster, *Definition of endocrinology*. Endocrinology is a branch of medicine concerned with disorders of the endocrine system, including the thyroid. <https://www.merriam-webster.com/dictionary/endocrinology>. (The website was accessed on May 19, 2020.)

²⁶ Facility leaders included the Chief of Staff, Chiefs of Mental Health and Police, the Acting Chief of Community Care, Section Chief Mental Health Social Work, and Assistant Director.

²⁷ When a community care provider wishes to extend treatment beyond the initially approved timeframe, a secondary authorization is required.

healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Patient Case Summary

The patient, in their 30s, received care at both the facility and in the community from 2015 through 2019.²⁸ In the summer of 2015, the patient saw the primary care provider (PCP 1) at the facility's Memphis South Community Based Outpatient Clinic and reported a history of high blood pressure, low back pain, depression, and trouble sleeping.²⁹ PCP 1 documented a positive depression screening test and a negative suicide risk screen, indicating the patient was low risk for suicide. PCP 1 prescribed sertraline, an antidepressant medication, and referred the patient to a facility psychologist (psychologist 1).³⁰ A transition care case manager completed a suicide safety prevention plan.³¹

The patient was seen by psychologist 1 the same day; during the evaluation, the patient reported symptoms suggestive of posttraumatic stress disorder (PTSD).³² The following month, the patient attended an appointment with a facility licensed clinical social worker where the patient was diagnosed with PTSD, and agreed to participate in an outpatient PTSD counseling program. At that visit, the patient denied suicidal thoughts. The patient attended 11 mental health

²⁸ The OIG uses the singular form of their (they) in this instance for privacy purposes.

²⁹ Merriam-Webster, *Definition of blood pressure*. Blood pressure is the force on the walls of the blood vessels when the heart pumps. <https://www.merriam-webster.com/dictionary/blood%20pressure>. (The website was accessed on January 16, 2020.) Merriam-Webster, *Definition of depression*. Depression is a mood disorder which is characterized by feelings of sadness, problems with concentration and changes in sleep patterns. <https://www.merriam-webster.com/dictionary/depression#medicalDictionary>. (The website was accessed on January 16, 2020.)

³⁰ Sertraline is a medication prescribed to treat depression, anxiety, and PTSD. <https://www.pdr.net/drug-summary/Zolofit-sertraline-hydrochloride-474>. (The website was accessed on December 18, 2019.)

³¹ VHA Directive 1010, *Transition and Care Management of Ill or Injured Servicemembers and New Veterans*, November 21, 2016. A transition care case manager plans, implements, and monitors healthcare services to meet the needs of a patient requiring a higher level of care management; Department of Veterans Affairs and Department of Defense, *VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*. Version 2.0- 2019. A suicide safety plan includes limiting access to lethal means.

³² A psychologist is a mental health professional who provides counseling therapy. A psychologist does not prescribe medication; Department of Veterans Affairs and Department of Defense, *VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder*, Version 3.0–2017. PTSD is a clinically significant condition with symptoms that have persisted for more than one month after exposure to a traumatic event and caused significant distress or impairment in social, occupational, or other important areas of functioning.

counseling sessions with a facility licensed clinical social worker.³³ In early 2016, the patient completed the last counseling session; at that visit, sleep was noted to be “good” and there had been a significant improvement in PTSD.

Nine months later, the patient sent a secure message to PCP 1 complaining of trouble sleeping and stress; a nurse notified the patient that PCP 1 had relocated and that a facility psychologist (psychologist 2) would be scheduling the patient for an appointment. Two weeks later, psychologist 2 evaluated the patient who denied suicidal thoughts. The patient had experienced life stressors and had stopped taking an antidepressant (sertraline) for three months.³⁴ Psychologist 2 enrolled the patient in the facility’s behavioral health lab depression monitoring program and referred the patient for psychotherapy through community care.³⁵

The facility’s community care staff authorized mental health care for treatment of the patient’s depression, anxiety, and insomnia, and in the beginning of 2017, the patient began treatment with a community care nurse practitioner and a community care licensed counselor.³⁶ The community

³³ Cognitive processing therapy is a specific type of cognitive behavioral therapy that has been effective in reducing symptoms of PTSD. Cognitive processing therapy is generally delivered over 12 sessions and helps patients learn how to challenge and modify unhelpful beliefs related to trauma. American Psychological Association, *Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder*, December 18, 2019. The sessions included cognitive processing therapy as recommended treatment for PTSD; Department of Veterans Affairs and Department of Defense, *VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder*, Version 3.0–2017; VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014. This handbook was amended on May 26, 2017. Clinical Video Telehealth uses video conferencing technologies and provides an alternative to in-person encounters while still providing a “face-to-face interaction between the patient...and other health care providers.”

³⁴ PCP 1 had not acknowledged the patient’s summer 2016 request for a refill of antidepressant medication.

³⁵ Mayo Clinic, *psychotherapy*. Psychotherapy is one type of therapy used in treating mental health problems by talking with a mental health provider. <https://www.mayoclinic.org/tests-procedures/psychotherapy/about/pac-20384616>. (The website was accessed on April 9, 2020.) For the remainder of the report, the word psychotherapy refers to mental health counseling. VA Health Care Mental Illness Education Clinical (MIRECC) Center of Excellence, *Behavioral Health Lab*, https://www.mirecc.va.gov/visn4/BHL/BHL_home.asp. (The website was accessed on January 2, 2020.) The VA Behavioral Health Laboratory employs an interdisciplinary team-based model of care consisting of psychology technicians, clinicians (nurses, social workers, psychologists), and a supervising psychiatrist who work collaboratively within the primary care teams. In 2016, *Veterans Access, Choice, and Accountability Act of 2014* required hospital care and medical services to be provided to veterans at specified non-VA facilities if veterans resided more than 40 miles away from a VA medical facility or an appointment could not be scheduled at a VA medical facility within the VA’s wait time goals.

³⁶ Merriam-Webster, *Definition of anxiety*. Anxiety is an abnormal overwhelming feeling of fear or apprehension, which may cause mental distress. <https://www.merriam-webster.com/dictionary/anxiety>. (The website was accessed on January 16, 2020.)

care nurse practitioner prescribed bupropion and prazosin.³⁷ In fall 2017, when the patient reported anxiety, clonazepam was added.³⁸

The patient saw a new PCP (PCP 2) at the facility's Tupelo Community Based Outpatient Clinic in fall 2017, the patient's first visit to the facility's primary care service since summer 2015.³⁹ Routine laboratory tests showed abnormal thyroid function, indicating hyperthyroidism.⁴⁰ PCP 2 assessed the abnormalities as "mild" and recommended monitoring these laboratory tests every six months. The EHR did not contain evidence that PCP 2 ordered follow-up thyroid function laboratory tests until late summer 2018.

When the patient saw PCP 2 in late summer 2018 for a routine annual exam, laboratory tests again showed abnormal thyroid function. PCP 2 communicated the test results to the patient by letter the following day, advising the patient of a plan to monitor and consult with a facility endocrinologist.⁴¹ Two days later, PCP 2 placed an electronic consult to the endocrinologist who recommended additional laboratory tests, a thyroid ultrasound, and advised that the patient be scheduled for an office consultation with the Endocrinology Service "for management of hyperthyroidism."⁴² The facility's Endocrinology Service documented that the patient could see a community care endocrinologist "if patient does not want to be seen in Memphis due to [the patient's] distance from our location." The facility program support staff documented unsuccessful attempts to reach the patient by phone, and sent letters to the patient to schedule the

³⁷ Bupropion is an antidepressant medication. <https://www.pdr.net/drug-summary/Wellbutrin-bupropion-hydrochloride-237.5886?mode=preview>. (The website was accessed on January 2, 2020.) Prazosin is a medication prescribed to prevent nightmares in patients with PTSD. <https://www.pdr.net/drug-summary/Minipress-prazosin-hydrochloride-999>. (The website was accessed on December 18, 2019.)

³⁸ Clonazepam is a benzodiazepine medication used to treat anxiety. <https://www.pdr.net/drug-summary/Klonopin-clonazepam-3064>. (The website was accessed on December 18, 2019.)

³⁹ Primary care appointments scheduled in fall 2015, fall 2016, and summer 2017 were canceled due to provider leave. Primary care appointments in early 2017, early summer 2017, and late summer 2017 were canceled by the patient, and the patient did not show for a scheduled primary care appointment in spring 2017. The patient attended a primary care appointment in early fall 2017.

⁴⁰ Hyperthyroidism is a condition caused by an overactive thyroid. Laboratory values in hyperthyroidism are characterized by elevated T4 and/or T3 and low TSH levels. <https://www.thyroid.org/wp-content/uploads/patients/brochures/ata-hyperthyroidism-brochure.pdf>. (The website was accessed on January 13, 2020.)

⁴¹ For the purposes of this report, the consultation ordered for the patient's thyroid monitoring will be the endocrinology consultation. Merriam-Webster, *Definition of endocrinologist*. An endocrinologist specializes in a branch of medicine concerned with disorders of the endocrine system hormones, including the thyroid. <https://www.merriam-webster.com/dictionary/endocrinologist>. (The website was accessed on February 10, 2020.)

⁴² VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016, was in effect when the endocrine consult was initiated and was superseded by VHA Directive 1232(2), *Consult Processes and Procedures*, August 23, 2016, which had same or similar language regarding consults. The endocrine consult was placed during the time frame of 1232(1). An electronic consult (e-consult) allows consult question to be answered without face to face examination of the patient; Merriam-Webster, *Definition of ultrasound*. An ultrasound is a diagnostic test that uses vibration to form an image of internal body structures to detect abnormalities. <https://www.merriam-webster.com/dictionary/ultrasound>. (The website was accessed on February 10, 2020.)

thyroid ultrasound and Endocrinology Clinic appointment. An Endocrinology Clinic nurse practitioner spoke to the patient on the telephone, noted that the patient preferred to repeat labs before “wasting a whole day of work” at the facility’s Endocrinology Clinic, and discontinued the endocrinology consult. Facility staff did not document offering the patient a community care referral to see an endocrinologist. The EHR did not contain evidence that the patient completed the recommended labs and thyroid ultrasound, or was ever seen by an endocrinologist.

The patient continued to see the community care licensed counselor through late fall 2018, and the community care nurse practitioner through spring 2019 for medication management to treat anxiety, depression, and insomnia. Community care mental health records repeatedly noted that the patient denied suicidal thoughts.

In summer 2019, the patient accompanied by a family member went to the facility’s Emergency Department and reported difficulty sleeping and being out of psychiatric medications for three days. The Emergency Department physician documented evaluating the patient and reviewing the patient’s medications and described the patient as awake, alert, and in no distress. After a negative screen for suicidal thoughts, the Emergency Department physician discharged the patient with the diagnosis of PTSD and a plan to refer the patient to mental health services for “medical management.” The Emergency Department physician’s discharge instructions advised the patient to “REPORT TO MH [mental health] CLINIC NOW.” The EHR did not contain evidence that the patient presented to or was treated in the facility’s Outpatient Mental Health Clinic.

