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Office of Inspector General**

Office of Healthcare Inspections

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Healthcare Inspection

Alleged Inadequate Mental Health Care Iowa City VA Health Care System Iowa City, Iowa

August 3, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection of the Iowa City VA Health Care System (system), Iowa City, IA, mental health (MH) unit admission policies and practices after a patient committed suicide shortly after allegedly not being admitted for treatment. We received review requests from five Members of Congress: Senator Tammy Baldwin, Senator Joni Ernst, Senator Chuck Grassley, Senator Ron Johnson, and Representative David Loebsack. Specifically, the requests were to:

- Examine the facts and circumstances surrounding a patient who was reportedly denied inpatient MH admission.
- Assess whether appropriate MH care was provided for this patient.
- Conduct a review of the admission policy and practice for inpatient MH to determine if this was an isolated incident, how often and why veterans seeking inpatient MH care are turned away, and how often this leads to adverse consequences.

We found that the patient requested inpatient MH admission and was not admitted. The patient's interaction with his psychiatrist at the time he requested admission was brief because the patient left the clinic abruptly. Therefore, the psychiatrist was unable to complete a full assessment of the patient's condition and needs. After the patient's departure, the psychiatrist followed him to his car and subsequently made attempts to call him by phone but was unable to further interact with the patient. The psychiatrist made a good faith effort to re-engage the patient after he abruptly left the session, and followed appropriate medical decision-making practices based on the information available to him at the time.

We determined that the patient had access to and participated in extensive MH services appropriate for his diagnoses and needs. The patient's mood, post-traumatic stress disorder, and suicidality were routinely assessed at the patient's MH visits. However, we identified system shortcomings involving adherence to Veterans Health Administration (VHA) policies on no-shows, treatment planning, and the use of principal MH providers.¹ It is difficult to determine the degree, if any, to which these shortcomings contributed to the patient's death by suicide. The ability to address the patient's problems was complicated by the fact that the patient's MH team was not made aware of all the psychosocial struggles the patient was experiencing, which if known to VHA providers may have altered the course of care.

We found system MH admission practices were in alignment with VHA and system policies, and included a plan for care when system MH beds were unavailable. Our review of patient advocate data and other VA OIG Hotline complaints did not identify a concern that patients seeking inpatient MH care were improperly turned away.

¹ The system uses the title of "MH Treatment Coordinator" for designated principal MH providers.

We reviewed the system's response to the patient's death. Although VHA requirements for review were met, the reviews were limited in scope to the electronic health record and interviews with clinicians and next of kin. As a result, information relevant to the case was missed. We discussed national post suicide review requirements with a VHA Suicide Prevention program office representative, who agreed that facility staff should make efforts to include all relevant information in their reviews. We noted opportunities for the system to plan proactively for the management of communications in similar future cases.

We recommended that the Acting Under Secretary for Health ensure that facility staff conduct thorough post suicide reviews to include all information that provides valuable context and details related to the event.

We recommended that the System Director ensure that:

- The system's No-Show policy and practice for mental health patients is in alignment with the expectations of the Office of MH Operations and that system leaders monitor compliance.
- Clinicians update outpatient MH treatment plans according to applicable requirements and guidance and that system leaders monitor compliance.
- The MH Treatment Coordinator program complies with VHA requirements and guidance, and that system leaders monitor compliance.

Comments

The Acting Under Secretary for Health, Veterans Integrated Service Network Director, and Facility Director concurred with the report and provided acceptable action plans. (See Appendixes B–D, pages 23–28, for the full text of the Acting Under Secretary for Health and the Directors' comments). For Recommendation 1 marked completed by the Acting Under Secretary for Health, we will follow up on the recently implemented actions to ensure that they have been effective and sustained. For the remaining open recommendations, we will follow up on the planned actions until they are completed.



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Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection of the Iowa City VA Health Care System (system), Iowa City, IA, mental health (MH) unit admission policies and practices. We received review requests from five Members of Congress: Senator Tammy Baldwin, Senator Joni Ernst, Senator Chuck Grassley, Senator Ron Johnson, and Representative David Loebsack.

