



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Mental Health Access and Treatment Issues at a VA Medical Center

To Report Suspected Wrongdoing in VA Programs and Operations:

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review to determine the validity of allegations from a complainant regarding a patient's care at a VA Medical Center (VAMC). The complainant alleged that:

- The facility denied the patient emergency admission from an outside community hospital Emergency Department (ED) in spring of 2010, because it was too late in the day for transfer, and there were not enough available beds.
- A facility Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) social worker chose not to assist with the desired transfer and failed to advise the complainant of transfer status or problems.
- Once the patient was admitted to a Department of Defense (DoD) hospital which houses a jointly managed DoD/ VAMC acute psychiatry unit, VAMC staff failed to follow up and arrange transfer to their facility.

Additionally, the complainant also believed that:

- “The VA did not properly evaluate or provide treatment options for [the patient's] post traumatic stress disorder (PTSD). The VA's failure to treat [the patient] and [the patient's] early discharge from the DoD medical center set in motion [the patient's] tragic death.”

Based upon the limitations of the telephone records received, we could not prove the allegation that this patient was denied admission to the VAMC in the spring of 2010. However, during the course of the inspection, we found documentation from an outside hospital (Hospital A) of two previous requests for after hours transfer of this patient to the facility in which staff from the outside hospital were told that transfer to the VAMC could not be considered until after 8:00 a.m. even though the VAMC documentation indicates that acute psychiatry units had available beds on both dates.

During the course of our interviews, we were also made aware of a more recent request for after hours transfer from a different outside hospital involving a different patient in the spring of 2011. An outside hospital ED staff member was reportedly told by a VAMC staff member that the VAMC does not take patients for transfer at night. The VAMC's Mental Health Evaluation Clinic (MHEC) clinical leadership recollected this occasion and reported that immediate feedback was provided to the Chief Resident who reiterated with all residents that it was not appropriate to deny admission in that situation.

We determined that the OEF/OIF case manager did make reasonable efforts to ensure that the patient's immediate medical and mental health (MH) needs were addressed. In particular, the patient was admitted to an inpatient MH treatment unit as arranged by county crisis workers. The OEF/OIF case manager accepted at face value the information from the crisis worker that the “VAMC would not accept a transfer for

admittance of the veteran this late in the day” and suggested that contact be made with Hospital A where the patient had been recently hospitalized.

We identified improvement opportunities related to the transition of responsibility between on-duty and off-duty OEF/OIF social work staff.

We did not substantiate the allegation that VA did not properly evaluate or provide treatment options for the patient’s PTSD. We determined that VA staff made multiple efforts to facilitate treatment options for this patient.

We could neither substantiate nor refute the allegation of an early discharge from the DOD hospital. The clinicians primarily involved in the discharge decision were DOD personnel. The DoD OIG declined a request for a review of this matter.

We identified improvement opportunities related to record keeping and oversight of inter-facility communications and related to the transition of responsibility between night psychiatrist on-duty and MHEC staff.

We also determined that the MHEC hours and staffing levels did not appear to be coordinated with the frequency and timing of MH patients’ admissions.

We recommended that the VAMC Director ensure that:

- Inter-facility MH transfer processes are consistent with facility policies.
- Record keeping of inter-facility communication is appropriately maintained and that internal oversight of after-hours admissions, dispositions, transition of responsibility and inter-facility communication is implemented.
- MHEC operating hours and staffing in relation to relevant factors, including the frequency and timing of admissions to inpatient MH units is evaluated.

The Veterans Integrated Service Network and VAMC Directors concurred with our recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director,

SUBJECT: Healthcare Inspection – Alleged Mental Health Access and Treatment Issues, VA Medical Center

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review to determine the validity of allegations from a complainant regarding a patient's care at a VA Medical Center.

Background

In the spring of 2010, an Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veteran in his mid-twenties was taken to a community hospital Emergency Department (ED) and placed on a temporary hold because he was delusional and responding to hallucinations. The patient was described as wandering around naked. He was diagnosed with post-traumatic stress disorder (PTSD) and psychosis. County crisis workers allegedly attempted to transfer the patient to the VAMC, but admission was allegedly denied because it was too late in the day, and there was not an available bed. The patient was subsequently transferred and admitted to a Department of Defense hospital (DoD hospital) which houses a jointly managed DoD/VAMC acute psychiatry unit. The patient was discharged 3 days later toward the end of his temporary commitment period. Within 4 hours of discharge, the patient died.

The complainant requested help in obtaining the patient's medical and military records. The complainant alleged that:

- The VAMC denied the patient emergency admission from an outside community hospital ED in the spring of 2010, because it was too late in the day for transfer, and there were not enough available beds.
- A facility OEF/OIF social worker¹ chose not to assist with the desired transfer and failed to advise the complainant of transfer status or problems. The patient was

¹ The OEF/OIF social worker will be referred to as the OEF/OIF case manager throughout the remainder of the report.

not sent to the VAMC “as planned” but instead was transferred to the DoD hospital.

- Once the patient was admitted to the DoD hospital, VAMC staff failed to follow up and arrange transfer to their facility.

Additionally, the complainant also believed that:

- “The VA did not properly evaluate or provide treatment options for [the patient’s] PTSD. The VA’s failure to treat [the patient] and [the patient’s] early discharge from the DoD hospital set in motion [the patient’s] tragic death.”

In his communication with us, the complainant also asked for assistance with retrieving DoD military and medical records. In a follow-up contact during the course of our evaluation, the complainant also inquired as to the outcome of a previously alleged patient abuse event in the winter of 2009 involving a nursing assistant assigned to care for the patient. VA Police had investigated the incident with the assistance of an OIG investigator. After reviewing witness statements and interviews of the patient and facility staff, the VA Police and OIG investigator determined that the allegation of patient abuse could not be substantiated because there was no factual evidence for or witnesses to the alleged abuse.

VAMC’s Mental Health Admission Process

The VAMC has a locked acute inpatient mental health (MH) unit. The unit is intended for the most acute patients, including those on a temporary hold.

