



# DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

## PODCAST TRANSCRIPT

# Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix VA Health Care System, Arizona

## Introduction

Hello listeners! Thank you for listening to this companion podcast produced by the Department of Veterans Affairs Office of Inspector General. Companion podcasts summarize and increase awareness of VA OIG published reports and regularly feature those OIG employees who conducted the report, inspection, or investigation. Find all VA OIG podcasts online at [va.gov/oig](http://va.gov/oig).

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## Dr. Terri Julian:

This is Dr. Terri Julian. I am the director of mental health programs within the VA Office of Inspector General. Joining me today is Associate Director Dr. Amber Singh to discuss the OIG report on [\*Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide in Phoenix, Arizona\*](#) published in early 2021. This inspection reviewed the care provided to a patient who began mental health care at the facility in 2017 and received PTSD treatment until 2018. About eight months later, in 2019, the patient asked to return to treatment. A social worker referred the patient to a non-VA mental health community provider for testing to clarify the patient's mental health diagnosis. Sadly, the patient died by suicide while waiting to be scheduled for the testing.

Dr. Singh, can you tell us how the OIG became involved and why?

## Dr. Amber Singh:

Absolutely. In the spring of 2020, in connection with work conducted by our Office of Audits and Evaluations, the Office of Healthcare Inspections identified concerns regarding staff's provision of care and completion of administrative processes.

## Dr. Terri Julian:

There were many aspects to this healthcare inspection. Let's take some time to discuss each of the areas of concern. First, can you tell me why the patient was referred to a non-VA mental health community provider for diagnostic testing?

Dr. Amber Singh:

Of course. It's helpful to understand that the patient received mental health treatment from 2017 to early 2018, when the patient discontinued treatment. Then, in spring 2019, the patient asked to re-establish treatment.

Dr. Terri Julian:

Then what happened?

Dr. Amber Singh:

A social worker evaluated the patient and observed that the patient presented as socially awkward. For example, the patient didn't seem to pick up on social cues and didn't recognize when their behaviors were inappropriate. The social worker referred the patient for psychological testing to determine if the patient's symptoms met criteria for an autism spectrum disorder or a personality disorder. Facility psychologists did not have the expertise to conduct autism spectrum disorder evaluations, so staff referred the patient to a non-VA mental health community provider that offered this type of specialized testing.

Dr. Terri Julian:

So, the social worker wanted to clarify the patient's diagnosis to determine the most appropriate treatment. Was the patient offered treatment or other support while waiting for diagnostic testing?

Dr. Amber Singh:

The social worker who evaluated the patient and referred the patient for testing did not offer interim treatment but did document a plan to follow up with the patient by telephone.

Dr. Terri Julian:

I know that suicide prevention has been a priority for the Veterans Health Administration, and leaders have implemented a standardized suicide risk screening process. Can you explain what the standards are regarding suicide risk assessment?

Dr. Amber Singh:

Yes, VHA requires suicide risk screening during all mental health intake evaluations and based on clinical judgment when there are stressors, warning signs for suicide, or worsening clinical conditions. Additionally, facility policy requires a suicide risk assessment when a patient is under increased stress.

Dr. Terri Julian:

So, based on these policies, what would you have expected to happen in this patient's situation?

Dr. Amber Singh:

That's a good question. We would have expected the social worker to complete a suicide risk assessment because during the evaluation the patient reported interpersonal, academic, housing and employment problems, as well some family conflicts. However, the social worker reported not perceiving the patient as being under increased stress and relied on another social worker's suicide risk assessment from eight months prior. Our concern is that failure to conduct a current risk assessment may have underestimated the patient's suicide risk level and contributed to an inadequate follow-up plan to mitigate the patient's suicide risk.

Dr. Terri Julian:

That is troubling. The report also described concerns about the staff following up with family members. Can you tell us about that?

Dr. Amber Singh:

In our review of the patient's electronic health record, we noted that the social worker documented that a family member left a voicemail message expressing concern about the patient's treatment. But during our inspection, we found that the social worker did not document essential information included in the voicemail. Specifically, the social worker failed to document that the family member reported that the patient died by suicide.

Dr. Terri Julian:

That does seem like a significant omission. Would not documenting the full content of the voicemail message in the patient's electronic health record mean that other staff would not have knowledge of the patient's death by suicide?