Background

The system includes an 83-bed tertiary care university-affiliated teaching hospital that provides acute inpatient care, including MH care, and outpatient care at the main facility and at nine community based outpatient clinics and one satellite outpatient clinic. The system is part of Veterans Integrated Service Network (VISN) 23.

Suicide.² Suicide is a serious public health problem that impacts individuals, families, and communities nationwide. The causes of suicide are complex. The goals of suicide prevention efforts are to reduce factors that increase the risk for suicidal thoughts and behaviors while increasing the factors that help support and protect individuals from suicide.

In 2014, suicide was the 10th leading cause of death in the United States. Suicide rates increased among the general population between 1999 and 2014. In comparison, rates among users of Veterans Health Administration (VHA) services have remained relatively stable in recent years with the exception of male users of VHA services aged 18–29, who experienced a rise in suicide rates.

Most suicides are associated with a MH disorder.³ Other known risk factors include a history of non-fatal suicide attempts and separation from active duty service for more recent veterans. In addition, veterans with post-traumatic stress disorder (PTSD) are 5.4 times more likely to report suicidality than those without PTSD.⁴ Those who have at least two additional MH conditions along with PTSD are 7.5 times more likely to report suicidal ideation.⁵

When coupled with MH disorders, a number of psychosocial factors are associated with increased risk for suicide and suicide attempts. These include events such as loss of

² On August 3, 2016, VA released a comprehensive report analyzing veteran suicide rates in the United States. More than 55 million veterans' records from 1979 through 2014 from every state in the nation were reviewed. U.S. Department of Veterans Affairs Office of Suicide Prevention, *Suicide Among Veterans and Other Americans, 2001-2014*, August 3, 2016.

³ Harris EC, Barraclough B. Suicide as an outcome for mental disorders. A meta-analysis. *BJP*. 1997; 170: 205-228.

⁴ Calabrese JR, Prescott M, Tamburrino M, Liberzon I, Slembariski R, Goldmann E, Shirley E, Fine T, Goto T, Wilson K, Ganocy S, Chan P, Serrano MB, Sizemore J, Galea S. PTSD Comorbidity and Suicidal Ideation Associated with PTSD Within the Ohio Army National Guard. *J Clin Psychiatry*. August 2011; 72.8, 1072-1078.

⁵ Ibid.

employment or housing, a loss of sense of a future, relationship difficulties, and problems with legal authorities.

VA Suicide Prevention Program. Each VA Medical Center and very large⁶ community based outpatient clinics (CBOC) must appoint and maintain a Suicide Prevention Coordinator (SPC) who is fully committed to suicide prevention activities.⁷ As part of that program, facilities are required to identify patients at high risk for suicide using a high-risk for suicide flag placed in patients' electronic health records (EHR) in order to communicate to VA staff that a patient is at high risk for suicide.⁸ The presence of the flag should be considered when making treatment decisions, and it should be removed as soon as clinically indicated in order to maintain its clinical safety value.⁹

The determination that a patient is at high risk may be made for a variety of reasons and is a clinical judgement made after an evaluation of risk factors, protective factors, and the presence or absence of warning signs. Warning signs may include a verified report of or witnessed suicide attempt, or a patient's discussion of current suicidal ideation, threats to hurt or kill oneself, looking for specific means to do so, and talking or writing about death, dying, or suicide when these actions are out of the ordinary.¹⁰

Veteran Crisis Line. The National Veterans Suicide Prevention Hotline began operations in July 2007 as a telephone suicide crisis hotline for veterans, families of veterans, and military personnel. In 2011, the VA renamed the Hotline as the Veterans Crisis Line (VCL) in hopes of encouraging veterans and their friends and families to use the resource at the point when issues reach a crisis point, well before the risk of suicide arises. Since its launch in 2007, VCL staff have answered more than 2.5 million calls, and have initiated the dispatch of emergency services to callers in crisis more than 66,000 times. They have engaged in more than 308,000 chats since 2009, and responded to more than 60,000 texts since 2011.¹¹

System MH Services. The system maintains a 15-bed locked unit for acute psychiatric care that accepts involuntary MH commitments.¹² Criteria for admission to this unit include the severity of a patient's symptoms and the potential for danger to self or others.¹³

⁶ Very large CBOCs are those that serve more than 10,000 unique veterans each year.