A VAMC memorandum requires MH patients to be evaluated in the MH Evaluation Clinic (MHEC) during business hours.² The MHEC is located in the VAMC ED and serves as an evaluation, consultation, and referral service for patients who present to the VAMC with MH problems. This includes acute inpatient psychiatry bed management and evaluation of appropriateness of admissions. MH patients presenting to the ED between 8:00 a.m. and 4:00 p.m. are evaluated by MHEC nurses, social workers, psychologists, and psychiatrists and are referred to psychiatric inpatient units as appropriate. The primary inpatient team is responsible for final admission decisions. Upon evaluation on the unit and with sufficient documentation, inpatient psychiatry staff may decide not to admit the patient. The MHEC is contacted if the patient is not admitted, and nursing staff escort the patient back to the MHEC for final disposition.

However, the memorandum does not address calls received from outside hospitals (such as other VA hospitals and community hospitals) after 4:30 p.m. Patients presenting to the VAMC after 4:00 p.m. with non-urgent issues are evaluated by the night psychiatrist on-duty (NPOD) in the ED. Emergent situations that arise between 4:00 p.m. and 4:30 p.m. are attended to by MHEC staff, while emergent situations that arise after 4:30 p.m. are

² Facility Memorandum, *Mental Health Evaluation Clinic*, 2010.

attended to by the NPOD.³ The NPOD, in conjunction with a super-attending⁴ and nursing supervisor, manages bed control and after hours admissions.

Scope and Methodology

In this inspection we reviewed the allegations set forth and articulated by the complainant. We extensively reviewed not only clinical events in the days before the patient's death but also his antecedent course of care in the VA system following separation from the military. We reviewed the following documents:

- The patient's VA medical records from 2005–2010.
- The patient's ED records and county crisis worker notes from his treatment at a private hospital (Hospital B) ED just prior to transfer to the DoD hospital inpatient MH unit.
- The patient's DoD medical records during his spring of 2010 admission.
- The patient's medical records from three prior MH admissions at an outside hospital (Hospital A), and the county's psychiatric crisis facility in 2008 and 2010.
- The patient's medical records from a Community Hospital (HOSPITAL C).
- The patient's medical records from a Rehabilitation Center
- The VAMC's patient advocate reports.
- The coroner's and corresponding community police reports following the patient's death.
- The VAMC's MHEC/NPOD alert and log sheets for select days in 2010 and 2011.
- MH Units staffing levels and bed census records for select days in spring of 2010 and summer of 2011.
- The DoD/VA sharing agreement for the DoD hospital inpatient MH unit.
- A list of admissions from outside hospitals to the facility's inpatient MH units during a five month period in 2010.
- Written statements from county crisis workers regarding their interactions with the patient and the facility in the spring of 2010.
- VA Police and OIG documents from the 2009 patient abuse allegation involving this patient.

We also reviewed VHA and facility memoranda, protocols, and documents, including:

- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1010.01, *Care Management of Operation Enduring Freedom (OEF) and Operation Iraqi (OIF) Veterans*, October 9, 2009.

³The NPOD is typically a psychiatric resident physician who is present at the facility during assigned off-tour, weekend, or holiday hours.

⁴ A super-attending is a staff psychiatrist who is available to the NPOD by phone if needed.

- Facility Memorandum, *Mental Health Council*, 2011.
- Facility Memorandum, *Mental Health Evaluation Clinic*, 2010.
- Facility Memorandum, *Assessment and Treatment Planning Policy for the Mental Health Clinics*, 2009.
- Facility Memorandum, *Management of Patients with Suicidal and Self Harming Behaviors*, 2011.
- *Current Protocol for Transferring Patients to [the VAMC] Inpatient Psychiatry from Outside Hospitals*, 2011.
- *Inpatient Admissions Protocol*, March 2009.
- *Admission Criteria for the Inpatient Mental Health Units* document (undated).
- *PTSD Clinical Team Standard Practices and Procedures*, May 18, 2011.
- An internal VAMC peer review related to a clinician's care of the patient.

We conducted a site visit to the VAMC in July 2011. We interviewed the following individuals in person or by telephone:

- The complainant and the patient's mother.
- VAMC and MH leadership.
- VAMC MHEC leadership and staff.
- VAMC patient safety manager, quality manager, patient advocate, and suicide prevention coordinator.
- VAMC AODs for select days in 2010 and 2011.
- VAMC NPOD's for select days in 2010 and 2011.
- The patient's OEF/OIF case manager.
- VAMC OEF/OIF supervisor.
- Other VAMC social workers.
- VAMC MH super-attending for a day in 2010.
- Other facility MH clinicians.
- VA nurse and social worker who worked at the DoD inpatient MH unit.
- A DoD nurse.
- A private hospital ED physician.
- Two private hospital ED clinical staff.
- Two community hospital ED clinical staff.

We subpoenaed records for the Hospital B ED telephone number identified by the county crisis workers and received incoming records only. A second subpoena was issued, and records were obtained for outgoing phone records for the same number and for three other extensions at the Hospital B ED. In addition, the VA OIG Office of Investigations obtained records of calls to and from the MHEC telephone extension for a day in spring of 2010.

We were unable to physically retrieve requested DoD medical and military records for the complainant but did make appropriate referrals to entities that could assist.

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

Case Summary

The patient was a veteran in his mid-20s with a history of combat in OEF/OIF. In 2005, while in the military, he had three visits with a community social worker who diagnosed PTSD, anxiety disorder not otherwise specified (NOS),⁵ and cocaine abuse. The social worker recommended an evaluation for medication treatment to address the patient's symptoms of depression, anxiety, and sleep disorder. He was briefly treated with an anti-depressant. He was separated from the military under a General Discharge (honorable conditions).

In November 2005, the patient presented at a VAMC clinic for his first VA MH evaluation for symptoms of anxiety and sleep disorder. He denied any MH problems prior to his military service. The following week, the patient had a general medical examination that revealed a low blood level of potassium. In December, a VAMC psychiatrist diagnosed him with PTSD, chronic anxiety, and rule out psychotic disorder NOS.

In January 2006, the patient had a compensation and pension MH exam at the VAMC and was diagnosed with combat-related PTSD, alcohol abuse, and a history of cocaine abuse.