That same day, the patient reported to the facility’s pharmacy and received a partial 10-day refill of an antidepressant medication, fluoxetine, but did not receive prazosin or temazepam.⁴³ Review of facility pharmacy records revealed that the patient had contacted the VA Mail Order Pharmacy to refill medications two days prior to the Emergency Department visit. The temazepam was mailed one day following the patient’s call for refills, however fluoxetine and prazosin were not mailed until five days after the patient’s call to the VA Mail Order Pharmacy.⁴⁴ The patient died by a self-inflicted gunshot wound one day after the visit to the Emergency Department. An autopsy by the State Medical Examiner ruled the manner of the patient’s death as suicide.

⁴³ Fluoxetine is an antidepressant medication. <https://www.pdr.net/drug-summary/Fluoxetine-Hydrochloride-fluoxetine-hydrochloride-24302>. (The website was accessed on December 18, 2019.) Prazosin is a medication prescribed to prevent nightmares in patients with PTSD. <https://www.pdr.net/drug-summary/Minipress-prazosin-hydrochloride-999>. (The website was accessed on December 18, 2019.) Temazepam is a medication used to treat insomnia. <https://www.pdr.net/drug-summary/Restoril-temazepam-793>. (The website was accessed on December 18, 2019.)

⁴⁴ The patient received medications from the VA Mail Order Pharmacy, which processes prescriptions and mails them to outpatients. https://www.pbm.va.gov/PBM/CMOP/VA_Mail_Order_Pharmacy.asp. (The website was accessed on February 10, 2020.)

Inspection Results

1. Allegation: Patient Did Not Receive the Care Needed

The OIG substantiated that the patient presented to the facility's Emergency Department seeking treatment for insomnia and was out of psychiatric medications but did not receive the care needed. The OIG found that the facility did not have a clear referral process for patients discharged from the Emergency Department in need of same day psychiatric medication management.

As part of VHA's same day access effort, patients in need of mental health treatment are to receive services the same day.⁴⁵ In summer 2019, the patient, accompanied by a family member, presented to the Emergency Department reporting difficulty sleeping and being out of psychiatric medications for three days. Emergency Department nursing staff and the Emergency Department physician assessed the patient and documented in the EHR that the patient was alert, denied suicidal thoughts, and was having difficulty sleeping. The Emergency Department physician documented discharging the patient at 9:33 a.m., with instructions to go to the facility's Outpatient Mental Health Clinic immediately for assistance with medication management; however, the OIG found no documentation that the patient registered or received treatment in the clinic.⁴⁶

The OIG found that the facility's Emergency Department Mental Health Handbook did not define a clear process for Emergency Department patients who require psychiatric medication management. The handbook indicates consults can be placed for outpatient needs and "[i]f the ER [Emergency Department] Physician wants to prescribe or alter medications that is at their discretion."⁴⁷ The Emergency Department physician stated that the Emergency Department's practice was to direct patients to the Outpatient Mental Health Clinic during business hours for medication refills and that a formal written consult was not required. The physician also reported telling the patient "the mental health clinic [Outpatient Mental Health Clinic] is open for walk-in; go right over there and they will manage your meds [medications] and get you refills."

While the OIG found no documentation that the patient registered in the Outpatient Mental Health Clinic, the patient's family member described accompanying the patient to the Outpatient Mental Health Clinic after leaving the Emergency Department, speaking with staff at the clinic's registration area, providing personal identifiers, and waiting approximately one hour to be seen by a staff member. During the discussion with the clinic staff member, the family member

⁴⁵ Deputy Under Secretary for Health for Operations and Management (10N), *Same Day Services Capabilities for Mental Health and Primary Care Survey*, November 30, 2016.

⁴⁶ The facility has a same-day access Outpatient Mental Health Clinic located on the second floor, above the Emergency Department.

⁴⁷ Facility Handbook, *Emergency Department Mental Health Handbook*, March 5, 2019.

recalled being told that the next available appointment was in one month and to contact the community care mental health provider. Additionally, the family member reported that a staff member called the facility's pharmacy and requested a partial refill of fluoxetine and directed the patient and family member to pick up the medication from the pharmacy.

Pharmacy staff did not recall the patient or having been contacted by Outpatient Mental Health Clinic staff, but stated the pharmacy's practice was to dispense a partial refill if a patient has a current prescription. Pharmacy records reflect that the patient received a partial refill for fluoxetine at 11:30 a.m.

The OIG found the Emergency Department physician determined that the patient needed psychiatric medication management by the Outpatient Mental Health Clinic; however, the Emergency Department physician relied on an informal process and did not order a consult for the patient's referral to the clinic. The OIG concluded that the facility did not have a clear referral process for patients discharged from the Emergency Department who needed to be seen the same day in the Outpatient Mental Health Clinic for medication management.

Related Care Concerns During the Patient's Visit to the Facility

The OIG identified three additional concerns with the care the patient received during the facility visit:

- The facility lacked written and clear guidance on the patient referral process from Emergency Department physicians to mental health providers who are co-located within the Emergency Department.
- The patient's medication list was not accurate at the time of discharge.
- The facility had gaps in the Outpatient Mental Health Clinic check-in process for patients without an appointment.

Emergency Department Referral to Mental Health Provider

The OIG was unable to determine whether the Emergency Department physician referred the patient to the Emergency Department mental health provider, due to the lack of an entry in the EHR and the written and clear patient referral process to Emergency Department mental health providers.

VHA policy requires all emergency departments to have a licensed mental health provider on-site or on-call during all hours of operation.⁴⁸ Facility policy states that Emergency Department

⁴⁸ VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017.

physicians “must involve MH [mental health] staff present in the ER [Emergency Department] ... in the assessment of all patients presenting with behavioral health issues.”⁴⁹

The facility has a mental health provider in the Emergency Department 24 hours a day to be the liaison for patients in the Emergency Department and the facility’s mental health programs.⁵⁰ However, the facility did not have written or clear guidance on the process for Emergency Department physicians to refer patients to Emergency Department mental health providers for a mental health assessment.

The Emergency Department physician and Emergency Department mental health provider told the OIG differing accounts of the department’s patient referral process. Both described an informal (not in writing) process in which the Emergency Department physician would ask the mental health provider to see patients. During interviews, the Emergency Department physician reported telling the Emergency Department mental health provider about the patient who needed medication refills. However, the Emergency Department mental health provider had no recollection of having a conversation with the Emergency Department physician regarding the patient’s medication refill or being asked to assess the patient.

The OIG did not find evidence in the EHR that the Emergency Department physician referred the patient to or had a discussion with the Emergency Department mental health provider about the patient’s mental health or medication treatment needs. Without documentation of an Emergency Department patient referral to mental health providers, patients are at risk for receiving inadequate care.

Medication Reconciliation

The OIG determined that the Emergency Department physician did not adequately reconcile the patient’s medications during the patient’s summer 2019 Emergency Department visit.

VHA established a medication reconciliation process to maintain and communicate accurate patient medication information by identifying, addressing, and documenting discrepancies between the medication list found in the EHR and the patient’s verbal report.⁵¹

The OIG reviewed the patient’s EHR and the state prescription drug monitoring program report and found that the medication list documented in the Emergency Department note included two current medications (bupropion and buspirone) that had been discontinued by the community

⁴⁹ Facility Policy 116A-12, *Management of Patients at Risk for Suicide*, February 26, 2018.

⁵⁰ Facility Handbook, *Emergency Department Mental Health Handbook*, March 5, 2019.

⁵¹ VHA Directive 2011-012, *Medication Reconciliation, March 9, 2011*. VHA defines medication reconciliation as a process which identifies, addresses, and documents medication discrepancies.

care nurse practitioner and a discrepancy in the dosage in another medication (clonazepam).⁵² When asked about completing medication reconciliation during the patient's visit, the Emergency Department physician reported "we talked about all...meds [medications]" and the patient had been out of medications for a few days, was getting some medications refilled from VHA and others from community pharmacies. The Emergency Department physician documented that the patient "has yet to contact...any providers to obtain refills" and having reviewed the medication list with the patient prior to discharge from the Emergency Department. The family member who accompanied the patient to the Emergency Department stated that when the Emergency Department physician asked about medications, the patient got confused and could not figure out which medications were from the VA and which were from the community care nurse practitioner.⁵³ The family member reported not knowing if a detailed medication list was made during the Emergency Department visit.

The OIG found that the Emergency Department physician did not identify, address, or document medication discrepancies. Accurate medication information can reduce the risk of injury, particularly for patients who receive care from multiple providers or patients who receive multiple medications.⁵⁴

Outpatient Mental Health Clinic Check-in Process

The OIG found that the current check-in process for patients presenting to the Outpatient Mental Health Clinic without an appointment did not include registering the patients into the facility's scheduling system upon arrival.

Mental health leaders (Section Chief, Mental Health Social Work, and Chief, Mental Health), reported that program support staff would register a patient who presented to the Outpatient Mental Health Clinic into the computer scheduling system to create an appointment prior to a patient being seen by a clinic nurse. However, the Section Chief Mental Health Social Work and Chief Mental Health, could not verify the patient presented to the Outpatient Mental Health Clinic after being seen in the Emergency Department due to lack of documentation.

The OIG team toured the Outpatient Mental Health Clinic and spoke with program support staff about the clinic check-in process for patients without appointments. Two of the clinic staff described different methods for communicating to nursing staff that an unscheduled patient

⁵² Buspirone is an anti-anxiety medication. <https://www.pdr.net/drug-summary/Buspirone-Hydrochloride-Tablets--USP--5-mg--10-mg--15-mg--30-mg--buspirone-hydrochloride-1524.2496>. (The website was accessed on January 2, 2020.) The prescription drug monitoring program (PDMP) is an electronic database used by healthcare providers to review and track controlled substance prescriptions, which can aid in identifying patients that may be at risk for overdose or misuse of certain medications. <https://www.cdc.gov/drugoverdose/pdmp/providers.html>. (The website was accessed on April 30, 2020.)

⁵³ The patient received medications from the VA Mail Order Pharmacy and community pharmacy.

⁵⁴ VHA Directive 2011-012.

presented to the clinic and was requesting to be seen. Additionally, program support staff described a registration process that included registering a patient in the computer scheduling system after clinic nursing staff assessed the patient.

The OIG was unable to determine whether the patient presented to, or was treated in the Outpatient Mental Health Clinic because there was no documentation in the EHR of staff contact with the patient or that the patient attended an unscheduled appointment. At the conclusion of the site visit, the OIG expressed concern to the Executive Leadership Team that unscheduled patients presenting to the Outpatient Mental Health Clinic may not get registered, which may result in a patient not being triaged or receiving mental health care.