⁷ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. This Handbook was scheduled for recertification on or before the last working day of September 2013 and had not been recertified.

⁸ VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk For Suicide*, July 18, 2008. This VHA Directive expired July 31, 2013 and has not been updated.

⁹ Ibid.

¹⁰ Ibid.

¹¹ About the Veterans Crisis Line. <https://www.veteranscrisisline.net/About/AboutVeteransCrisisLine.aspx>. Accessed January 5, 2017.

¹² An involuntary commitment is a legal process in which an individual is admitted against their will into a MH unit when they meet the standard of dangerousness to self or others (retrieved September 1, 2016 from https://www.law.cornell.edu/wex/involuntary_civil_commitment).

¹³ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

The system also operates a suicide prevention program. During fiscal year 2016, the system actively monitored 169 patients who were assessed as being at high risk for suicide, and reported 10 completed suicides.

Caregiver Support Program. The Veterans Omnibus Health Services Act of 2010 allows VHA to provide benefits to caregivers who support eligible veterans. Eligible veterans are those who have sustained a “serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty...on or after September 11, 2001”. Further, the veteran must be in need of personal care services because of “...an inability to perform one or more activities of daily living; and/or a need for supervision or protection based on symptoms or residuals of neurological impairment or injury...”¹⁴

Services available to caregivers through the program include: a monthly stipend, travel expenses, access to health care insurance, MH services and counseling, comprehensive training, and respite care.¹⁵ When a veteran no longer requires a caregiver due to improvement in the eligible veteran’s condition, death, or permanent institutionalization, the caregiver will continue to receive caregiver benefits for 90 days.¹⁶

VHA mandates a home visit component of the Caregiver Support Program for participants applying for and enrolled in the program. Home visits are characterized by a standardized assessment of the health and well-being of the veteran and the caregiver with the goal of optimizing their ability to manage successfully in the home environment. The Caregiver Support Coordinator is responsible for ensuring the home assessments are completed within the established time frames and documented in Computerized Patient Record System (CPRS) in a timely manner, and for recording and tracking home visits in the Caregiver Application Tracking system.¹⁷

Recent OIG Reviews. See Appendix A for other relevant OIG reports published in the past 5 years.

Congressional Requests. In July and August 2016, the OIG received letters from five Members of Congress: Senator Tammy Baldwin, Senator Joni Ernst, Senator Chuck Grassley, Senator Ron Johnson, and Representative David Loebsack, requesting review of the system’s MH unit admission policies and practices. Specifically, the requests were to:

- Examine the facts and circumstances surrounding a patient who was reportedly denied inpatient MH admission.
- Assess whether appropriate MH care was provided for this patient.

¹⁴ Public Law 111-163, *Caregivers and Veterans Omnibus Health Services Act of 2010*, May 5, 2010.

¹⁵ Ibid.

¹⁶ 38 CFR 71, *Caregivers Benefits and Certain Medical Benefits Offered to Family Members of Veterans*.

¹⁷ *Caregiver Support Program Guidebook*. Department of Veterans Affairs, Veterans Health Administration April 20, 2012.

- Conduct a review of the admission policy and practice for inpatient MH to determine if this was an isolated incident, how often and why veterans seeking inpatient MH care are turned away, and how often this leads to adverse consequences.

Scope and Methodology

We initiated our review in August 2016 and our work included a site visit August 4–5, 2016. We interviewed system staff, including a psychiatrist, a psychologist, an administrative officer, social workers, substance use counselors, suicide prevention team staff, Caregiver Support Program staff, and MH leadership, as well as non-VA employees who regularly interacted with the patient.