In April 2006, the OEF/OIF coordinator was contacted by the patient's father who was concerned about the patient's PTSD and increased substance abuse. Later that month, the patient presented to the VAMC's MHEC complaining of anxiety, depression, deterioration of function, auditory hallucinations, and polysubstance abuse. He reported being homeless and was admitted for his first psychiatric hospitalization at the VAMC. The patient was discharged 3 days later against medical advice (AMA).

In June 2006, the patient presented to the VAMC's General Medical Clinic Same Day Clinic complaining of muscle stiffness and neck pain. He stated that he was planning to move to another city to seek employment. He was referred for outpatient MH treatment but did not follow through.

In August 2006, the patient presented at another VAMC (VAMC2), stating that he was homeless and needed help with his psychiatric symptoms. He was accepted to temporary housing and was then referred to a transitional housing program. The patient was

⁵One of the psychiatric diagnoses specified in the Diagnostic and Statistical Manual IV

diagnosed with PTSD and major depressive disorder by a VAMC2 PTSD outpatient services team (POST) clinician the following week. The patient requested treatment with alprazolam (an anti-anxiety medication), but when this was denied he declined treatment with an anti-depressant or cognitive behavioral therapy.

In early September 2006, the patient was admitted to a VA domiciliary program (residential treatment program) at VAMC2 for approximately 1 month. He was seen by a POST clinician and agreed to trials of citalopram (an anti-depressant medication), quetiapine (a medication for psychosis and certain mood disorders), and temazepam (medication for insomnia). While at the domiciliary, the patient participated in groups and classes. He was discharged from the domiciliary program in early October 2006 due to alcohol intoxication. He declined referral for substance abuse treatment. He stopped taking his medications and began to drink and use cocaine on a regular basis. Six weeks later, he was accepted at another transitional housing program.

In early December 2006, he was arrested and incarcerated for 5 days for drug possession. One day after his release, he was re-admitted to the transitional housing program. The following day, he was seen by a VAMC2 POST nurse practitioner and his medications were re-initiated. He was seen 3 times by the POST nurse practitioner in December for follow-up. The patient declined entrance into a substance dependence treatment program. He was discharged from the transitional housing program in late December.

In 2007, the patient continued to receive his health care at VAMC2. His clinical course over the next month is unclear. According to available medical records, he was frequently homeless and reportedly abusing substances. In late February, he returned to the transitional housing program. In early March, he presented to the VAMC2 Opiate Treatment Program requesting methadone maintenance but did not meet program admission criteria requiring two failed detoxification attempts. He was encouraged to continue substance use treatment in the transitional housing program and to reconnect with POST. In mid-late March, he was incarcerated for several days. He was seen by the VA jail outreach worker during this time period.

In late April 2007, the patient returned to the POST requesting assistance with housing and medication review. He had returned to the transitional housing program.

In early May 2007, the patient presented to the VAMC2 ED with altered mental status. He was found to have a severely low potassium level, hypotension, and altered mental status. He was admitted to the Medical Intensive Care Unit. However, the next day he left the Hospital AMA after medical stabilization. In mid-May, he was arrested for drug possession. While incarcerated, he was seen by a VA jail outreach worker. From early June to early July, the patient returned to a transitional housing program. He reportedly refused referral to a substance abuse treatment program. He was arrested again in August, and subsequent to his release in September, he was referred to a Health Care for

Homeless Veterans per-diem program with a substance abuse treatment component. He had been mandated by the court to complete 6 months at a program.

In mid-October 2007, the patient presented to a POST clinician with altered mental status and was referred to the VAMC2 ED. He was found to have a low potassium level. The patient spent the night in the ED and subsequently left AMA. The following day, he was discharged from the substance use treatment program for having a positive drug screen. A note in the medical record from November indicates that the patient had relocated to live with family and was looking for a substance use treatment program.

In November 2007, the patient was screened by the Addiction Treatment Services (ATS) at the VAMC. At the time he was on probation and required approval from his probation officer prior to entering the program. The patient indicated that he was in the process of getting the approval and would contact ATS when this was received.

In December 2007, a polytrauma referral was placed but the VAMC was not able to make contact with the patient to make further arrangements.

In March 2008, the patient was admitted on a temporary hold to the VAMC following incarceration for public intoxication. He was diagnosed with: (1) mood disorder NOS; (2) substance-induced psychosis; (3) alcohol dependence; (4) polysubstance abuse (alcohol, cocaine, opioids, and methamphetamine); and (5) rule out PTSD. He was treated with olanzapine (an anti-psychotic medication). He was discharged one and a half weeks later with plans for outpatient treatment. However, he did not appear for his follow-up MH appointment.

In April 2008, the patient received approval from the county of his probation to attend ATS at the VAMC, but the patient wished to clarify this clearance from the county prior to entering the program.

In May 2008, the VAMC received a telephone call from Hospital A, requesting admission for the patient, who had been brought to that hospital on a temporary hold. However, a follow-up call between the facility and Hospital A indicated that he had left the hospital in the care of his family.

The next day, the VAMC again received a telephone call from Hospital A requesting admission for the patient. VAMC clinical staff asked Hospital A staff to fax required patient information such as laboratory results and evaluation notes. The information was faxed to MHEC and handed off to the NPOD due to the change of shift. The NPOD reviewed the paperwork and contacted Hospital A, asking them to address additional medical issues (elevated white blood cell and CPK counts⁶ and to rule out the medical causes for these).

⁶ White blood cell and CPK (creatine phosphokinase) are laboratory blood tests.

Once these were addressed, the patient was admitted to the VAMC the next morning. He was diagnosed with: (1) psychotic disorder NOS (possible stimulant induced psychotic symptoms, rule out primary psychotic disorder such as schizophrenia); (2) PTSD; and (3) dependence (early full remission, in a controlled environment). He was treated with olanzapine, citalopram, and trazodone. An application was filed for temporary conservatorship.^{7,8} Following a 1-month hospitalization, he was discharged directly to the ATS program at the VAMC where he remained for a few hours. He was then readmitted to the VAMC acute MH unit due to severe agitation.

The patient was admitted for another 2 weeks during which time multiple family meetings were held. The patient received polytrauma neuropsychological evaluations. After discharge he was treated in a dual diagnosis treatment program capable of providing high level care. While in the program, he was seen at the VAMC2 POST and by MH at the VAMC2 Clinic. He was briefly hospitalized for 3 days at the VAMC2 in September 2008 for low potassium levels and metabolic disturbance. He continued in the dual diagnosis program until he was suspended for intoxication. He was briefly readmitted to the dual diagnosis program in October but was discharged due to ongoing alcohol consumption. In the following weeks, he engaged sporadically in outpatient treatments.