In January 2020, facility leaders implemented changes in the Outpatient Mental Health Clinic to include posting temporary signs in the clinic indicating that unscheduled appointments are available and directing patients to register with program support staff.⁵⁵ In addition, facility leaders were developing a patient registration standard operating procedure.

2. Additional Concerns: Coordination of Care Between Primary Care and Endocrinology

The OIG found that while eligible for community care treatment, the endocrinology nurse practitioner did not offer the patient a community care endocrinology consult. The OIG determined that PCP 2 ordered an endocrinology consult and ultrasound; however, did not follow up with or clinically reassess the patient when the consult and ultrasound order were discontinued. Further, the OIG found that on two occasions between late summer 2018 and early spring 2019, PCP 2 did not update the patient's non-VA medication list with the correct medication dosage, which resulted in an incorrect EHR medication list.

Endocrinology Clinic Failure to Offer the Patient Community Care

VHA defines care coordination as “the administrative process that facilitates integration of health care services and navigation through complex health care systems. Care coordination involves working across care settings, accessing health care providers, and other services such as community programs, when appropriate.”⁵⁶

In summer 2018, after the patient's thyroid function laboratory tests were abnormal, PCP 2 sent a letter notifying the patient of the laboratory test results and ordered an endocrinology consult. An endocrinology physician received the consult, agreed that endocrinology would see the patient and requested additional thyroid function laboratory tests and a thyroid ultrasound for further evaluation of the patient's hyperthyroidism. An endocrinology resident documented in the EHR

⁵⁵ Facility leaders used temporary signage until permanent signage could be completed.

⁵⁶ VHA Handbook 1101.10(1).

consult that the patient could be sent to a community care endocrinologist “if patient does not want to be seen in Memphis due to [the patient’s] distance from our location.” PCP 2 ordered the recommended additional thyroid function laboratory tests and a thyroid ultrasound to be conducted at the facility.

In fall 2018, the facility’s Endocrinology Clinic and radiology program support staff attempted to schedule the patient for an Endocrinology Clinic appointment and an ultrasound. After being unable to contact the patient, the Endocrinology Clinic staff referred the consult to the endocrinology nurse practitioner who discontinued the consult after speaking with the patient, indicating that the patient declined to see endocrinology. The endocrinology nurse practitioner also documented a request for PCP 2 to discuss the plan with the patient and place another consult if the patient agrees to see an endocrinology provider.

The endocrinology nurse practitioner told the OIG that the call to the patient was an effort to schedule an endocrinology appointment prior to discontinuing the consult. The nurse practitioner did not recall speaking with the patient about community care endocrinology services and explained that the program support staff usually speak with patients about community care.

Facility radiology scheduling staff called the patient to schedule the ultrasound and after being unable to reach the patient by phone, sent the patient a letter with a request to call the facility to schedule the ultrasound.⁵⁷ After no response, radiology scheduling staff discontinued the thyroid ultrasound order following VHA policy.⁵⁸

The OIG determined that Endocrinology Clinic staff and radiology scheduling staff followed VHA policy for consult review, appointment scheduling, and discontinuation of the endocrinology consult and ultrasound order; however, the endocrinology nurse practitioner did not offer the patient a community care endocrinology consult. Hyperthyroidism is associated with psychiatric symptoms including anxiety, insomnia, and confusion. Failure to evaluate and treat a thyroid disorder may have contributed to the patient’s anxiety and insomnia.

Primary Care Provider’s Failure to Reassess Hyperthyroidism

VHA policy states the provider requesting the consult is responsible for ensuring patients receive timely care, and for reviewing discontinued consults to determine if further care is necessary.⁵⁹

⁵⁷ Merriam-Webster, *Definition of Radiology*. Radiology is type of medicine that uses radiant energy to aid in diagnosis or treatment. <https://www.merriam-webster.com/dictionary/radiology?src=search-dict-box>. (The website was accessed on February 10, 2020.)

⁵⁸ VHA Directive 1230(1), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended July 12, 2019.

⁵⁹ VHA Directive 1232(1).

Providers receive a view alert for discontinued consults and orders and are required to review the alert to determine if additional treatment is needed.⁶⁰

During an OIG interview, PCP 2 acknowledged forgetting about the patient's endocrinology consult and did not recall receiving a view alert for the discontinued consult. The facility Chief of Staff told the OIG that PCP 2 should have received a view alert when the consult was discontinued, and it would be the responsibility of PCP 2 to reorder a consult if necessary.

The OIG reviewed view alert reports and found that PCP 2 received a view alert for both the discontinued endocrinology consult and ultrasound order. However, the OIG was unable to determine if PCP 2 read the view alerts or reviewed the discontinued endocrinology consult and ultrasound order.

The OIG found that PCP 2 did not clinically reassess the patient's need or refer the patient for endocrinology care when the consult and ultrasound order were discontinued.⁶¹ Failure to further evaluate the patient's hyperthyroidism represented a missed opportunity to treat a disorder that may have contributed to the patient's psychiatric illness.

Primary Care Provider's Failure to Reconcile Medications

VHA and facility policy requires that providers reconcile medications before and after a patient evaluation, and "at every episode or transition in level of care where medications will be administered, ordered, modified, or may affect the care given."⁶²

PCP 2 checked the state prescription drug monitoring program in summer 2018 at the time of the patient's primary care appointment, and in spring 2019 prior to writing a prescription for the patient's clonazepam refill. The OIG identified that PCP 2 did not update the patient's EHR non-VA medication list to reflect the higher dosage of clonazepam from the summer 2018 and spring 2019 prescription drug monitoring reports. When the OIG asked PCP 2 about medication reconciliation completion, PCP 2 indicated that nursing staff were usually tasked with completing medication reconciliation.

The OIG determined that PCP 2 did not complete medication reconciliation as required by VHA policy. Accurate medication information is necessary especially when multiple providers are providing treatment and patients are receiving multiple medications.⁶³

⁶⁰ View alerts are EHR notifications that provide information to staff about clinical or administrative events to review and determine whether further action is needed.

⁶¹ VHA Directive 1232(1).

⁶² VHA Directive 2011-012; Facility Policy 119-06, *Medication Reconciliation Process*, October 16, 2017.

⁶³ VHA Directive 2011-012.

3. Additional Concerns: Inadequate Oversight of Mental Health Community Care

The Choice program was established into law in 2014 to provide eligible patients with access to many VHA services, including mental health care, through a network of community providers managed through a contractual third party administrator (TPA).⁶⁴ On November 5, 2014, the Choice program introduced the 40 mile eligibility criteria which authorized services to enrolled patients residing greater than 40 miles from the nearest VA facility.⁶⁵ VHA authorized the TPA, TriWest Healthcare Alliance (TriWest), to facilitate healthcare services to patients approved to receive care from community providers including those eligible under the Choice 40 criteria.⁶⁶ See [appendix A](#) for additional information about the Choice program.

Gaps in Community Care Mental Health Treatment

The OIG found the patient did not receive several community care counseling sessions due to deficiencies in coordination of care between the facility community care staff, community care providers, and the TPA. The OIG also found that the facility lacked clinical oversight of the patient's community care, which may have contributed to gaps in the patient's community care mental health treatment.

Coordination of Community Care

The Joint Commission requires facilities “to coordinate the patient’s care, treatment and services” when external resources are used to meet the patient’s needs.⁶⁷ VHA established procedures for Transition and Care Management Teams to facilitate the transition of care, coordinate services, and provide case management for patients in need of care management

⁶⁴ U.S. Department of Veterans Affairs, VA Fact Sheet, Veterans Access, Choice, and Accountability Act of 2014 Title 1: Choice Program and Health Care Collaboration. VHA Publication, Veterans Access, Choice and Accountability Act of 2014 (VACAA). The Choice Program and the Choice Card, March 2015. A third party administrator is a company that VA has a contract with to manage the Choice program. TriWest Healthcare Alliance, Department of Veteran Affairs Patient-Centered Community Care (PC3) and Veterans Choice Program (VCP) Provider Handbook, 2019.

⁶⁵ VHA Publication, *Veterans Access, Choice and Accountability Act of 2014 (VACAA). The Choice Program and the Choice Card*, March 2015. VACAA required hospital care and medical services to be provided to veterans with specified non-VA facilities if the veterans resided more than 40 miles away from a VA medical facility or an appointment could not be scheduled at a VA medical facility within the VA’s wait time goals. TriWest Healthcare Alliance, *Provider Fact Sheet*, January 2019.

⁶⁶ U.S. Department of Veterans Affairs Patient-Centered Community Care (PC3) - Community Care, “Patient-Centered Community Care (PC3)”, April 11, 2019.
<https://www.va.gov/COMMUNITYCARE/programs/veterans/pccc/index.asp>. (The website was accessed on December 9, 2019.)

⁶⁷ The Joint Commission is a nationally recognized organization which accredits healthcare organizations based on quality and safety standards. An external resource is identified as a resource available to veterans outside of the VA.

services.⁶⁸ The transition patient advocate has a primary role to assist patients in accessing services needed at the facility and in the community.

In late 2016, psychologist 2 placed a consult for the patient to receive community care mental health counseling; facility community care staff approved the request and authorized both counseling and medication management for six months.⁶⁹ In early 2017, the patient began treatment with a community care nurse practitioner (for medication management) and a community care licensed counselor (for counseling sessions).

In fall 2017, the patient contacted the transition patient advocate and requested additional treatment with the community care providers. The following day, psychologist 2 placed a new consult for 24 additional community care treatment sessions over six months. Three weeks later, the facility community care staff contacted the TPA to schedule the appointments; however, the OIG found that the TPA scheduled the appointment two months after the community care staff contact. The patient continued to see the community care licensed counselor through late fall 2018, and the community care nurse practitioner through late spring 2019.

In late fall 2018, the community care licensed counselor terminated counseling sessions due to developing a friendship with the patient outside the professional environment.

The OIG did not find that the community care licensed counselor documented terminating counseling sessions, submitted medical record documentation to the facility, or referred the patient to another mental health counselor. When asked about making recommendations for another therapist to continue with treatment, the community care licensed counselor reported having encouraged the patient to stay on the medications and to promptly address issues if they were to arise. The OIG did not find that the community care licensed counselor advised the patient on how to obtain assistance should issues arise.

The OIG identified a three-month delay from the time when the patient contacted the transition patient advocate requesting additional treatment, to when the TPA scheduled the community care counseling appointments. The OIG was unable to find documentation to explain the delay, but determined the change in VHA community care eligibility rules, which gave the TPA scheduling responsibilities, may have contributed to the delay. The OIG also determined that the patient did not receive community care counseling after fall 2018.

The OIG concluded that due to the lack of community care coordination, the patient did not attend several counseling sessions and was not afforded the opportunity to discuss any worsening symptoms.

⁶⁸ VHA Directive 1010. Transition Care Management Team includes the Transition and Care Management Program Manager, nurse and social worker case managers, and transition patient advocates.