We reviewed the patient’s EHR with particular focus given to the 6 months preceding the patient’s death.

We reviewed relevant VHA and facility policies and procedures as well as applicable clinical guidelines, other OIG Hotline complaints, admission criteria for inpatient MH units (including diversion data), census data for inpatient MH units, system suicide data (high risk flags and completed suicides), National Utilization Management Integration (NUMI) data, reports of all system responses/actions related to the event, system EHR audits related to patient treatment plans, patient advocate data, phone records, police reports, peer reviews, a Root Cause Analysis, required SPC reports, Joint Commission (JC) reviews, and selected, relevant scientific research articles, professional society guidelines, and peer-reviewed journals.

Three VHA policies cited in this report were expired or beyond their recertification dates:

- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008 (recertification due date September 30, 2013).
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011 (recertification due date March 30, 2016).
- VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008 (expired July 31, 2013).

We considered these policies to be in effect as they had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),¹⁸ the VA Under Secretary for Health (USH) mandated the “...continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance.”¹⁹ The USH also tasked the Principal Deputy Under

¹⁸ VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.

¹⁹ VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document*, June 29, 2016.

Secretary for Health and Deputy Under Secretaries for Health with ensuring "...the timely rescission or recertification of policy documents over which their program offices have primary responsibility."²⁰

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.

²⁰ VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document*, June 29, 2016.

Case Summary

VHA Care Following First Military Discharge

The patient was a male in his thirties, with a medical history that included PTSD; chronic back, leg, and knee pain; and other MH diagnoses, who completed three deployments to the Middle East and initiated care with the system following his second deployment and first discharge from service in 2008. A system psychiatrist diagnosed him with PTSD soon after his discharge. A few weeks after being diagnosed with PTSD, the patient joined another military service. A month after joining the other military service, the patient was referred for evaluation of possible brain injury. A psychiatrist found no clear evidence of brain injury, but documented the patient was depressed.

Over the next year the patient received psychotherapy and medication for his PTSD and other MH diagnoses. In 2009, he was charged with driving while intoxicated in another state. A few weeks after he was charged with driving while intoxicated, the VA Suicide Prevention team called the patient following a community hospital admission. The patient denied trying to kill or harm himself. During this same period, the patient enrolled in outpatient MH services.

Return to Active Duty

In 2010, the patient served an 11-month deployment after which he married and became a father. He continued treatment for PTSD and other MH diagnoses. A psychiatrist prescribed medications for PTSD and other MH symptoms, and the patient was followed by a social worker for MH concerns at a military community based clinic. In 2012, the patient was admitted to a private MH hospital in another state, after his wife found him appearing to attempt suicide with a gun. A few months after the suicide attempt, the patient was readmitted to the same hospital for treatment of PTSD and other MH diagnoses. Following the second admission, the patient participated in outpatient MH treatment. In 2013, after suffering some emotional stress and while experiencing severe symptoms of PTSD, the patient attempted suicide by overdosing on his medications. He was admitted to the out-of-state hospital a third time. Several months after this suicide attempt, a referral was generated by the military to transfer the patient's care to the VA in advance of his second discharge.

VHA Care Following Second Military Discharge

A few days prior to his second discharge from the military, the patient returned to the VHA system for care. He received psychiatric medications and attended individual and group treatment for his PTSD and other MH diagnoses. The patient was in the process of a divorce and had supervised visits with his child. He began dating a woman who ultimately became his caregiver. In 2014, a speech language pathologist working with the patient referred him for a second (Traumatic Brain Injury) TBI evaluation as a result of additional exposures, including a fall and blasts, occurring during 2010–2011. Providers concluded that he likely had a mild TBI, but his current symptoms were more likely related to his MH diagnoses.