In November 2008, the OEF/OIF supervisor attempted to reengage the patient in treatment. The patient declined hospitalization but agreed to outpatient care. On two occasions in November, he did not show up for his appointments.

In December 2008, a VAMC facility contacted the VAMC requesting admission for the patient, who had been brought there by VA police after coming to the Dental Clinic intoxicated. He was admitted to the VAMC within 3 hours as he was psychotic and disorganized. During this admission, he was diagnosed with an eating disorder with bulimic-like symptoms. He received inpatient treatment but was released 17 days later when he could no longer be legally held in the hospital. The patient was discharged AMA. Subsequently, he did not keep his scheduled outpatient MH follow-up appointment.

In January 2009, the patient was brought to Hospital A by police on a temporary hold. Hospital A contacted the VAMC requesting admission. The next day, he was admitted to the VAMC after a low potassium level was stabilized. During the hospitalization, the patient was diagnosed with: (1) schizoaffective disorder vs. schizophrenia (exacerbated by methamphetamine); (2) eating disorder NOS; (3) amphetamine dependence; (4) marijuana abuse, rule out dependence; (5) polysubstance dependence; and (6) PTSD by

⁷ Under the state Law, if a patient is hospitalized on a 14-day hold, at the end of the hold the patient may be placed on a 30-day temporary conservatorship, if the court believes that the patient is seriously disabled. Conservatorship is set up after a judge decides that a person (conservatee) cannot take care of himself or his finances.

⁸ A conservator (another person or organization) is appointed to be in charge of the conservatee's care or finances, or both.

history. Citalopram was discontinued, and olanzapine was replaced by quetiapine. The treatment team pursued temporary conservatorship, but this was denied due to an offer of third party assistance by a family member. The patient was discharged AMA after a 19-day hospitalization. He did not keep his scheduled outpatient psychiatric follow-up appointment, but received a follow-up call from the psychiatrist.

In April 2009, the patient was brought to a Rehabilitation Center by police on a temporary hold. Providers at the Rehabilitation Center contacted the VAMC requesting admission. He was admitted to the VAMC that evening and was hospitalized for approximately 6 weeks. His diagnoses were now: (1) schizoaffective disorder; (2) eating disorder NOS; (3) amphetamine dependence; (4) marijuana abuse; (5) polysubstance dependence; and (6) PTSD by history. A temporary conservatorship was pursued.

The patient was discharged to the Rehabilitation Center. Two weeks after discharge, the Rehabilitation Center contacted the VAMC requesting readmission due to low potassium levels resulting from his eating disorder. He was hospitalized for approximately 7 weeks. Quetiapine was changed to risperidone (an antipsychotic medication), and fluoxetine (an antidepressant medication) were added. During this hospitalization the patient was under a temporary conservatorship.

The patient was discharged back to the Rehabilitation Center. He was treated there for 2 months until he left AMA. This occurred after the county conservator's office determined that he was no longer seriously disabled and dropped the patient's conservatorship.

In early 2010, due to concern about the patient's mental state, the patient's father brought him to a VAMC clinic. Clinic staff contacted the VAMC, and the patient was admitted after being cleared in the ED. Three days later, he was discharged AMA to the care of a family member.

Several weeks later, the patient was attacked by a dog and was severely injured. His right upper lip area was completely torn off by the bite. He also had an extensive laceration of his right lower lip and the left side of his nose. He went to the Rehabilitation Center where his lacerations were sutured, and antibiotics were prescribed. The following day, he presented to a VAMC clinic. He was sent to the facility's ED, had a plastic surgery consultation, and was seen in the Plastic Surgery Clinic.

Later in 2010, the patient was found running in and out of traffic. At the family's request, he was brought to Hospital A by police and admitted there for 3 days.

The following month, the patient was found naked walking in the street. He was brought to Hospital A by police. According to Hospital A records, a staff member spoke with a VAMC psychiatrist who suggested calling back in the morning regarding a transfer. The patient was admitted to Hospital A's inpatient MH unit and was discharged home the

following day. Several days later, the patient was arrested and incarcerated. His VA OEF/OIF case manager visited him at the jail and obtained a release for medical records to be provided to jail medical staff.

Four days after his release, the patient was evaluated by a plastic surgeon at the VAMC, and surgery was scheduled for the following month. The surgeon indicated that he would review the patient's current MH status with the patient's social worker and psychiatrist since untreated MH issues and/or active methamphetamine use would be a contraindication for surgery.

A few weeks later, the patient was incarcerated briefly for shoplifting. At an arraignment hearing, the patient's OEF/OIF case manager developed a plan with the patient and a family member. The patient was to have a plastic surgery appointment at the VAMC the following day, immediately after which he would be admitted to the MH inpatient unit where he would remain throughout the preparation, operation(s), and recovery. However, the following day, the patient's family called to inform the social worker that the patient had apparently "left town."

Nine days later, the patient's OEF/OIF case manager was informed by a family member "that veteran had been taken to the ED at Hospital B for psychiatric evaluation." The OEF/OIF case manager noted that he "contacted the... county crisis worker...and spoke with her about the patient's current condition... presentation is psychotic and it is her inclination to place him on a temporary hold for serious disability" (chart entry 4:12 p.m.). In a subsequent note (chart entry 4:35 p.m.), the OEF/OIF case manager documented "Follow up call with [county name] County crisis worker: [the crisis worker's name] contacted (an inpatient unit at the facility [VAMC]) and was told they would not accept a transfer for admittance of veteran this late in the day (16:20 [4:20 p.m.])." Three days later, on [date] an addendum to his previous note about the first conversation with the crisis worker, the OEF/OIF case manager wrote "The number given to county crisis worker for admission to [the VAMC] was: [telephone number]" which is the MHEC telephone number.