⁶⁹ The facility authorization was for a psychiatrist for mental health and medication management, but the community care services were provided by a mental health nurse practitioner.

Clinical Oversight of Community Care

The OIG team interviewed staff to determine responsibility for clinical oversight of patients receiving community care services. The Acting Chief, Community Care stated that when medical records from community care providers are available in the EHR, the referring provider has responsibility for clinical oversight, but if records are not available, the responsibility is unclear. The community care nurse manager stated the community care provider is considered an extension of VHA and is responsible for the patient's care. Psychologist 2 stated that once a community care consult is placed, the process for clinical management is unclear, but that the facility's community care staff coordinates care. Psychologist 2 also expressed concerns that patients receiving care from a community care provider could get lost in the system or forgotten. Other staff expressed uncertainty and concerns about the lack of community care coordination.

The OIG determined that there were gaps in the patient's community care mental health treatment and opined that the facility's lack of designated staff to review the patient's community care treatment contributed to these gaps.

Failure to Obtain Mental Health Community Care Medical Records

The OIG determined that facility community care staff did not obtain medical record documentation for treatment the patient received from community care providers after early fall 2017.⁷⁰

VHA requires community care providers to submit medical record documentation within 30 calendar days of the initial appointment and at the end of each episode of care to ensure continuity of care.⁷¹ VHA is responsible for contacting community providers, including providers for patients eligible under Choice 40, if medical record documentation is incomplete or not provided.⁷²

During interviews, the facility community care nurse manager and staff stated that they were aware of the requirement to obtain medical record documentation, but because the patient was receiving care under Choice 40 eligibility criteria, they were not required and did not make attempts to obtain the medical records. The facility community care nurse manager stated

⁷⁰ The OIG discussion regarding the absence of community care medical records after fall 2017 coincides with when the patient began requesting assistance from the facility to obtain prescriptions in fall 2017.

⁷¹ TriWest Healthcare Alliance, Department of Veterans Affairs Patient-Centered Community Care and Veterans Choice Program Provider Handbook, 2019; Veterans Health Administration, VA Community Care VCP Provider Agreement Information Sheet; TriWest Healthcare Alliance, Behavioral Health Authorization Forms, 2019.

⁷² U.S. Department of Veterans Affairs, Medical Documentation—Veteran Choice Program, updated June 5, 2019; TriWest Healthcare Alliance, Medical Documentation Requirements—Quick Reference Guide—All Regions, April 26, 2019.

community care medical records were received in 2016, but when the patient's eligibility was changed in 2017 to Choice 40, no further attempts were made to retrieve the records.

Initially, the OIG found EHR documentation for 2 of 37 counseling and medication management sessions the patient received (summer 2017, and fall 2017). For community care services the patient received between fall 2018 and late 2018, the OIG made several written requests to the facility and community care providers and obtained all 19 medical records for counseling services, and 12 of 18 records for medication management visits.

The OIG did not find evidence that facility community care staff obtained the patient's medical records from community care providers after early fall 2017. Additionally, the OIG could not find documentation to support the facility community care staff's statements that they were not required to obtain medical records for the patient receiving care under Choice 40 criteria. Without the medical record documentation, facility staff were unable to review the care provided, impacting the ability to coordinate the patient's mental health care.

Untimely Care Authorization Requests

The OIG determined that on multiple occasions between fall 2017 and spring 2019, the patient was unable to refill several medications at the facility pharmacy that were prescribed by the community care nurse practitioner due to expired care authorizations.⁷³ The OIG found that the community care nurse practitioner did not submit authorizations to the TPA as required and facility community care staff did not approve authorizations timely.

Facility policy states that a current authorization for community care is required for the pharmacy to dispense medications to patients from prescriptions written by community care providers.⁷⁴

Between early fall 2017 and spring 2019, the patient was prescribed six psychiatric medications. One medication (bupropion) was not filled at the facility pharmacy in fall 2017 due to an expired authorization.

In early fall 2017, the community care nurse practitioner's office faxed a prescription to the facility pharmacy to be filled. A facility pharmacist identified that the authorization was expired and notified the community care nurse practitioner that the prescription could not be refilled due to the expired authorization, and provided instructions on how to submit an authorization request to the TPA. A facility pharmacist also sent a letter to the patient with information about the

⁷³ TriWest Healthcare Alliance, *Behavioral Health Authorization Forms*, 2019. A secondary authorization request (authorization) is required when the initial authorization expires, but the community care provider wishes to extend treatment. After the initial authorization for community care services expired, the community care providers were required to submit an authorization to the TPA for review and approval of continued care.

⁷⁴ Facility Policy 119-01, *Pharmacy Service*, October 16, 2017.

expired authorization and a request for the patient to contact the community care nurse practitioner.

Also, in early fall 2017, the community care nurse practitioner's office faxed an authorization and medical record documentation from recent appointments with the patient to the TPA. A few weeks later, a facility member scanned the authorization and medical record documentation into the patient's EHR and completed the initial consult; however, the OIG could not find evidence that facility community care staff approved the authorization.⁷⁵

During interviews with the OIG, the facility community care nurse manager and nursing staff described that department practices included staff reviewing community care provider medical record documentation from previously approved care to complete consults and approve new authorizations. The community care nurse manager told the OIG of being unable to view the fall 2017 authorization on the shared internet site, and that if the TPA would have placed the authorization on the site, community care nursing staff would have had the ability to view and approve the authorization.⁷⁶

The OIG found that in late spring 2018, the TPA sent a letter to the community care nurse practitioner's office, which authorized care previously provided from early fall 2017 through late spring 2018.

The OIG also identified that five of the patient's medications (fluoxetine, buspirone, prazosin, temazepam, and clonazepam) were not filled at the facility between summer 2018 and summer 2019 due to a second expired authorization.

In summer 2018, a facility pharmacist could not refill prescriptions received from the community care nurse practitioner due to another expired authorization. The facility pharmacist notified the community care nurse practitioner that the patient's prescriptions could not be refilled, and provided instructions on how to submit an authorization request to the TPA. Pharmacy staff sent another fax to the community care office two months later to follow up on the authorization request.

The community care nurse practitioner's office provided documentation to the OIG that indicated two faxes with an authorization request were sent in fall 2018. However, the OIG did not find documentation that the TPA received or submitted the authorization to the shared internet site, or that facility community care staff approved the authorization.

In late fall 2018, the patient contacted the community care nurse practitioner's office twice inquiring about medications; the community care nurse practitioner's office contacted a local

⁷⁵ Community care providers were required to submit recent medical record documentation from care provided along with an authorization for additional services.

⁷⁶ The TPA established an internet site for VHA, TPA, and community care providers to access medical record documentation and authorizations.

community pharmacy to fill a 30-day prescription (fluoxetine). In late 2018, the patient saw the community care nurse practitioner who documented a plan for the patient to continue five medications (fluoxetine, buspirone, prazosin, temazepam, and clonazepam), and that the patient requested written prescriptions to fill at a local pharmacy. The OIG found that the patient filled temazepam at the local pharmacy in late 2018 and early 2019 but could not determine whether the four other prescriptions were filled.⁷⁷

In spring 2019, the patient called the transition patient advocate and reported not being able to receive community care mental health services for two months, being out of mental health medications, and the inability to sleep. The transition patient advocate notified PCP 2, who renewed two of the patient's medications (temazepam and clonazepam) for two months, and the facility community care staff who approved an authorization for the patient to resume community care treatment with the community care nurse practitioner through spring 2019. The same day the patient filled the temazepam and clonazepam prescriptions at the local pharmacy.

The OIG determined that the community care nurse practitioner's office faxed authorizations to the TPA for additional care after previous authorizations expired, and that facility community care staff reported not approving authorizations timely because the TPA did not submit the authorizations to the shared internet site for the staff to view and approve. Without current authorizations the patient was unable to refill several medications at the facility pharmacy.

Inadequate Clinical Review of Authorizations

The OIG determined that the facility clinical delegates did not complete a clinical review of authorizations for the patient.⁷⁸ VHA policy requires the facility to designate staff to conduct a clinical review of community care authorizations.⁷⁹ The facility designated three community care nurse practitioners to complete community care clinical reviews.

During interviews, facility community care leaders and staff reported differing understandings of the requirements for and responsibilities of community care nursing staff to approve authorizations. The Acting Chief, Community Care stated that the process was for the facility nurse practitioner to review and authorize community care. Another community care leader (nurse manager) stated a facility community care nurse could approve the patient's authorization without consulting a physician prior to approval. A facility community care nurse reported

⁷⁷ The OIG reviewed the state prescription drug monitoring program and facility pharmacy reports.

⁷⁸ A clinical review process includes using standardized and evidence-based guidelines to review requested services for a patient to ensure clinical appropriateness prior to authorization for services. A clinical delegate is appointed by the Chief of Staff to review, approve, deny, or extend community care services.

⁷⁹ Deputy Under Secretary for Health for Operations and Management (10N), *Community Care Utilization Management Program Guidance*, January 8, 2018.

approving the patient's authorizations and not consulting a physician because of being unable to locate an identified PCP for the patient in the EHR.

The OIG found that a facility community care nurse approved authorizations for the patient's community care mental health services in early 2018 and spring 2019 without ensuring that one of the designated clinical staff reviewed the authorizations. The OIG also found that community care nursing staff lacked a clear understanding of the requirements for a clinical review prior to the approval of the patient's community care authorization; a clinical review would have afforded the opportunity for the facility to evaluate and identify gaps in the patient's community care mental health treatment.

4. Other Findings: Deficiencies in the Facility's Response After the Patient's Death

Following the patient's death by suicide, a family member submitted a complaint to the transition patient advocate. The OIG determined that the facility failed to address, document, and resolve the complaint. The OIG identified other deficiencies in the facility's completion of the supervisory fact finding (fact finding), behavioral health autopsy report, issue brief, and root cause analysis.⁸⁰

Family Member Complaint

The facility's patient advocacy program policy requires the facility to

- Provide a response to the complainant, which addresses the complaint issues within seven days of receipt,
- Resolve complaints timely,
- Input complaints in the Patient Advocate Tracking System, and

⁸⁰ Deputy Under Secretary for Health for Operations and Management (10N), *10N Guide to VHA Issue Briefs*, March 29, 2018. Issue briefs provide information to VHA leaders regarding an event or issue and allows leadership to determine whether policies surrounding the event were met; VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. Root Cause Analysis "is a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."; Department of Veterans Affairs Data.Gov. <https://catalog.data.gov/dataset/behavioral-health-autopsy-program-bhap>. (The website was accessed November 18, 2019.) Department of Veterans Affairs defines a behavioral health autopsy report as a document that VHA suicide prevention coordinators complete that includes behavioral data about a veteran prior to death by suicide.