From 2014 until 2015, the patient had multiple MH inpatient and residential treatment program admissions. In 2014, his ex-wife threatened to remove his rights for visitation with his child, and the patient attempted to kill himself by taking pills. He was admitted to a non-VA hospital and transferred to the system's inpatient MH unit where he reported feeling "like he had nothing left." While an inpatient, he developed a suicide safety plan with the guidance of staff, and staff placed a high-risk for suicide flag in his EHR. During this admission, the patient reported experiencing other MH issues months earlier, but did not disclose to the VA staff at the time fearing that it might negatively affect his custody case. The patient was scheduled to begin treatment for his other MH issues the day after his discharge.

The patient was readmitted to the system's inpatient MH unit in mid-2014 after presenting to the system Emergency Department (ED) and reporting feelings of hopelessness and suicidal thoughts. The flag previously placed in his EHR indicating that he was at high risk for suicide remained in place. On the day of discharge, the patient attended the Intensive Outpatient Program (IOP) located at the CBOC closest to his home (CBOC #1). He engaged in daily care there for a few weeks before being admitted to a MH residential treatment program. He left the program against the advice of his treatment team after about 10 days. He agreed to return to IOP but did not engage in the program as planned.

Later the same month, the patient was seen by a psychiatrist who discussed a recent general threat the patient had allegedly made against VA. The patient denied making the threat, stated he was no longer interested in IOP, and walked out. Staff, concerned for his safety, requested local law enforcement conduct a welfare check. The patient was picked up by local law enforcement and taken to a community hospital for evaluation, which resulted in a short admission. After his community hospital discharge, he presented to the system ED and was voluntarily admitted. While an inpatient, he created a new suicide safety plan with guidance from staff and the high-risk for suicide flag remained active.

A few weeks after his discharge from the inpatient MH unit, the patient was readmitted to the residential treatment program. The patient completed the program and was discharged several weeks later with an aftercare plan that included attending IOP and community support group meetings.

The patient engaged in IOP and continued individual therapy for his PTSD. In early 2015, he reported that his mood was very good and that things had been improving for him over the past few months. His psychologist conducted an assessment and determined the patient to be at low-risk for suicide. The high-risk for suicide flag in his EHR was removed.

Two weeks after the flag was removed, the patient presented to the system ED with suicidal ideation, and other MH symptoms. He was admitted to the inpatient MH unit for a brief stay, during which he requested to be discharged with follow-up in the IOP. The patient's EHR was again flagged to indicate that he was at high risk for suicide.

The patient was enrolled in the IOP at CBOC #1 for several months. He missed sessions and had a series of increasingly contentious interactions with the staff. The social worker documented the patient's request to shift his care elsewhere, as the patient felt the therapeutic relationship had been negatively impacted. He was offered and agreed to enrollment in the IOP at a system CBOC (CBOC #2) located an hour away.

The patient established care with a new psychiatrist and counselor. He maintained his ongoing relationship and treatment with his PTSD psychologist. After enrolling in the IOP, the suicide prevention case manager removed the high-risk for suicide flag in his EHR in mid-2015, after determining he no longer met criteria due to consistently low-risk for suicide ratings. Over the course of the next several months, the patient was actively enrolled in IOP. The patient enrolled in the VA Caregiver Support Program and his girlfriend served as his caregiver. At the end of 2015, the patient presented to the system ED with MH complaints.

In 2016, clinicians documented in the EHR that the patient consistently described how great he was feeling. He was hopeful and reported positive things in his life. He stated that his relationship with his girlfriend was going very well. The patient was engaged in psychotherapy for PTSD, anger management classes, IOP, and the Caregiver Support Program. Four suicide risk assessments completed by his psychiatrist and counselor determined his risk for suicide to be low to none.

Later in 2016, he successfully completed IOP and agreed to participate in individual counseling and weekly support groups.