The patient was admitted later that evening to an inpatient MH unit at the DoD hospital on a temporary hold. The patient was released from the hospital three days later toward the end of the 72 hour hold. Within 4 hours of discharge, the patient died. The County Coroner's Office performed an autopsy that concluded the cause of death was blunt injuries and the manner of death (accidental or suicide) could not be determined. The Coroner's report did note that the patient had high levels of phenylpropanolamine⁹ in his blood.

⁹ Phenylpropanolamine is a medication that is used as a decongestant, stimulant and/or appetite suppressant.

Inspection Results

Issue 1: Emergency Admission

Based upon the limitations of the telephone records received, we could not prove the allegation that this patient was denied admission to the VAMC on the subject day in spring 2010. However, during the course of the inspection, we found a previous request for the after-hours transfer of this patient to the VAMC approximately two months earlier in 2010 in which a staff member from an outside hospital was told that a bed was not available and advised to call back in the morning. Review of VAMC patient census documentation for this date indicates that both acute psychiatry units had available beds. In addition, we found a request for the after-hours transfer of this patient to the facility approximately one month prior to the subject day in 2010 for which ED staff from Hospital A contemporaneously documented telephone contact with the VAMC. Hospital A ED staff were advised to call back in the morning for possible transfer and given the MHEC phone number. A Hospital A staff member documented that one of the Hospital A administrators gave permission to admit the patient to their inpatient MH unit “due to VA not having enough beds-present pt to VA in a.m. after 8 a.m.” A review of VAMC bed census and staffing records indicate availability of beds on two mental health units on the evening the Hospital A ED inquired about transfer.

During the course of our interviews, we were also made aware of a more recent request for after hours transfer from a different outside hospital (Hospital C) involving a different patient in May 2011. A Hospital C ED staff was reportedly told by a VAMC staff member that the facility does not take patients for transfer at night. MHEC clinical leadership recollected this occasion and reported that immediate feedback was provided to the Chief Resident who reiterated with all residents that it was not appropriate to deny admission in that situation.

Visit to Hospital B ED and Alleged Calls to the VAMC

On the subject day in spring 2010, the patient’s family notified the OEF/OIF case manager that the patient had returned to the VAMC area but was unwilling to re-engage with the VA system. At 1:20 p.m. that day, the OEF/OIF case manager documented having reviewed options and limitations for hospitalization under serious disability or danger to self with the complainant and having “advised him to keep me informed on progress.” The OEF/OIF case manager also documented that he left a message for the patient’s brother, encouraging him to bring the patient in to discuss plans for the scheduled plastic surgery.

At 4:12 p.m. that day, the OEF/OIF case manager documented that he was notified by the complainant that the patient had been taken to Hospital B ED. The OEF/OIF case manager spoke with the county crisis worker who had evaluated the patient at the ED, found the patient to be psychotic, and felt that the patient should be placed on a

temporary hold. The OEF/OIF case manager gave the crisis worker contact numbers for the inpatient unit at the facility. In a later addendum to the note, the OEF/OIF case manager documented the telephone number he gave to the crisis worker for admission to the facility, which was the number for the MHEC.

At 4:35 p.m. the OEF/OIF case manager documented a follow-up conversation with the county crisis worker, who reported having contacted a psychiatric inpatient unit at the VAMC, and was told they “would not accept a transfer for admittance of the veteran this late in the day.” The OEF/OIF case manager appeared to take this information at face value and told the crisis worker that the patient was last hospitalized at Hospital A and that she might start there to find a bed for the night.

The county crisis worker documented the patient’s presentation and psychiatric symptoms, including delusions, hallucinations, and unkempt appearance. She noted that the patient had not eaten in several days. The note lists the OEF/OIF case manager’s name followed by the phone number for the MHEC. Under “disposition,” the crisis worker documented “attempted to contact VA-they do not start transfers this late in the day. Will place him somewhere else and they can follow-up tomorrow.”

Later in the afternoon, a second county crisis worker documented that the patient was responding to an anti-psychotic medication given in the ED and was answering some questions but that they were not relevant to the questions asked. Under “disposition,” it was documented that the “crisis worker attempted admit at 3 VA hospitals. Patient transferred to [DoD hospital]. Crisis worker was unable to contact any family member to advise of [temporary hold].”

During the course of this inspection, the county crisis workers provided written statements regarding their recollection of the events of the subject day in spring 2010. The first crisis worker reported that the patient was evaluated at approximately 3:45 p.m., and contact was made with the OEF/OIF case manager and with the police officer who brought the patient to the ED. After determining the patient required inpatient admission, the first crisis worker reported that the VAMC psychiatric intake unit was called at approximately 4:30 p.m. to begin the process of admission. The first crisis worker recalled having spoken with a man who stated that the VA did not begin transfers this late in the day, that the crisis worker should find a hospital elsewhere, and that the facility would coordinate a transfer the next day. The first crisis worker updated the second crisis worker regarding the facility’s response, and reportedly the second crisis worker indicated that she would try to find “the vet a bed that was willing to take a VA patient.”

The evening shift (second) county crisis worker reported that she was informed that the patient was a veteran who suffered from PTSD related to his service overseas and an incident that left members of his platoon dead and part of his mouth blown off. The patient was reportedly delusional. The second crisis worker recalled that contact was made with the VAMC and an intake staff member confirmed that the patient was a fully

disabled veteran; however, the crisis worker was told that there were no beds available. The same crisis worker recalled that after asking for names of other VA psychiatric facilities, VA locations for three other facilities were provided. Although the crisis worker could not remember the order in which these three locations were called, she reported that they all refused to take the patient and wanted her to call another Hospital before they would consider taking him. The crisis worker stated that the DoD Hospital accepted the patient, and he was transferred early the next morning.

During interviews, VAMC staff (other than the OEF/OIF case manager) consistently denied having received a phone call regarding this patient on the subject day in spring 2010. Bed availability records indicate available beds on both mental health units that afternoon. MH leadership and MHEC staff reported that the inpatient MH units accept admissions and transfers 24 hours per day, 7 days per week.