- Follow issues until closure.⁸¹

Service chiefs and supervisors are responsible to ensure employees review and resolve complaints timely. Resolution of a complaint entails that the complainant was contacted by the staff member who assumed the responsibility to resolve the complaint and to verify that issues were addressed and resolved.⁸²

In summer 2019, the patient's family member sent an email to the transition patient advocate identifying inadequate care the patient received from the facility's Emergency Department and a mental health staff member.⁸³ The email also included information about the patient's death by suicide the day following the patient's visit to the facility's Emergency Department. The transition patient advocate responded promptly to the family member, expressed condolences, and indicated that the information would be given to facility leaders to address the care concerns, however, did not enter the complaint into the Patient Advocate Tracking System.

The transition patient advocate forwarded the email to the Transition and Care Management Program Manager (program manager), and requested assistance. The family member's email was shared with several facility leaders including the Chief of Staff; Deputy, Chief of Staff; Chiefs of Mental Health and Social Work; and the Section Chief, Mental Health Social Work. After receipt of the email, the Deputy, Chief of Staff requested completion of a "Heads Up" [Heads Up Message], which the Acting Supervisor, Suicide Prevention Program (acting supervisor) reported completing along with an issue brief.⁸⁴ The Executive Leadership Team submitted a Heads Up Message to the VISN regarding the veteran's death by suicide the day following the receipt of the family member's email.

The OIG concluded that despite several facility staff and leaders having awareness of the family member's complaint, no staff member assumed responsibility to contact the family, address, or resolve the complaint.

During interviews with the OIG, the transition patient advocate reported having been trained on the Patient Advocate Tracking System and having access to the system to enter complaints, but could not recall having entered the complaint into the system. The program manager confirmed that the transition patient advocate had responsibility to input complaints into the Patient

⁸¹ Facility Policy 00-73, *Customer Service Program-Putting Veterans First*, February 22, 2016. A patient advocate provides facility level response to customer concerns and documents compliments and complaints in the Patient Advocate Tracking system. Patient Advocate Tracking System is a computerized program used to document complaints, facility responses and resolution to complaints; VHA Handbook 1003.2, *Service Recovery in the Veterans Health Administration*, February 4, 2004.

⁸² Facility Policy 00-73, *Customer Service Program-Putting Veterans First*, February 22, 2016.

⁸³ The OIG determined the mental health staff to be the outpatient mental health staff.

⁸⁴ Deputy Secretary for Health for Operations and Management (10N), *10N Guide to VHA Issue Briefs*, March 29, 2018. A "Heads Up Message" is a brief summary of a significant issue while facts are collected for inclusion in an issue brief.

Advocate Tracking System, but had not thought to have the transition patient advocate input the complaint into the system. After reporting the complaint to the Chief, Social Work, the program manager thought that facility customer service staff would complete an assessment of the complaint and enter the complaint into the Patient Advocate Tracking System, and that mental health and executive leaders would address the serious care issue reported by the family member.

The Chief of Staff told the OIG of having thought that someone from service recovery followed up on the complaint; however, the Assistant Chief, Customer Service, reported not having awareness of the complaint and after checking the Patient Advocate Tracking System did not find that the complaint had been entered.⁸⁵ The Assistant Chief, Customer Service, indicated having responsibility along with staff in the service, to monitor complaints in the Patient Advocate Tracking System and addressing unresolved complaints with responsible staff and supervisors. The Section Chief, Mental Health Social Work, acknowledged that the facility's Suicide Prevention Program supervisor would have responsibility to follow up on family member concerns, but had no recollection of who was given responsibility for addressing the complaint or any follow up with the family.

The OIG determined that the transition patient care advocate did not input a complaint into the Patient Advocate Tracking System and the program manager did not ensure entry of the complaint into the system, which would have afforded the opportunity for customer service staff to monitor that the complaint was addressed and resolved.

Fact Finding

The OIG found that the documentation related to the fact finding stating that the Emergency Department mental health provider failed to assess the patient, resulted in facility leaders to pre-determine that a failure by the Emergency Department mental health provider had occurred. In addition, facility leaders did not consider conducting an administrative investigation to resolve the discrepancy between the information obtained from the Emergency Department mental health provider during the fact finding and the verbal statement the Emergency Department physician reported to the Section Chief, Mental Health Social Work, prior to the facility initiating the fact finding.

VHA policy indicates that the fact finding process is “used for initial gathering of facts associated with a particular incident, usually by collecting individual signed statements” and may necessitate the need for an administrative investigation to resolve conflicting statements.⁸⁶

⁸⁵ Facility Policy 00-73, *Customer Service Program—Putting Veterans First*, February 22, 2016. Service recovery is a medical center initiative led by the Chief, Customer Service to acquire feedback on complaints from patients, family members and visitors to make improvements.

⁸⁶ Department of Veterans Affairs, *Administrative Investigations: Do it Right the First Time Resource Guidebook*, July 2004.

The OIG learned that four days after the patient's death, the Chief, Mental Health requested that a fact finding be completed after the Emergency Department physician told the Section Chief, Mental Health Social Work, of having referred the patient to the Emergency Department mental health provider and that the provider did not assess the patient. Only two staff members, the Emergency Department mental health provider and the Emergency Department mental health provider's supervisor were interviewed during the fact finding. Each of the interviewees signed statements, which included the interview questions and answers. During the fact finding and in the interview with the OIG, the Emergency Department mental health provider reported no recollection of having a conversation with the Emergency Department physician regarding the patient or being asked to assess the patient. Facility leaders did not interview or obtain a signed statement from the Emergency Department physician during the fact finding.

The Chief of Staff told the OIG of believing the Emergency Department physician's account of having a conversation with and requesting a patient assessment from the Emergency Department mental health provider. The Chief of Staff reported believing the Emergency Department physician's account based on information from the fact finding and the Emergency Department physician's reputation.

The OIG determined that facility leaders relied on a statement outside of the fact finding and approached the initial gathering of facts in a manner inconsistent with VHA policy, which led facility leaders to believe the fact finding was done accurately. The OIG opined that the documentation from the fact finding identified a pre-determined failure, limited the scope of the facility review to the Emergency Department, and excluded concerns of inadequate care of the patient from the Outpatient Mental Health Clinic. In addition, the OIG determined that facility leaders should have considered conducting further review to address the differing accounts of the Emergency Department physician and Emergency Department mental health provider regarding the patient referral to ascertain whether the Emergency Department failed to follow facility policy.

Behavioral Health Autopsy Program

The OIG determined that the acting supervisor completed an insufficient behavioral health autopsy report by failing to contact the next of kin after the death of the patient. In December 2012, VHA implemented the Behavioral Health Autopsy Program, a VHA quality improvement

program “that seeks to understand the context of Veterans’ lives prior to their suicides.”⁸⁷
Following a patient’s death by suicide, suicide prevention coordinators are to

- Call the next of kin to offer condolences,
- Explain the family interview program to the next of kin and ask permission to be contacted for an interview to provide an opportunity for a family member to share information about a patient’s life, and
- Complete a behavioral health autopsy report including information of the patient’s history and related medical concerns identified from a medical record review.⁸⁸

The family interview program provides an opportunity for the survivor to share information about potential barriers to seeking assistance during times of distress.

The acting supervisor used information from the EHR and emails from the patient’s family member and another VA Medical Center (Jackson VA Medical Center) to complete the behavioral health autopsy report 12 days after the patient’s death. The acting supervisor also reported incorporating information obtained from community care medical record documentation in the behavioral health autopsy report but did not contact the facility community care staff to determine whether additional community care documentation was available.

The acting supervisor reported being unaware of the requirement to contact the family after the patient’s death due to a lack of training and having been told by the Section Chief, Mental Health Social Work, not to communicate with the patient’s family members. The Section Chief, Mental Health Social Work, reported not being aware of the requirement to contact the family and understood that information sources to complete the behavioral health autopsy report included the EHR and providers involved in the patient’s care.

The OIG concluded that the Section Chief, Mental Health Social Work, and acting supervisor’s lack of knowledge of the Behavioral Health Autopsy Program requirements and the absence of training of the acting supervisor contributed to the omission of contacting the next of kin after the patient’s death. The facility and VHA missed an opportunity to gain knowledge about the

⁸⁷ VA Deputy Under Secretary for Health for Operations and Management (10N), *Behavioral Autopsy Program Implementation*, December 11, 2012; VA VISN 2 Center of Excellence Newsletter, *Suicide Prevention News, Understanding Veteran Suicides- VA’s Behavioral Health Autopsy Program*, May 2015. https://www.mirecc.va.gov/suicideprevention/News/Newsdocs/1505_CoE_News_May.pdf. (The website was accessed on November 18, 2019.); The family interview program is part of the VA Behavioral Health Autopsy Program which allows the next of kin of a patient who died by suicide the opportunity to share information about the patient’s life, awareness of resources and potential barriers to seeking assistance during times of distress; VA’s Integrated Approach to Suicide Prevention: Ready Access to Quality Care *Suicide Prevention Coordinator Guide*, January 5, 2018.

⁸⁸ VA Deputy Under Secretary for Health for Operations and Management (10N), *Behavioral Autopsy Program Implementation*, December 11, 2012; VA’s Integrated Approach to Suicide Prevention: Ready Access to Quality Care *Suicide Prevention Coordinator Guide*.

deceased patient's life and barriers to seeking assistance when in distress, implement changes to reduce any identified barriers, and strengthen suicide prevention initiatives.

Issue Brief

The OIG found that the Chief, Mental Health, and social work leaders knew of the patient's death by suicide within three days of the patient's death; however, the Executive Leadership Team submitted a Heads Up Message to the VISN 12 days after the patient's death.⁸⁹ VHA policy states that submission of an issue brief for a patient death by suicide is not to exceed two business days from the time of the facility's awareness of the incident.⁹⁰

The Chief of Staff told the OIG of being notified about the patient who died by suicide after receipt of the family member's email complaint sent to the facility in summer 2019. However, the OIG found documentation that two days after the patient's death, the suicide prevention coordinator from another VA Medical Center (Jackson, Mississippi) sent an email to the facility's suicide prevention team with information about the patient's death by suicide.⁹¹

The OIG interviewed three facility staff (facility suicide prevention coordinator, a supervisory suicide prevention coordinator, and Section Chief, Mental Health Social Work), who received the email. Two staff members who received the email stated being off work the week following the patient's death; upon return to work, one of the employees reported submitting a draft issue brief for the patient's death by suicide to the Section Chief, Mental Health Social Work. The Section Chief, Mental Health Social Work, reported being told verbally two or three days after the patient's death and was unsure who reported the information but thought it was the Chief, Mental Health.

The Chief, Mental Health, indicated having learned of the patient's death when the Deputy, Chief of Staff, sent an email requesting a review of the patient's death the week after the patient had died by suicide. The Chief, Mental Health, reported that the Chief, Social Work, notified the Deputy, Chief of Staff, of an email the patient's family member sent to the facility with information about the patient's death by suicide after a visit to the Emergency Department, being sent to the Outpatient Mental Health Clinic and not getting care.