A few weeks after the patient's graduation from IOP, his caregiver girlfriend called the Caregiver Support Coordinator to request couples counseling which ultimately did not occur due to scheduling conflicts. Over the next few weeks, the patient canceled or failed to attend several scheduled groups. In interviews with us, the patient's ex-wife said that she noticed the patient was not doing well during this time period, and his caregiver girlfriend agreed. Also about this time, documentation in the patient's EHR shows the patient's counselor called to check on the patient's progress, left the patient a voicemail, but never received a return call.

A few weeks prior to his death, the patient called the VCL and reported suicidal thoughts, although he denied a plan or intent to harm himself. He explained that he was having a bad day, had nobody to talk to, his relationship with his girlfriend was ending, and he was not motivated to attend two scheduled MH appointments the following day. The patient, in conjunction with the VCL staff, developed a safety plan while on the call. The following day, the patient attended both MH appointments. The patient's first appointment with his counselor occurred prior to the call to the VCL being documented in the patient's EHR.²¹ The patient shared that he was depressed and outlined a

²¹ Following a call to the VCL, VCL staff notify the SPC at the VA where the patient receives care. The SPC reviews actions taken by staff at the VCL, attempts to reach the patient and discusses the situation with the patient's care team as warranted. All actions are documented by the SPC in the EHR.

number of stressors. The counselor informed the patient that he would no longer be working with him as he was leaving his position at VA. Following the visit, his counselor documented that the patient had recent suicidal ideation without plan or intent, as well as hopelessness, but determined the patient had an overall low-risk for suicide. At the time of the patient's second appointment with his psychologist later that day, the SPC had documented the patient's call to the VCL in his EHR. The psychologist saw the VCL note prior to meeting with the patient. In their treatment session, the patient told the psychologist that "I haven't felt this depressed in a couple years." The psychologist documented "There was no strong indication of risk of harm to self/others. Pt's mood was overall depressed; downtrodden; affect WNL [within normal limits]." The treatment plan was for the patient to return to see his psychologist on an as needed basis. The EHR lacks documentation to indicate that the patient self-reported his call to the VCL during either of these appointments. In a follow-up consult sent to the SPC by VCL staff, the SPC attempted to reach the patient. When unable to reach the patient directly, the SPC contacted the patient's counselor and read the most recent psychology note. Based on the review, the SPC concluded that the patient did not appear to be at high risk for suicide, intervention from the Suicide Prevention Team was not needed, and requested that the consult be closed.

About a week later, a Caregiver Support Program nurse visited the patient and his caregiver/girlfriend in their home. The nurse noted in the EHR that the patient reported an increase in depression. He denied suicidal ideation but documentation in the EHR indicated that he "states feels hopeless and does have periods where he thinks about how things would be if he wasn't around and if it would take the burden off others." The patient reported that he had not told his psychiatrist how he was feeling. The nurse told the patient that she would contact his psychiatrist for follow-up with him.

Later the same day, the patient's clinic nurse and psychiatrist called the patient. The patient again acknowledged that he was "in a really dark place right now." The psychiatrist provided the patient with medication and scheduled him for follow-up in 2 weeks.

About a week later, the patient's caregiver girlfriend called the Caregiver Support Program Coordinator and said she felt the patient needed a VA appointed payee²² due to his having exhausted all his funds and "inability to manage his finances." She declined to discuss if the patient had relapsed or elaborate on the status of her relationship with the patient.

The following day, the patient met with his new counselor and he presented with a good mood but with emotional lability. He identified playing with his child as a positive aspect of his life and reported that he and his girlfriend were going through an amicable break-up. The counselor assessed that the patient had no identifiable risk of suicide. The patient requested to resume IOP and the counselor agreed to discuss the request with the coordinator. The counselor documented that he left a voicemail for the patient a few

²² A VA appointed payee is a fiduciary, approved by the VA, who is responsible to the veteran and oversees financial management of VA benefit payments.

days later that outlined the patient's IOP options, the plan to inform the patient's psychiatrist of the IOP options, and offered to attempt to make contact with the patient at his psychiatry appointment days later. The EHR shows that the psychiatrist was made aware of the IOP options, but the counselor did not document having met with the patient a few days later.