To resolve this discrepancy, we first requested incoming phone records for the VAMC. However, VAMC staff stated that incoming calls could not be tracked as the VAMC did not have the information technology software to track calls. We then requested outgoing calls from the VAMC for approximately a three month period in 2010. VAMC staff stated that outgoing telephone call records are stored, and the VAMC used a contracted company to store these records. Vendor archived records for outgoing calls were requested and received from the VAMC. No outgoing calls were recorded from any VAMC extension to anywhere on the subject day in spring 2010. We requested records of outgoing calls for the period March 1, 2010, through May 30, 2011. There were no outgoing calls recorded for any date in 2011. Since it would not be plausible that no outgoing calls were made from any VAMC extension on the subject day in spring 2010, or for any date in 2011, the data did not appear to be valid. VAMC staff could not explain the reason for the absence of the data as the VAMC reported that the phone system automatically collects the call records and transmits them directly to the vendor for storage.

A subpoena was served for telephone records of calls made on the subject day in spring 2010 to and from the Hospital B ED telephone extension from which the second county crisis worker recalled having made outgoing calls. Records from the telephone company indicated only a few incoming calls to that number and no outgoing calls. A second subpoena was served for records of calls for that same day and the same telephone extension and for three other telephone extensions at the Hospital B ED. Inexplicably, these records did not agree with the originally subpoenaed records; they showed no incoming or outgoing calls from three of the four telephone extensions and only two outgoing calls from one extension. The records did not show a call to the VAMC. The extension to which a few incoming calls were recorded in the first set of records was listed as having no incoming or outgoing calls in the second set of records. Based upon the limitations of the telephone records received, we therefore could not prove the allegation of denial of admission for this patient on the subject day in spring 2010.

Proximate After Hours Inquiries for Transfer of this Patient to the VAMC

Early spring 2010: Late one evening in 2010, the patient was brought to the Hospital A ED by the local police and placed on a temporary hold. He was reportedly running in and out of traffic and was almost hit by a car. The physician's evaluation determined that the patient was psychotic. Hospital A staff contacted the VAMC regarding transfer of the patient for an inpatient MH admission. The VAMC AOD reportedly informed Hospital A staff that there were no beds available until after 8:00 a.m. the next day and that other patients were already waiting to be admitted. Hospital A staff decided to treat the patient at their MH unit and to follow up with the VAMC later that day, if necessary. The following morning, Hospital A staff called the VAMC MHEC to inquire about bed availability for this patient. The case was discussed with the VAMC physician and a phosphorus level was requested of Hospital A since the patient had re-feeding syndrome.¹⁰

Contemporaneous documentation in the Hospital A medical record noted that the patient would be considered for inpatient psychiatric treatment "once they [the VA] receive discharges." A review of patient census documentation for this date indicates that both mental health units had available beds.

Late one evening the following month in 2010, the patient presented to the Hospital A ED. According to copies of the patient's medical records at Hospital A, he had been brought in by ambulance after being found walking down the street naked and talking incoherently. The patient was placed on a temporary hold and evaluated in the ED, after which the VAMC was called to request arrangements for transfer for admission. A handwritten progress note from the Hospital A ED indicated that an initial call to the VAMC was made and that a message was left during the early morning hours of the following day. The NPOD returned the call to Hospital A within 5 minutes and told staff to "call back in a.m. for possible transfer [sic MHEC phone number listed]". Within 30 minutes, a Hospital A staff member documented that one of their administrators gave permission to admit the patient to the inpatient MH unit "due to VA not having enough beds-present pt to VA in a.m. after 8 a.m.-[sic MHEC phone number]."

The patient was subsequently treated on the Hospital A inpatient MH unit and discharged the following day. A review of bed census and staffing records indicate availability of beds on the mental health units at the VAMC on the date the Hospital A ED inquired about transfer.

¹⁰ Re-feeding syndrome occurs when previously malnourished patients are fed with high carbohydrate loads, resulting in a fall in phosphate, magnesium, and potassium, leading to a variety of complications.

May 2011 Request for After Hours Transfer of a Different Patient to the VAMC

Late one morning, another patient known to the facility was brought to Hospital C by Adult Protective Services for treatment of psychosis. According to ED documentation in the patient's record, Hospital C ED staff obtained a temporary hold and contacted the VAMC. MHEC staff reportedly requested documentation of a MH examination, a medical history and physical examination, and results of laboratory tests. The MHEC staff member instructed Hospital C staff to call back after the MH evaluation was done and explained the after-hours NPOD process.

After performing the examinations and laboratory work, Hospital C staff faxed the information to the VAMC and followed up with a phone call early on the evening shift. The call was reportedly received by an NPOD, who stated that the information had not yet been reviewed and that their call would be returned. Hospital C staff later called the VAMC and reportedly spoke again with an NPOD, who still had not reviewed the information. Approximately 3 hours later, they received a call from a second NPOD, who reportedly informed them "we don't accept patients for transfer at night." This patient was subsequently admitted to the MH unit at the DoD hospital. The NPOD reported having no recollection of the reported events. MHEC clinical leadership recollected this occasion and reported that immediate feedback was provided to the Chief Resident who reiterated with all residents that it was not appropriate to deny admission in that situation.

Issue 2: Coordination of Care

Actions of OEF/OIF Case Manager

We determined that the OEF/OIF case manager did make reasonable efforts to ensure that the patient's immediate medical and MH needs were addressed. In particular, the patient was admitted to an inpatient MH treatment unit at the DoD Hospital as arranged by county crisis workers, one with whom the VAMC OEF/OIF case manager had been in contact. The OEF/OIF case manager accepted at face value the information from the crisis worker that the "facility would not accept a transfer for admittance of the veteran this late in the day" and suggested that contact be made with Hospital A where the patient had been recently hospitalized. The OEF/OIF social worker left for the day before the patient's ultimate disposition was known. The evening shift county crisis worker documented that she did not know the phone numbers for the parents of the patient and was therefore unable to contact family.

Transition of Responsibility (OEF/OIF Social Work Staff)

Subsequent to the unsuccessful effort to admit the patient to the VAMC on the subject day in spring 2010, no attempt was made to transfer the patient to the VAMC in the days that followed. The OEF/OIF case manager ended his work day shortly after speaking

with the county crisis worker a second time and learning that the patient would not be admitted to the VAMC. He assumed that the patient would be admitted to Hospital A as he had suggested.