The issue brief for the patient who died by suicide included information that the facility learned of the patient's death from the family member's email rather than the earlier notification from the Jackson VA Medical Center.

⁸⁹ Deputy Secretary for Health for Operations and Management (10N), *10N Guide to VHA Issue Briefs*, March 29, 2018.

⁹⁰ Deputy Secretary for Health for Operations and Management (10N), *10N Guide to VHA Issue Briefs*.

⁹¹ The suicide prevention coordinator was informed of the patient's death by suicide from the facility's Chief of Staff, who was notified by a colleague. The facility's Suicide Prevention Team included the suicide prevention coordinators and mental health staff.

The OIG concluded that the Chief, Mental Health, and social work leaders were aware of the patient's death by suicide within three days of the patient's death; the OIG could not find evidence that facility leaders notified the Executive Leadership Team of the patient's death. This failure to notify executive leadership resulted in untimely submission of the issue brief to the VISN. Untimely issue brief submissions delay the facility and VISN leaders' review of and response to the situation and increases the potential of a repeat occurrence.

Root Cause Analysis

The OIG determined that the facility's root cause analysis team did not interview individuals vital to the Emergency Department patient assessment and referral processes.

VHA provides guidance for conducting a root cause analysis on appointing and training a team, establishing the initial sequence of events using facts, and gathering information to supplement the initial sequence of events by interviewing employees, and reviewing policies, procedures, and the EHR. VHA requires individuals directly involved with an adverse event "be interviewed as part of the root cause analysis process and asked for suggestions about how to prevent the same or similar situations from happening again."⁹²

The Facility Director chartered a root cause analysis to determine the root cause and contributing factors for the patient's death by suicide.

During interviews with the OIG, root cause analysis team members reported inconsistent statements about which staff were questioned during the analysis. The patient safety manager reported that the Emergency Department physician and Emergency Department mental health provider were interviewed as part of the root cause analysis; however, both employees told the OIG they were not interviewed. The Section Chief, Mental Health Social Work, reported questioning the Emergency Department physician and Emergency Department mental health provider a few days after the patient's Emergency Department visit, but not during the root cause analysis. The OIG also learned that the root cause analysis team did not interview staff from the Outpatient Mental Health Clinic.

The Patient Safety Manager and Section Chief, Mental Health Social Work, reported that deficiencies were identified related to the Emergency Department patient referral process. Facility leaders told the OIG of implementing new procedures to include

- An EHR patient referral template to standardize communication between the Emergency Department and the Outpatient Mental Health Clinic. Staff training was planned once implemented; and

⁹²VHA Handbook 1050.01, VHA defines adverse events as harmful occurrences directly associated with facility care or services.

- Emergency Department mental health providers will see every patient who presents to the Emergency Department with significant mental health history or a mental health complaint including patients with a negative suicide screen.

The OIG found that the root cause analysis team failed to conduct a sufficient review by not interviewing individuals vital to the Emergency Department assessment and patient referral processes. Excluding input from key staff involved in the patient's care and referral process increases the likelihood of the same or similar situations reoccurring.

Conclusion

The OIG substantiated that the patient presented to the facility Emergency Department seeking treatment for insomnia and was out of psychiatric medications but did not receive the care needed.

The Emergency Department physician discharged the patient with instructions to go to the facility's Outpatient Mental Health Clinic immediately for assistance with medication management; however, the OIG found no documentation in the EHR that the patient registered or received treatment in the clinic.

The OIG found the facility did not have a clear referral process for patients discharged from the Emergency Department who needed to be seen the same day in the Outpatient Mental Health Clinic for psychiatric medication management. The Emergency Department's practice was to direct patients to the Outpatient Mental Health Clinic during business hours for medication refills, and that a formal written consult was not required. The Emergency Department physician relied on this informal process and did not order a consult for the patient's referral to the clinic.

The OIG was unable to determine whether the Emergency Department physician referred the patient to the Emergency Department mental health provider prior to discharge, due to a lack of a documented patient referral. Without a clear referral process, patients are at risk for receiving inadequate care.

The OIG determined that the Emergency Department physician did not adequately reconcile the patient's medications during the patient's summer 2019 Emergency Department visit.

The current check-in process for patients presenting to the Outpatient Mental Health Clinic without an appointment did not include registering patients into the facility's scheduling system upon arrival. The OIG was unable to determine from the EHR whether the patient presented to or was treated in the Outpatient Mental Health Clinic because there was no documentation of staff contact with the patient, or that the patient attended an unscheduled appointment.

While eligible for community care treatment, the facility endocrinology nurse practitioner did not offer the patient a community care endocrinology consult.

PCP 2 ordered an endocrinology consult and ultrasound; however, did not follow up with or clinically reassess the patient when the consult and ultrasound order were discontinued. The OIG found the PCP 2 received a view alert for both the discontinued endocrinology consult and ultrasound order, however, was unable to determine if PCP 2 read the view alerts or reviewed the discontinued endocrinology consult and ultrasound order. PCP 2 acknowledged forgetting about the patient's endocrinology consult and did not recall receiving a view alert for the discontinued consult. The EHR did not contain evidence that the patient completed the recommended labs and thyroid ultrasound or was ever seen by an endocrinologist.

On two occasions PCP 2 did not document a higher dose of clonazepam on the patient's non-VA medication list resulting in an incorrect EHR medication list. Accurate medication information is necessary especially when multiple providers are providing treatment and patients are receiving multiple medications.

The patient did not receive several community care counseling sessions due to deficiencies in coordination of care between the facility community care staff, community care providers and the TPA. The OIG identified a three-month delay between fall 2017 – early 2018 in the patient's community mental health treatment, but was unable to find documentation to explain why the delay occurred. The change in VHA community care eligibility rules which gave the TPA scheduling responsibilities may have contributed to the delay. In fall 2018, the community care licensed counselor terminated the patient's counseling sessions but did not document terminating the sessions submit documentation to the facility or refer the patient to another mental health counselor.

The OIG determined that facility community care staff did not obtain medical record documentation for treatment the patient received from community care providers after fall 2017. Without the medical record documentation, facility staff were unable to review the care provided, impacting the ability to coordinate the patient's mental health care.

The OIG determined the community care nurse practitioner and facility community care staff did not ensure care authorizations were current; without current authorizations the patient was unable to refill several medications at the facility pharmacy.

A facility community care nurse approved authorizations for the patient's community care mental health services in early 2018 and spring 2019 but did not ensure a facility designated clinical staff reviewed and approved the authorizations. The OIG found the facility community care nursing staff lacked a clear understanding of the requirement for a facility clinical review prior to approval of a community care authorization; a clinical review would have afforded the opportunity for the facility to evaluate and identify gaps in the patient's community care mental health treatment.

The patient's family member sent an email to the facility 11 days after the patient's death by suicide. The email described concerns of inadequate care the patient received from the facility Emergency Department and Outpatient Mental Health Clinic staff. The OIG concluded that despite several facility staff and leaders having awareness of the family member's complaint, no staff member assumed responsibility to contact the family, address or resolve the complaint. Transition care management staff did not document the complaint in the Patient Advocate Tracking System and the program manager did not ensure the complaint was entered into the system.

Facility leaders relied on a statement outside of the fact finding and approached the initial gathering of facts inconsistent with VHA policy. In addition, facility leaders should have considered conducting further review to address the differing accounts by the Emergency Department physician and Emergency Department mental health provider regarding the patient referral to ascertain whether the Emergency Department mental health provider failed to follow facility policy.

The acting supervisor completed an insufficient behavioral health autopsy report by failing to contact the next of kin after the death of the patient. The Section Chief, Mental Health Social Work and acting supervisor's lack of knowledge of the Behavioral Health Autopsy Program requirements and absence of training, contributed to the omission of contacting the next of kin after the patient's death. The facility and VHA missed an opportunity to gain knowledge about the deceased patient's life and barriers to seeking assistance when in distress, implement changes to reduce any identified barriers, and strengthen suicide prevention initiatives.

The Chief, Mental Health and social work leaders were aware of the patient's death by suicide within three days of the patient's death; however, the OIG could not find evidence that the facility leaders notified the Executive Leadership Team of the patient's death. This resulted in an untimely issue brief submission to the VISN.

The OIG found that the root cause analysis team failed to conduct a sufficient review by not interviewing individuals vital to the Emergency Department patient assessment and referral processes.

Recommendations 1–16

1. The Memphis VA Medical Center Director evaluates the current process for patients discharged from the Emergency Department who need to be seen the same day in the Outpatient Mental Health Clinic for medication management, establishes a clear referral process to the Outpatient Mental Health Clinic, and verifies that patients receive the care needed.
2. The Memphis VA Medical Center Director reviews the Emergency Department Mental Health Handbook and defines a clear process for medication management in the Emergency

Department, and ensures that patients receive same day psychiatric medication management when indicated.

3. The Memphis VA Medical Center Director evaluates the current process for Emergency Department physicians to refer patients to the Emergency Department mental health provider for a mental health assessment and verifies that patients who require mental health provider assessment receive the care needed.

4. The Memphis VA Medical Center Director reviews the current medication reconciliation processes in the Emergency Department and Primary Care Clinics and verifies that providers complete and document medication reconciliation in accordance with policy and makes changes as necessary.

5. The Memphis VA Medical Center Director assesses the Outpatient Mental Health Clinic check-in process and verifies mental health patients are registered, triaged, and receive mental health services as needed.

6. The Memphis VA Medical Center ensures that patients are offered the option of community care consult, as appropriate.

7. The Memphis VA Medical Center Director evaluates the outpatient consult process and verifies that providers manage discontinued consults appropriately.

8. The Memphis VA Medical Center Director evaluates the process for community care clinical oversight, clarifies who has responsibility for coordinating care for patients receiving mental health in the community, and verifies that patients receive authorized community mental health care.

9. The Memphis VA Medical Center Director evaluates the process for timely retrieval of medical records from community care providers, verifies the medical records are uploaded into patients' electronic health records, and takes action as necessary.

10. The Memphis VA Medical Center Director evaluates the clinical review process for community care authorizations, ensures staff are trained on the process, verifies that authorizations have clinical delegate review, and are processed timely.

11. The Memphis VA Medical Center Director reviews the complaint reporting, responding and tracking processes and ensures that complaints are addressed, resolved, and documented in accordance with current facility policy.

12. The Memphis VA Medical Center Director ensures leaders and supervisors are trained on initiating and conducting a fact finding.

13. The Memphis VA Medical Center Director considers conducting further review to address the differing accounts of the Emergency Department physician and Emergency Department

mental health provider regarding the patient referral to ascertain whether the Emergency Department failed to follow facility policy, and takes action if needed.