Dr. Amber Singh:

That is exactly our concern.

Dr. Terri Julian:

You also reviewed the timeliness of the non-VA appointment scheduling. The Veterans Choice Program allows eligible veterans to receive care through non-VA community providers. VHA staff can request non-VA care when a service cannot be provided within the VA facility. You explained why the social worker requested non-VA mental health diagnostic testing. Can you explain the non-VA consultation process further?

Dr. Amber Singh:

Of course. Within three days of the request for consultation with a non-VA community provider, a clinical review must be completed to determine approval. Once the request is approved, a third-party administrator, which is a company that contracts with VA to manage non-VA appointments and scheduling, identifies a non-VA community provider and schedules the patient for the requested service. The appointment should be scheduled within 30 days of approval.

Dr. Terri Julian:

So, there are some clear expectations. Did you find that facility staff followed the required process?

Dr. Amber Singh:

Yes and no. We found that a clinical review of the request was completed in eight days, not within three days as expected. The individual who completed the review told us that, when the consult was placed, there was only one staff member authorized to complete non-VA clinical reviews, which contributed to the delay. We also learned that, since that time, six additional staff members have been authorized to complete the clinical reviews, and now non-VA requests are typically reviewed within 24 to 48 hours.

Dr. Terri Julian:

So, the non-VA care request process took longer than it should have for this patient. After the request was approved, was the patient's appointment scheduled within the expected timeframe?

Dr. Amber Singh:

Yes. The third-party administrator scheduled the patient with a non-VA community provider within 30 days of approval. However, the third-party administrator scheduled the patient for therapy rather than diagnostic testing, so the patient did not receive the testing that was requested. The social worker who placed the non-VA request contacted the third-party administrator to clarify the request; but sadly, the patient died by suicide before another appointment was scheduled.

Dr. Terri Julian:

Have facility or VHA leaders taken action to make sure this kind of scheduling error doesn't occur again?

Dr. Amber Singh:

That is a great question. VHA medical centers began assuming responsibility for care coordination and scheduling of non-VA consults—rather than relying on third-party administrators—in June 2019. And as of October 22, 2020, the facility scheduled 59 percent of non-VA mental health community provider requests.

Dr. Terri Julian:

You also had concerns about some administrative processes at the facility, including missed appointment procedures. What should happen when a patient misses an appointment?

Dr. Amber Singh:

The missed appointment procedures vary depending on the setting. In the primary care setting, VHA requires staff to complete a minimum of two contacts following the missed appointment—one telephone call and one letter. In this case, the patient missed a scheduled primary care appointment the day before the patient's death. The patient's primary care physician documented the missed appointment, and a medical support assistant subsequently closed the appointment as a no-show. However, neither the primary care physician nor medical support assistant called the patient or sent a letter to the patient to reschedule the missed appointment. We determined that this was a missed opportunity to assess the patient's status and reschedule medical care.

Dr. Terri Julian:

You also found that staff did not complete a behavioral health autopsy report after notification of the patient's death by suicide. What is a behavioral health autopsy?

Dr. Amber Singh:

A behavioral health autopsy is a standardized medical record review intended to be used for quality improvement and program evaluation. Using a national template, suicide prevention coordinators must complete the autopsy report within 30 days of learning of a patient's death by suicide. In this case, the behavioral health autopsy was completed approximately one year after facility staff learned of the patient's death by suicide. Failure to complete a timely autopsy could result in incomplete information for suicide prevention quality improvement and program evaluation processes.

Dr. Terri Julian:

Dr. Singh, thank you for exploring the issues related to this patient's care and the inspection. The OIG team made seven recommendations to the facility director related to treatment and monitoring, timeliness of community care consults, completion of missed appointment follow-up procedures, accuracy and timeliness of electronic health record documentation, and administrative actions following a patient's death by suicide. Dr. Singh, what are the next steps?

Dr. Amber Singh:

VA has submitted actions plans to address each of the identified deficiencies, and the OIG will follow up on the planned actions until they are completed.

Dr. Terri Julian:

Thank you again. This report along with the status of each recommendation is available on OIG's website. There, listeners can also find other companion podcasts highlighting the OIG's oversight.

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