The OEF/OIF case manager reported speaking with the OEF/OIF supervisor about this case and was on a regular day off the next day. However, the OEF/OIF supervisor did not recall if the conversation took place on the subject day, or four days later. The OEF/OIF supervisor reported that she believed the patient was at Hospital A. She reported that she did not initiate any effort to follow up because she assumed that the patient would still be hospitalized the following Monday when the OEF/OIF case manager was scheduled to return to work.

Approximately a week and a half prior to the patient's presentation at Hospital B ED, the OEF/OIF case manager had planned with the family for the patient to present to the facility for concurrent inpatient mental health treatment and reconstructive surgery for his severe facial injury. The patient did not show up for this planned admission. On the morning of the subject day in spring 2010, the OEF/OIF case manager reviewed with the patient's father the options and limitations of hospitalization of the patient under serious disability or danger to self (i.e., temporary hold).

From a systems perspective, a clear handoff with timely attempts to proactively ascertain the patient's location and initiate liaison with the DoD hospital would have provided an opportunity to better ensure continuity of treatment for this complex patient. Per VHA policy OEF/OIF program managers (supervisors) act as a back-up team member in the absence of the OEF/OIF case manager.¹¹

Issue 3: Treatment for Patient's PTSD

We did not substantiate the allegation that the VA did not properly evaluate or provide treatment options for the patient's PTSD. We found documented evidence of multiple efforts by VA staff (VAMC and VAMC2) to facilitate this patient's treatment options.

From 2005 until his death in 2010, VAMC staff made several attempts to engage the patient in sustained, outpatient MH care and rehabilitation programs. There were numerous outpatient clinic appointments made for the patient, but he failed to show or cancelled the majority of them.

Between 2006 and 2010, the patient also had multiple inpatient MH admissions at the VAMC and at VAMC2 in which he was evaluated and received treatment for PTSD, a psychotic disorder, and substance abuse issues. In several of these admissions, he was discharged AMA. Some of the patient's later hospitalizations had extensive lengths of stays, involved intensive treatment, and were coupled with discharge to therapeutic

¹¹ VHA Handbook 1010.01, *Care Management of Operation Enduring Freedom (OEF) and Operation Iraqi (OIF) Veterans*, October 9, 2009.

treatment facilities. The longer hospitalizations tended to occur when the patient was on temporary holds or under temporary conservatorship. A timeline for the overall treatment received by the patient is summarized on the next page.

Timeline for Health Care

2005

Discharged from Army: 100% SC for PTSD
 Diagnosis: anxiety disorder (NOS), polysubstance abuse, PTSD
November, December: VAMC Clinic
December: VAMC

2007

February: Transitional housing program
March: VAMC2 opiate treatment program – failed admission criteria
April: POST Clinic
May: VAMC2 admission; dc AMA
June-July: Transitional housing, refused substance abuse treatment program
September: VAMC2 homeless/substance abuse program
October: VAMC2 ED; dc AMA and dc from substance abuse program due to positive drug screen; POST clinic

2009

January: HOSPITAL A transfer patient to VAMC; dc AMA
April: SRMC transfer patient to VAMC; dc to Rehabilitation Center
June: Rehabilitation Center transfer patient to VAMC; dc to Rehabilitation Center, dc AMA

AMA: Against Medical Advice
 DC: Discharge
 HOSPITAL A ED: Emergency Department
 HOSPITAL B NOS: Not Otherwise Specified
 PTSD: Post Traumatic Stress Disorder
 POST: PTSD Outpatient Services Team

2006

April: VAMC admission; dc AMA
June: VAMC Clinic
August: VAMC2 transitional housing program; POST Clinic
September: VAMC2 residential treatment program
October: Dc from treatment program due to alcohol use
November: Referred to 2nd transitional housing program
December: POST Clinic; VAMC2 transitional housing program, dc regular

2008

March: VAMC admission; dc regular
May: HOSPITAL A attempt to transfer patient to VAMC; dc to parents
May: HOSPITAL A transfer patient to VAMC; dc regular to VAMC substance abuse program
June: Readmit to VAMC; dc regular to a drug rehabilitation program; POST Clinic
September: VAMC2 admission; dc to same drug rehab program; dc from program due to alcohol use
December: VAMC admission; dc AMA

2010-a 4-month period,

VSRMC Clinic transfer patient to VAMC; dc AMA
Private MC ED; VAMC ED
 HOSPITAL A admission; dc regular
 HOSPITAL A admission; dc regular
 VAMC clinic
 Transfer patient from HOSPITAL B to DoD hospital; dc regular

Issue 4: Early Discharge from DOD Hospital

We could neither substantiate nor refute the allegation of an early discharge from DoD hospital. The MH unit at the DoD hospital is jointly staffed by DoD and the VAMC. We interviewed two VAMC employees, a nurse and a social worker, who work on the inpatient MH unit and interacted with the patient. However, these two staff members were not directly involved in the discharge decision pertaining to the patient. The clinicians primarily involved in the discharge decision were DoD personnel. The DoD OIG declined a request for a review of this matter.

Issue 5: Other Relevant Issues

During the course of this inspection, we noted inadequate record keeping and oversight related to inter-facility communications. We also found issues in the transition of responsibility between NPODs and MHEC staff. Lastly, we noted that MHEC hours and staffing levels did not appear to be coordinated with the needs of the MH units and the timing of MH patients' admissions.

Record Keeping and Oversight Related to Inter-Facility Communications

We found that after hours incoming telephone calls from outside facilities were not maintained by the AOD as permanent records. This impairs the facility's ability to internally monitor for compliance with the local 24 hours per day, 7 days per week admission policy. Although the MHEC and NPODs keep informal alert and log sheets, in the absence of a corresponding AOD log, there are no means for review and oversight. In the busy and sometimes hectic environment of a hospital, if an NPOD forgets or fails to log an entry or to follow up on a request for admission, then there is no means to validate that a call was received.

Transition of Responsibility (MHEC and NPOD)

At the end of the shift, the NPOD returns the alert and log sheets to the MHEC. We were told that sometimes there is discussion with an MHEC clinician and at other times the log is simply left for MHEC staff to review. Some information from the alert and log sheets is entered into a computerized spreadsheet. There does not appear to be a consistent in-person discussion between the NPOD and a supervising MHEC physician of the night's activities. As a result, there is inconsistent review of incoming transfer requests and patients' dispositions. This may also be a missed opportunity for attending physician to resident physician teaching.

