



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Summary Report

Evaluation of Mental Health Treatment Continuity at Veterans Health Administration Facilities

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections evaluated the continuity of care for mental health (MH) patients at Veterans Health Administration facilities. The purpose of the evaluation was to determine whether patients who were discharged from acute MH received timely follow-up.

Inspectors evaluated MH treatment continuity during 24 Combined Assessment Program reviews conducted from April 1 through September 30, 2012.

We identified two areas where the Veterans Health Administration needed to improve compliance. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensures that:

- Facilities take action to improve post-discharge follow-up for MH patients, particularly those who were identified as high risk for suicide.
- Clinicians consistently follow the required processes for patients who fail to report for scheduled MH appointments and document actions taken.



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

TO: Under Secretary for Health (10)

SUBJECT: Combined Assessment Program Summary Report – Evaluation of Mental Health Treatment Continuity at Veterans Health Administration Facilities

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections evaluated the continuity of care for mental health (MH) patients at Veterans Health Administration (VHA) facilities. The purpose of the evaluation was to determine whether patients who were discharged from acute MH received timely follow-up.

Background

MH literature documents that patients' suicide risk is heightened after an acute psychiatric episode. Among patients who attempted suicide after an inpatient MH stay, most attempts occurred within 1 week after discharge. One study found that 70 percent of those reporting severe suicidal ideation (SI) prior to hospitalization exhibited a reemergence of SI post-discharge.¹ Considerable numbers of discharged MH patients who lacked significant SI during hospitalization later developed SI during the outpatient treatment period.² Research studies have concluded that increased engagement in follow-up care is beneficial.³ Additionally, lack of follow-up can be a factor in psychiatric readmissions.⁴ Citing those same risks, VHA established metrics for MH post-discharge continuity of care.

¹ B. A. Gaudino, M. S. Andover, and I. W. Miller, "The emergence of suicidal ideation during the post-hospital treatment of depressed patients," *Suicide and Life Threatening Behavior*, Vol. 38, No. 5, October 2008, pp. 539–551.

² B. A. Gaudino, M. S. Andover, and I. W. Miller.

³ C. K. Kan, T. P. Ho, J. Y. Dong, and E. L. Dunn, "Risk factors for suicide in the immediate post-discharge period," *Social Psychiatry and Psychiatric Epidemiology*, Vol. 42, No. 3, March 2007, pp. 208–214.

⁴ M. A. Ilgen, K. U. Hu, R. H. Moos, and J. Mckellar, "Continuing care after inpatient psychiatric treatment for patients with psychiatric and substance use disorders," *Psychiatric Services*, Vol. 59, No. 9, September 2008, pp. 982–988.

In May 2010, the OIG found that VHA continues to struggle with ensuring follow-up within 7 days of inpatient discharge from acute MH.⁵ The OIG also found that VHA was at 66 percent nationally on this metric and recommended that VHA take steps to implement VHA Handbook 1160.01. VHA's response to the OIG report included an action plan to hire staff and provide technical assistance toward full implementation of the handbook. However, March 2011 VHA data revealed that VHA remained at 66 percent nationally on this monitor, with facilities ranging from 57–82 percent.

At the time this review was initiated in 2012, 7-day post-discharge MH follow-up was a VHA performance measure with a 75 percent target, and there was a performance measure target for patients deemed at high risk of suicide receiving four MH follow-up appointments within 30 days of discharge of 85 percent.

Scope and Methodology

Inspectors evaluated the follow-up of patients discharged from acute MH at VHA facilities during 24 Combined Assessment Program reviews conducted from April 1 through September 30, 2012. These facilities were a stratified random sample of all VHA facilities. The facilities reviewed represented a mix of size, affiliation, geographic location, and Veterans Integrated Service Networks (VISNs). We generated an individual Combined Assessment Program report for each facility. For this report, we summarized the data collected from the individual facility Combined Assessment Program reviews.

For each of the 24 facilities, we reviewed a sample of patients' electronic health records (EHRs). The patient sample within each facility was not a probability sample, and thus does not represent the entire patient population of that facility. Therefore, the summary results presented in this report are not generalizable to the entire VHA. Patients were excluded from review if they were transferred to another inpatient or residential unit at discharge, if they were readmitted to any hospital within 7 days of discharge, or if their post-discharge MH follow-up was arranged at another VHA facility. After exclusions, we reviewed the EHRs of 690 patients. Patients were grouped by whether or not they had been identified as high risk for suicide at the time of hospital discharge. We also reviewed facility policies and interviewed key staff. We used the VHA performance measure targets to assess compliance at the facility level.