14. The Memphis VA Medical Center Director ensures that responsible staff receive training on completing behavioral autopsy reports as required by the Veterans Health Administration Behavioral Health Autopsy Program and verifies that behavioral autopsies are completed in accordance with policy.

15. The Memphis VA Medical Center Director reviews the issue brief reporting requirements with supervisors and ensures timely issue brief reporting for patients who die by suicide.

16. The Memphis VA Medical Center Director ensures that staff who conduct root cause analyses are trained on the guidelines for interviewing individuals vital to the root cause analysis charter and identified processes, and verifies the root cause analysis interview guidelines are followed.

Appendix A: Community Care

The Patient Centered-Community Care (PC3) program was created in 2013 to offer community care services to eligible veterans when timely access to primary, mental health, inpatient or outpatient specialty care was not available.⁹³

In 2014, the Veterans Access, Choice, and Accountability Act established the Veterans Choice Program (Choice) as a temporary program under Public Law 113-146.⁹⁴ Choice was developed after the implementation of PC3 to meet health care needs when veterans faced prolonged wait times and burdensome travel commutes to VHA facilities.⁹⁵ The Choice program provided eligible patients with access to multiple services, including primary, mental health, and specialty care through a network of community providers managed through a contractual TPA.⁹⁶

In June 2018, the Government Accountability Office published a report identifying long standing issues with the Choice program and identified VHA's struggle to stay up-to-date with current requirements due to approximately 40 TPA contract modifications between October 2014 and July 2017.⁹⁷ The report identified the importance of care coordination and information sharing among patients, VHA staff, community providers and TPA staff to provide a seamless communication process. The report made 10 recommendations; one focused on implementing a process for better communication and electronic information sharing from VHA and community providers, while another focused on VHA issuance of a comprehensive policy and operations manual for the community care program with updates when program changes occur.

In June 2018, the VA MISSION Act was signed into law to consolidate VHA's community care programs, with the goal of enhancing care coordination, providing better customer service, implementing urgent care access, creating a new provider network, and modernizing information

⁹³ TriWest Healthcare Alliance, Department of Veterans Affairs (VA) *Patient - Centered Community Care (PC3) and Veterans Choice Program (VCP) Provider Handbook*, 2019; U.S. Department of Veterans Affairs Patient-Centered Community Care (PC3) - Community Care, "Patient-Centered Community Care (PC3)", April 11, 2019. <https://www.va.gov/COMMUNITYCARE/programs/veterans/pccc/index.asp>. (The website was accessed on December 9, 2019.)

⁹⁴ Department of Veterans Affairs, VA Fact Sheet, Veterans Access, Choice, and Accountability Act of 2014 Title 1: Choice Program and Health Care Collaboration; Veterans Access, Choice and Accountability Act of 2014 (VACAA), The Choice Program and the Choice Card, March 2015.

⁹⁵ TriWest Healthcare Alliance, Department of Veterans Affairs (VA) *Patient -Centered Community Care (PC3) and Veterans Choice Program (VCP) Provider Handbook*, 2019.

⁹⁶ U.S. Department of Veterans Affairs Patient-Centered Community Care (PC3) - Community Care, "Patient-Centered Community Care (PC3)", April 11, 2019. <https://www.va.gov/COMMUNITYCARE/programs/veterans/pccc/index.asp>. (The website was accessed on December 9, 2019.)

⁹⁷ United States Government Accountability Office Report to Congressional Addresses, VETERANS CHOICE PROGRAM: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of its Community Care Programs, Report Number GAO-18-281, June 2018.

technology systems.⁹⁸ VHA was given one year to implement this new program, which began in June 2019. Eligible veterans that were receiving care utilizing Choice 40 criteria were grandfathered in under the VA MISSION Act.

⁹⁸ U.S. Department of Veterans Affairs, Veteran Health Administration, Office of Community Care, *VA MISSION Act and New Veterans Community Care Program*, June 15, 2018; U.S. Department of Veterans Affairs, *Understanding the changes in Community Care for Veterans*, March 29, 2019, U.S. Department of Veterans Affairs VHA Office of Community Care Fact Sheet, *Veterans Community Care General Information*, September 9, 2019.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 30, 2020

From: Director, VA MidSouth Healthcare Network (10N09)

Subj: Healthcare Inspection— Deficiencies in Care, Care Coordination, and Facility Response to a Patient Who Died by Suicide, Memphis VA Medical Center in Tennessee

To: Director, Office of Healthcare Inspections (54HL09)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. I have reviewed the draft report “Deficiencies in Care, Care Coordination, and Facility Response to a Patient Who Died by Suicide” from the Office of the Inspector General (OIG) and I concur with the recommendations from this review.
2. I would like to take this opportunity to thank the OIG Team for this consultative site visit and the opportunity to respond to these findings.

(Original signed by:)

Cynthia Breyfogle, FACHE

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 30, 2020

From: Director, Memphis VA Medical Center (614/00)

Subj: Healthcare Inspection—Deficiencies in Care, Care Coordination, and Facility Response to a Patient Who Died by Suicide, Memphis VA Medical Center in Tennessee

To: Director, VA MidSouth Healthcare Network (10N09)

1. Attached please find the Memphis Medical Center's response to the OIG Draft Report, Deficiencies in Care, Care Coordination, and Facility Response to a Patient Who Died by Suicide, Memphis VA Medical Center in Tennessee, dated June 30, 2020.
2. If there are any further questions regarding this response, please contact the Memphis VA Accreditation Manager, who can be reached at 901-523-8990 extension 7203.

(Original signed by:)

David K. Dunning, MPA
Medical Center Director

Facility Director Response

Recommendation 1

The Memphis VA Medical Center Director evaluates the current process for patients discharged from the Emergency Department who need to be seen the same day in the Outpatient Mental Health Clinic for medication management, establishes a clear referral process to the Outpatient Mental Health Clinic, and verifies that patients receive the care needed.

Concur.

Target date for completion: October 5, 2020

Director Comments

To ensure continuity of care between Emergency Department (ED) medical care and ED mental health care, templates have been created to document the communication between providers, including a discussion of disposition. When a determination by the Emergency Department provider that a patient requires same-day outpatient mental health service during Open Access hours, the ED Mental Health provider (Social Worker, Psychologist, Nurse, Psychiatry Resident, or Psychiatrist) will escort the patient to the Mental Health Clinic for same day care. The ED Mental Health provider will perform a hand-off to the Mental Health Clinic Medical Support Assistant (MSA). The MSA will contact a Mental Health Registered Nurse (RN) for triage and enter an appointment into the Open Access Nursing Clinic. Upon completion of triage the RN will handoff the patient to the appropriate mental health provider.

To verify that the patient received the care needed monthly chart audits will be performed on patients seen in the ED and referred to same day outpatient mental health service during Open Access hours. Chart audit results will demonstrate a 95% compliance rate with the referral process for three consecutive months. The monthly chart audit will be reported in the Quality, Safety and Value Board (QSVB) meeting, co-chaired by the Medical Center Director.

Recommendation 2

The Memphis VA Medical Center Director reviews the Emergency Department Mental Health Handbook and defines a clear process for medication management in the Emergency Department, and ensures that patients receive same day psychiatric medication management when indicated.

Concur.

Target date for completion: October 30, 2020

Director Comments

The Emergency Department (ED) Mental Health Handbook has been revised to include explicit instructions on psychiatric medication management, that ED medical providers will attend to medication concerns and consult with Psychiatry as needed.

Thirty charts will be audited monthly for three consecutive months to ensure that patients receive same day psychiatric medication management when indicated. A target of 95% compliance is expected. Compliance rate will be reported monthly to the Medical Executive Committee (MEC), and then forwarded to the Executive Management Council (EMC).

Recommendation 3

The Memphis VA Medical Center Director evaluates the current process for Emergency Department physicians to refer patients to the Emergency Department mental health provider for a mental health assessment and verifies that patients who require mental health provider assessment receive the care needed.

Concur.

Target date for completion: October 30, 2020

Director Comments

All patients seen in the Emergency Department (ED) with a mental health complaint will have the communication template completed documenting the request by the ED medical provider for assessment and response by the ED mental health provider. The template will have clear instructions for disposition, along with routine safety and suicide risk assessment. Dispositions will fall in general categories of the following:

- Consultation via in-person psychiatry assessment resulting in admission once medically stabilized by ED provider or discharge for possible out-patient follow-up.
- Consultation via phone resulting in admission once medically stabilized by ED provider or discharge for possible out-patient follow-up.
- Discharge to Mental Health Outpatient Clinic.
- Discharge home by ED provider as clinically indicated with instructions for follow-up accordingly.

Monitoring of completed template documentation will be performed by the ED until 100% compliance for three consecutive months is demonstrated. Reporting of compliance will go to the Medical Executive Committee (MEC). The MEC reports to the Executive Management Council (EMC).

Recommendation 4

The Memphis VA Medical Center Director reviews the current medication reconciliation processes in the Emergency Department and Primary Care Clinics and verifies that providers complete and document medication reconciliation in accordance with policy and makes changes as necessary.

Concur.

Target date for completion: November 30, 2020

Director Comments

The Memphis VA recognizes the importance of the medication reconciliation process for the safety and well-being of its patients. For Primary Care Clinic providers, compliance with the Medication Reconciliation process is monitored as part of chart reviews. The audits are conducted on a monthly basis for provider evaluation, and data is reported to the Quality Safety and Value Board (QSVB) with appropriate actions as required. Primary Care Clinic providers will receive re-education on the outlined medication reconciliation process at the next scheduled session on July 16, 2020. The Deputy Associate Chief of Staff of Ambulatory Care will review 10 random patient records per week for the next four weeks for compliance with an expected goal of 90% or greater and monthly thereafter until a consistent 90% goal is reached for three consecutive months.

The ED will review completion of the Medication Reconciliation Clinical Reminder on patients requiring mental health screening per policy. Primary Care has access to the completed clinical reminder which will bridge the setting between emergency department and primary care. A 90% goal rate for compliance with completion of Medication Reconciliation Clinical Reminder for the ED is set.

Completion of the Clinical Reminder for the ED patients, and the primary care audit will be reported monthly in QSVB until in compliance for three consecutive months. QSVB reports to the Medical Center Director at the Executive Management Council (EMC).

Recommendation 5

The Memphis VA Medical Center Director assesses the Outpatient Mental Health Clinic check-in process and verifies mental health patients are registered, triaged, and receive mental health services as needed.

Concur.

Target date for completion: October 30, 2020

Director Comments

Patients are registered upon arrival to the Outpatient Mental Health Clinic when checking in for both scheduled and unscheduled appointments. For unscheduled appointments the Medical Support Assistant (MSA) contacts the Mental Health Registered Nurse (RN) for triage and places an appointment into the Open Access Nursing Clinic. The RN handoff is then done to the appropriate mental health provider upon completion of triage. This standardized procedure was implemented in February of 2020.