MHEC Operating Hours

The MHEC is open Monday through Friday from 8:00 a.m. to 4:30 p.m. and is staffed with a nursing assistant, two registered nurses, and a physician. MH and MHEC leadership at the facility reported that a majority of admissions occur during evenings,

nights, and weekends when the MHEC function essentially falls upon the AOD and the NPOD. The MHEC hours and staffing levels did not appear to be coordinated with the frequency and timing of patient admissions to the facility.

Conclusions

Based upon the limitations of the telephone records received, we could not prove the allegation that this patient was denied admission to the VAMC on the subject day in 2010. However, during the course of the inspection, we found documentation from an outside hospital of two previous requests for after hours transfer of this patient to the VAMC earlier in 2010 in which staff from the outside hospital were told that transfer to the VAMC could not be considered until after 8:00 a.m. even though VAMC documentation indicates that acute psychiatry units had available beds on both dates.

During the course of our interviews, we were also made aware of a more recent request for after hours transfer from Hospital C involving a different patient in May 2011. An outside hospital ED staff member was reportedly told by a VAMC staff member that the VAMC does not take patients for transfer at night. MHEC clinical leadership recollected this occasion and reported that immediate feedback was provided to the Chief Resident who reiterated with all residents that it was not appropriate to deny admission in that situation.

We determined that the OEF/OIF case manager did make reasonable efforts to ensure that the patient's immediate medical and MH needs were addressed. We noted improvement opportunities related to the transition of responsibility between on-duty and off-duty OEF/OIF social work staff.

We did not substantiate the allegation that VA did not properly evaluate or provide treatment options for the patient's PTSD. We determined that VA staff made multiple efforts to facilitate treatment options for this patient.

We could neither substantiate nor refute the allegation of an early discharge from the DoD hospital. The clinicians primarily involved in the discharge decision were DoD personnel. The DoD OIG declined a request for a review of this matter.

We identified improvement opportunities related to record keeping and oversight of inter-facility communications and related to the transition of responsibility between NPODs and MHEC staff.

We also determined that the MHEC hours and staffing levels did not appear to be coordinated with the frequency and timing of MH patients' admissions.

Recommendations

Recommendation 1. We recommended that the VAMC Director ensures that inter-facility MH transfer processes are consistent with facility policies.

Recommendation 2. We recommended that the VAMC Director ensures that record keeping of inter-facility communication is appropriately maintained and that internal oversight of after hour admissions, dispositions, transition of responsibility, and inter-facility communication is implemented.

Recommendation 3. We recommended that the VAMC Director evaluates the appropriateness of MHEC operating hours and staffing in relation to relevant factors, including the frequency and timing of admissions to inpatient MH units.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 23-26, for the Directors' comments.) We will follow up on the planned actions until they are completed.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: February 3, 2012

From: Director,

Subject: **Healthcare Inspection – Alleged Mental Health Access and Treatment Issues, VAMC.**

To: Director,

Thru: Director, VHA Management Review Service (10B5)

1. Attached is the completed action plan from the VAMC addressing the findings from the OIG Health Care Inspection that was conducted regarding alleged Mental Health Access and Treatment Issues.
2. I concur with their actions and the monitoring plan they have developed.

(original signed by:)

Attachments

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: February 2, 2012

From: Director,

Subject: **Healthcare Inspection – Alleged Mental Health Access and Treatment Issues,**

To: Director,

1. Thank you for your inquiry of January 27, 2012, regarding the Healthcare Inspection Alleged Mental Health Access and Treatment Issues.
2. My staff and I have carefully reviewed the recommendations and concur.

(original signed by:)

**Director's Comments
to Office of Inspector General's Report**

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendation

Recommendation 1. We recommended that the Facility Director ensures that inter-facility Mental Health (MH) transfer processes are consistent with facility policies

Concur

Target Completion Date: April 30, 2012

Facility's Response:

During the latter half of 2010, Mental Health (MH) inter-facility transfer processes and policies were reviewed. The process for initial contact from a referring facility was redesigned by an interdisciplinary team with the aim of simplifying transfers to the VAMC. The redesigned process ensured contact would be made with the appropriate MH personnel and allow for the use of a 1-800 contact number. These new MH processes were implemented January 1, 2011. We will continue to monitor our off tour admission data and our transfer log data during FY 2012 (described in response number 2 below) to ensure transfer requests are managed appropriately. Results of the monitoring will be presented to the Mental Health Inpatient Process Improvement workgroup quarterly and will also be provided to VAMC senior leadership quarterly.

Recommendation 2. We recommended that the Facility Director ensures that record keeping of inter-facility communication is appropriately maintained and that internal oversight of after hour admissions, dispositions, transition of responsibility and inter-facility communication is implemented.

Concur

Target Completion Date: April 30, 2012

Facility's Response:

The Administrator Officer of the Day (AOD) and the Night Psychiatrist on Duty (NPOD), who act as the initial contact for transfers, will each keep logs of contacts made by outside facilities for VAMC bed requests. Copies will be provided to the Mental Health Evaluation Clinic (MHEC) each morning and will be reviewed by MHEC staff for follow-up. Results of the monitoring will be presented to the Mental Health Inpatient Process Improvement workgroup quarterly. All AODs will complete the inservice for this process.

Recommendation 3. We recommended that the Facility Director evaluates the appropriateness of MHEC operating hours and staffing in relation to relevant factors, including the frequency and timing of admissions to inpatient MH units.

Concur

Target Completion Date: April 30, 2012

Facility's Response:

Past and current review processes regarding appropriateness of MHEC operating hours and staffing, take into account relevant factors, such as the frequency and timing of admissions to inpatient Mental Health (MH) units. Based on our review, we have added MHEC staff from 10:00am to 6:00pm Monday through Friday to provide overlapping hours with the NPOD who begins work at 4:30pm. Subsequent reviews have confirmed that these are appropriate hours of operation with adequate coverage. This new staffing coverage will be reflected in our revised local MHEC policy.

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Kathleen Shimoda, RN, Team Leader Daisy Arugay, MT Alan Mallinger, MD Simonette Reyes, RN Michael Shepherd, MD Mary Toy, RN

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