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

⁵ *Healthcare Inspection – Progress in Implementing the Veterans Health Administration's Uniform Mental Health Services Handbook* (Report No. 08-02917-145, May 4, 2010).

Inspection Results

Issue 1: Follow-Up of MH Patients

Processes to Augment Follow-Up. VHA requires that patients discharged from acute MH have follow-up appointments in place at the time of discharge.⁶ We found that clinicians consistently scheduled patient follow-up appointments prior to discharge. However, staff reported frequent inaccuracies in patient contact information as a follow-up challenge. Validation of accurate contact information was cited in a recent Government Accountability Office report on VHA scheduling practices.⁷ We also noted that facilities varied in the extent that staff made contacts with patients to remind them of their follow-up appointments. Appointment reminder calls were not documented for 50 percent of the patients whose EHRs we reviewed.

VHA encourages the use of telemental health⁸ to support the delivery of MH services, including follow-up.⁹ Four of 24 facilities (17 percent) did not offer telemental health services at the time of our review. Sixteen of the 20 facilities (80 percent) that offered telemental health reported that this service was used for MH post-discharge follow-up. However, we found that only 5 patients had their first post-discharge MH follow-up by telemental health.

Patients at High Risk for Suicide. VHA requires facilities to identify patients deemed at high risk for suicide.¹⁰ Additional follow-up requirements exist for these patients. During the first part of fiscal year 2012, VHA had a performance measure target of 85 percent for patients at high risk for suicide receiving 4 MH follow-up evaluations within 30 days of discharge (2 encounters between days 0–14 and 2 encounters between days 15–30). VHA dropped the performance measure at mid-year but still requires clinicians to evaluate patients at least weekly during the first 30 days after discharge.¹¹

We found that patients deemed at high risk for suicide did not consistently receive post-discharge follow-up at the required intervals within the first 30 days after discharge. Of 215 patients deemed at high risk for suicide, 65 patients (30 percent) did not receive all 4 follow-up evaluations within 30 days of discharge.

⁶ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

⁷ Government Accountability Office, *Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement*, (Report No. GAO-13-130, December 21, 2012).

⁸ Telemental health uses live, interactive videoconferencing to provide MH services to patients in rural and underserved communities. Telemental health is considered a face-to-face encounter, so it meets the follow-up requirement after a telephone encounter.

⁹ VHA Handbook 1160.01.

¹⁰ VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

¹¹ Principal Deputy Under Secretary for Health and Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.

Suicide prevention coordinators have responsibility to follow up with high-risk patients after discharge.¹² Facilities varied in how they used suicide prevention staff to make contacts with patients or monitor contacts made by other providers. Seventy-one of the 215 EHRs (33 percent) of high risk for suicide patients did not contain documented post-discharge contact attempts by suicide prevention coordinators or case managers.

Patients not at High Risk for Suicide. VHA requires that all patients discharged from acute MH receive a MH evaluation within 7 days of discharge. Evaluations may be completed face-to-face, by telemental health, or by telephone. If the initial evaluation is by telephone, a face-to-face or telemental health evaluation must occur within 14 days of discharge.¹³ Because patients at high risk for suicide had more extensive follow-up requirements, we evaluated how facilities met this requirement for those not at high risk for suicide.

We reviewed the EHRs of 475 patients who were discharged from acute MH and were not identified as high risk for suicide. We found that 370 patients (78 percent) had some type of MH evaluation within 7 days. However, of the 79 patients who had an initial telephone contact within 7 days, 30 (38 percent) did not receive a face-to-face or a telemental health evaluation within 14 days of discharge. Overall, 135 of 475 patients (28 percent) did not receive follow-up that met the requirements for post-discharge MH follow-up. During onsite interviews, lack of transportation was the most frequently cited challenge in MH continuity of care.

VHA policy encourages facilities to provide follow-up within 48 hours of discharge.¹⁴ We found that 348 of 475 patients (73 percent) did not receive a follow-up evaluation within 48 hours of discharge.

We recommended that facilities take action to improve post-discharge follow-up for MH patients, particularly those who were identified as high risk for suicide.

Issue 2: Patient Failure to Attend Appointments (No-Shows)

VHA requires that clinicians initiate and document appropriate follow-up actions, such as phone or face-to-face contacts, when patients fail to report for scheduled MH appointments.¹⁵ Of the 690 patients whose EHRs we reviewed, 264 (38 percent) missed 1 or more post-discharge MH appointments. We found no documentation of action taken for 34 (13 percent) of these patients.

One hundred and seven of the 264 patients who missed 1 or more appointments were identified as high risk for suicide. Staff did not document follow-up attempts for missed

¹² VHA Handbook 1160.01.

¹³ VHA Handbook 1160.01.