To verify the above standardized registration, triage and handoff procedure is occurring, Mental Health Service will perform a review of all patients seen on an unscheduled basis each month to verify a 100% compliance rate. Staff retraining will be performed for any audit that demonstrates noncompliance with the established process. The results of reviews and chart audits will be reported to the Mental Health Council, then to the Medical Executive Committee (MEC) until in compliance for three consecutive months. The MEC reports to the Executive Management Council (EMC).

Recommendation 6

The Memphis VA Medical Center ensures that patients are offered the option of community care consult, as appropriate.

Concur.

Target date for completion: October 30, 2020

Director Comments

Currently with MISSION Act, patients may be referred to community care by a joint decision of appropriateness between the facility provider, the patient, and MISSION Act Quality Standards (best medical interest, travel and wait times). If referred the patient may opt in if they are an established patient waiting greater than 20 days of preferred or create date for primary care or mental health, or 28 days of preferred or create date for specialty care. The patient may also be referred to community care if they must travel greater than 30 minutes for primary care or mental health care or 60 minutes for specialty care.

Community Care will receive and approve once the Community Care consult is entered internally, or, as a community provider requests additional services. Charts will be audited for three months to ensure that patients are offered options for community referrals or VA services. The audit sample size will include a minimum of 30 charts for patients who are eligible and opt in for the referred care, for a compliance rate of 90%. If compliance falls below the 90% rate, then corrective actions will be taken as appropriate. Data will be reviewed by the Memphis VA Business Office and reported monthly to the Consult Committee Chair (facility Group Practice

Manager). That data will be reported to the Medical Executive Committee (MEC) and further reported to the Executive Management Council (EMC).

Recommendation 7

The Memphis VA Medical Center Director evaluates the outpatient consult process and verifies that providers manage discontinued consults appropriately.

Concur.

Target date for completion: October 30, 2020

Director Comments

Community Care will perform monthly audits of discontinued community consults for three consecutive months initially for endocrinology and urology community consults. The monthly audits will confirm at least a 90% compliance rate demonstrating that the requesting and consulting provider managed the consult appropriately in accordance with policy. If compliance falls below the 90% rate, then corrective actions will be taken as appropriate. The audit results will be reported monthly at the Community Care Oversight Committee and to the Quality, Safety and Value Board (QSVB) which is co-chaired by the Medical Center Director.

Recommendation 8

The Memphis VA Medical Center Director evaluates the process for community care clinical oversight, clarifies who has responsibility for coordinating care for patients receiving mental health in the community, and verifies that patients receive authorized community mental health care.

Concur.

Target date for completion: October 30, 2020

Director Comments

All Community Care mental health consults are received, reviewed and approved by Nurse Practitioners (NPs). Community Care staff are responsible for coordinating care of patients receiving mental health in the community. The facility recently transitioned to a new national process, Referral for Service (RFS). This replaces the previous Secondary Authorization process with the Third-Party Administrator (TPA). The facility Community Care clinical staff now receive the RFS via a designated fax line from the community providers. The RFS is transcribed into a Community Care consult and undergoes review by the Community Care NP for appropriateness, approval and continuation of care in the community.

Monitoring of the RFS will yield a 90% compliance rate using monthly audits of 30 community mental health charts performed for three consecutive months in accordance with policy. If compliance falls below the 90% rate, then corrective actions will be taken as appropriate. Reporting of compliance rates will be done through the Community Care Oversight Committee (CCOC) and to the to the Quality, Safety and Value Board (QSVB), co-chaired by the Medical Center Director.

Recommendation 9

The Memphis VA Medical Center Director evaluates the process for timely retrieval of medical records from community care providers, verifies the medical records are uploaded into patients' electronic health records, and takes action as necessary.

Concur.

Target date for completion: October 30, 2020

Director Comments

Medical records from community providers for mental health care will be monitored for receipt date. If medical records are not received within 60 days of the patient's initial appointment with the community provider, then a formal request to obtain the community provider records will be submitted. If the 60-day records request yields no response from the community provider, then two additional records requests will be made; one 30 days after the initial request, and one 30 days after the second request for a total of the three required attempts. An audit will be performed of 30 charts every month over three consecutive months to demonstrate 100% compliance with the records retrieval attempts for mental health community care.

When the above medical records are received facility policy states that they must be uploaded into the patient's chart within five business days of receipt. Any data outside of the five-business day target requires an action plan, which is monitored on a weekly basis by VISN 9 until corrected. The Medical Records Committee reports scanning data at their monthly meeting and will report any action plans that have been initiated. That information will be reported to the Medical Executive Committee (MEC) quarterly demonstrating three consecutive months of compliance with the five-business day target, and the status of any open action plans. MEC reports to the Executive Management Council.

Recommendation 10

The Memphis VA Medical Center Director evaluates the clinical review process for community care authorizations, ensures staff are trained on the process, verifies that authorizations have clinical delegate review, and are processed timely.

Concur.

Target date for completion: October 30, 2020

Director Comments

A pending report is pulled daily for clinical review by the Nurse Practitioner (NP). The clinical review by the NP will be audited monthly for three consecutive months to verify the authorizations have clinical review as appropriate, and that 90% have met the 7-day target time. Pending authorizations falling below the 90% compliance rate and outside of the 7-day target would require an action plan. The Community Care Oversight Committee (CCOC) will report monthly to the Quality, Safety and Value Board (QSVB) for three consecutive months demonstrating meeting rates of compliance. QSVB is co-chaired by the Medical Center Director.

Recommendation 11

The Memphis VA Medical Center Director reviews the complaint reporting, responding and tracking processes and ensures that complaints are addressed, resolved, and documented in accordance with current facility policy.

Concur.

Target date for completion: October 30, 2020.

Director Comments

Customer Service provided an in-service with the Transition Care Management Advocates and Supervisors covering Policy Memorandum 00-73 and documentation in the Patient Advocate Tracking System-Replacement (PATS-R). Transition Advocates meet daily to discuss complex cases and review any training updates with a supervisor in Social Work Service. Transition Care Management Advocates will also sign an Advocate Reporting Statement acknowledging reporting and documenting urgent issues, with a copy given to staff and input placed into the staff's employee file.

Customer Service Advocates conducted the training and signed the Advocate Reporting Statement in April of 2020. That training will be reported at the August 2020 Quality, Safety and Value Board (QSVB) meeting. There will also be reporting to QSVB of three consecutive months of the PATS-R report demonstrating a 100% compliance rate with addressing, resolving and documenting complaints. If the compliance rate drops below 100% corrective actions will be taken as appropriate.

Recommendation 12

The Memphis VA Medical Center Director ensures leaders and supervisors are trained on initiating and conducting a fact finding.

Concur.

Target date for completion: November 30, 2020

Director Comments

Training for initiating and conducting a fact finding will occur for Memphis VA Service Chiefs, Managers, Supervisors, and Administrative Officers. The training will be conducted as a virtual Skype-based, PowerPoint guided session, with extensive participation and encouragement of sharing problems encountered in the past. The training will be done by the Supervisor, Employee Relations/Labor Relations (ER/LR), who also serves as Consultant from the ER/LR Shared Service Unit at the Mid-South Healthcare Network (VISN 9).

Training participation and follow up regarding the fact-finding education will be reported in the November 2020 Executive Management Council (EMC) meeting.

Recommendation 13

The Memphis VA Medical Center Director considers conducting further review to address the differing accounts of the Emergency Department physician and Emergency Department mental health provider regarding the patient referral to ascertain whether the Emergency Department failed to follow facility policy, and takes action if needed.

Concur.

Target date for completion: October 30, 2019

Director Comments

The Medical Center Director (MCD) moved to make immediate proactive changes after the incident and after the OIG exit. Changes already implemented include revising the Emergency Department Policy and education of all Emergency Department Mental Health staff and Licensed Independent Practitioners to formalize the process of referral for same day mental health treatment. Due to staff turnover and the length of time which has elapsed since the incident, the MCD feels further review specific to the differing provider accounts will be ineffectual.

OIG Comment

The OIG considers this recommendation closed.

Recommendation 14

The Memphis VA Medical Center Director ensures that responsible staff receive training on completing behavioral autopsy reports as required by the Veterans Health Administration

Behavioral Health Autopsy Program and verifies that behavioral autopsies are completed in accordance with policy.

Concur.

Target date for completion: December 30, 2020

Director Comments

The Memphis Suicide Prevention Coordinator, Suicide Prevention Programs Supervisor, and Section Chief of Mental Health Social Work and Recovery Programs received training from National Suicide Prevention Program staff on completion of the Behavioral Health Autopsy Program (BHAP) and Family Interview Contact Form (FIT-C) on July 14, 2020. The training also included a script for the interviewer to use as an introduction when conducting an interview of the family interviewee. Completion of this training was reported to the Mental Health Council on July 23, 2020 and will be reported to the Medical Executive Committee (MEC) at their next reporting in August 2020. Any suicide and the subsequent Behavioral Health Autopsy Report will be audited for completion with a 100% compliance rate and reported to MEC. MEC reports to the Executive Management Council (EMC).

Recommendation 15

The Memphis VA Medical Center Director reviews the issue brief reporting requirements with supervisors and ensures timely issue brief reporting for patients who die by suicide.

Concur.

Target date for completion: December 30, 2020

Director Comments

Updated Issue Brief (IB) guidance was provided to all Memphis VA Managers, Supervisors, Service Chiefs, and Administrative Officers by the Medical Center Director on July 6, 2020. The guidance included the 10N Guide to Issue Briefs (updated March 29, 2018); IB subject line instruction; and, designated formatting for IBs. The guidance also presented a comprehensive list of instances or events that should trigger the submission of an IB, including a Veteran suicide or suicide attempt.

This Issue Brief guidance provided via email will be discussed by the Medical Center Director in the August 2020 Executive Management Council (EMC). Issue Briefs submitted that reference a suicide or suicide attempt will be monitored for six months, demonstrating a 100% compliance rate.

Recommendation 16

The Memphis VA Medical Center Director ensures that staff who conduct root cause analyses are trained on the guidelines for interviewing individuals vital to the root cause analysis charter and identified processes, and verifies the root cause analysis interview guidelines are followed.

Concur.

Target date for completion: October 30, 2020

Director Comments

The Chief of Quality discussed and reviewed all Root Cause Analysis (RCA) training guidelines with the Patient Safety Officer (PSO) in November 2019. The PSO revised the training PowerPoint and the confidentiality statement for RCA members to include a clear statement regarding discussions, interviews and 38 U.S.C. §5705 protected information. An individual RCA audit in FY20 indicated that all appropriate individuals had been interviewed.

The revised PowerPoint and updated statement will be presented at the July 2020 Quality Safety and Value Board (QSVB) meeting which the Medical Center Director Co-Chairs. Beginning August 1, 2020, the next three RCA's will be audited to verify that the appropriate interview process has occurred with a compliance rate of 100%. That compliance rate will also be reported through QSVB.

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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