¹⁴ VHA Handbook 1160.01.

¹⁵ VHA Handbook 1160.01.

appointments for 9 (8 percent) of these patients. Inspectors discussed all nine patients with facility managers. Of the 157 patients not deemed at high risk for suicide, staff did not document follow-up attempts for missed appointments for 25 (16 percent).

Of the 264 patients with a MH appointment no-show, 211 (80 percent) were discharged to a home setting; 22 (8 percent) were homeless at the time of discharge; and 31 (12 percent) were discharged to a transitional or long-term facility, a family member's or friend's residence, or other location. Difficulty reaching homeless or transient patients was the second most cited staff concern for MH continuity of care after transportation. Facilities reported success using homeless outreach staff to help complete MH follow-up evaluations for these patients.

All the facilities we reviewed had processes detailing actions to be taken when MH patients fail to report for a scheduled MH appointment; however, facilities did not consistently follow those processes.

We recommended that clinicians consistently follow the required processes for patients who fail to report for scheduled MH appointments and document actions taken.

Conclusions

Although MH providers scheduled follow-up appointments prior to patient discharge, timely post-discharge MH evaluations were not consistently provided. Additionally, patients deemed at high risk for suicide did not consistently receive 4 follow-up appointments within the first 30 days after discharge. MH appointment no-shows compromise VHA's ability to provide timely post-discharge evaluations. VHA needs to improve efforts to reach out to patients who do not report to scheduled MH appointments, document contact attempts, and consider expanding the use of telemental health services for post-discharge evaluations.

Recommendations

Recommendation 1. We recommended that the Under Secretary for Health, in conjunction with VISN and facility leaders, ensures that facilities take action to improve post-discharge follow-up for MH patients, particularly those who were identified as high risk for suicide.

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with VISN and facility leaders, ensures that clinicians consistently follow the required processes for patients who fail to report for scheduled MH appointments and document actions taken.

Comments

The Under Secretary for Health concurred with the findings and recommendations. The implementation plan is acceptable, and we will follow up until all actions are completed.



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

Under Secretary for Health Comments

**Department of
Veterans Affairs**

Memorandum

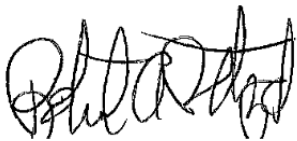
Date: April 17, 2013

From: Under Secretary for Health (10)

Subject: **Combined Assessment Program Summary Report –
Evaluation of MH Treatment Continuity at VHA Facilities
(2013-01742-HI-0399) (VAIQ 7348296)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and concur with the report's recommendations. Attached are corrective action plans.
2. Should you have additional questions, please contact Karen Rasmussen, M.D., Director, Management Review Service, at (202) 461-6643, or by e-mail at karen.rasmussen@va.gov.



Robert A. Petzel, M.D.

Attachment

VHA Action Plan

OIG, Draft Report, CAP Summary Report – Evaluation of MH Treatment Continuity at Veterans Health Administration Facilities (VAIQ 7348296)

Date of Draft Report: March 25, 2013

Recommendations/ Actions	Status	Completion Date
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OIG Recommendations

Recommendation 1. We recommended that the Under Secretary for Health, in conjunction with VISN and facility leaders, ensures that facilities take action to improve post-discharge follow-up for MH patients, particularly those who were identified as high risk for suicide.

VHA Comments

Concur

VHA will issue a memo charging facilities with creating a local patient registry for follow-up on all patients discharged from their inpatient mental health units. The patient registry will document the date/time of the scheduled follow-up appointments within 7 and 14 days, confirmation that patient contact information is correct, confirmation of reminder call for the appointments, and confirmation of attendance at the appointments. For patients at high risk for suicide, this will include documentation, reminder calls, and confirmation of follow-up appointments within 30 days of discharge. Facilities will be required to document these actions in the electronic health record. Confirmation that these registries have been created will be required to be submitted by each facility.

In progress November 30, 2013

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with VISN and facility leaders, ensures that clinicians consistently follow the required processes for patients who fail to report for scheduled MH appointments and document actions taken.

VHA Comments

Concur

VHA will issue a memo that reminds facilities of the requirement to contact Veterans who miss appointments and to have this documented in the electronic health record. At least three attempts will be made to contact a Veteran who has missed a mental health appointment and these attempts will be documented in the medical record. Facilities will be asked to develop local policies to audit this documentation requirement using chart reviews completed by local supervisors to assess if these process requirements are followed. Confirmation that these policies have been created will be required to be submitted by each facility to the VISN Mental Health Lead.

In progress

November 30, 2013

OIG Contact and Staff Acknowledgments

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