The patient's final appointment with his psychiatrist was the day prior to his death, during which he reported experiencing a recurrence of certain MH issues and requested inpatient admission. The psychiatrist documented that the patient denied other active problems in need of attention. The psychiatrist told the patient the inpatient unit was full and that he would "probably not" be admitted, as his treatment could be started on an outpatient basis. Though not documented, the psychiatrist told us the patient declined his offer to remain in the outpatient MH clinic while receiving treatment for his reported MH issue. Documentation in the EHR shows that the psychiatrist inquired about the patient's finances and his caregiver girlfriend's request that he have a VA payee, asking the patient for his thoughts on the matter. The patient responded saying "My thoughts about it don't matter. They are going to do what they want to do. They won't let me come in the hospital to get help, but they'll take my money." The psychiatrist documented that the patient then "abruptly" left the appointment prior to completing the full session, and that the psychiatrist followed him to his car in an effort to re-engage him in care. The psychiatrist noted in the EHR that the appointment lasted only a few minutes. He also documented "I don't find an indication for hospitalization, though I was not able to make a complete suicide risk assessment due to veteran leaving the appt [sic] prematurely." The psychiatrist documented, and phone records confirm, his two attempts to reach the patient by phone later that day and once the afternoon of the following day.

At some point after the last visit to the psychiatrist and prior to his death, the patient posted on social media that he sought admission for inpatient treatment and expressed concern for his health and safety.

The following day, after learning of the patient abruptly leaving his appointment, the Caregiver Support Program Coordinator documented calling the patient's caregiver/girlfriend. Throughout the course of the call, the caregiver/girlfriend reported information regarding the patient's MH and financial issues, and the status of their relationship including that the patient was not staying at her residence but she saw him most days. She reported that the patient came to her home in the early morning that day, but she was not aware of his whereabouts at the time of the call. She told us that on the morning of the patient's death, after speaking with the Caregiver Support Program Coordinator, she went to the patient's home to check on him. She found the patient deceased and called 911. In an interview with us, the Suicide Prevention Case Manager said that she learned of the patient's death several days later and notified members of the patient's treatment team.

Information in the local police report, including two notes found near the patient, reflect that the patient committed suicide.

Inspection Results

Issue 1: Request for Admission

We found that the patient requested inpatient MH admission the day prior to his death and was not admitted. The psychiatrist's decision not to admit the patient was within acceptable practice based on the information available to him at the time. However, if the admitting psychiatrist had been aware of the extent of the patient's psychosocial struggles, as discussed later in this report, the psychiatrist may have decided to admit the patient. Moreover, the psychiatrist made a good faith effort to re-engage the patient after he abruptly left the session.

We found that the patient's interaction with his psychiatrist at the time he requested admission was brief and ended when the patient left the clinic abruptly. Therefore, the psychiatrist was unable to complete a full assessment of the patient's condition and needs. After the patient's departure the psychiatrist followed him to his car. He subsequently made attempts to contact the patient by phone but was unable to further interact with him.

Reports of the patient's statements regarding the need for admission differed among EHR documentation and interviews with family. EHR documentation indicated that the patient told his psychiatrist that he lacked confidence he could successfully undergo treatment as an outpatient and denied other psychosocial issues that may have warranted admission.

The reasons documented by the psychiatrist as to why he did not admit the patient included: management of the patient's symptoms was most often done as an outpatient; the inpatient unit was full; and the patient denied other acute MH needs. We confirmed that on the day prior to the patient's death, the MH unit was full, and that if a completed assessment had indicated admission was warranted, system policy delineates that the patient would have been admitted to a non-VA community hospital.

Issue 2: Appropriate MH Care

We determined that the patient had access to and participated in extensive MH care appropriate²³ for his diagnoses and needs. However, we did identify some deficiencies in patient care by the system, including in the areas of adherence to the national no-show policy, treatment planning, and MH treatment coordination.

No-Show Policy

An opportunity to assess and treat a patient is lost when he or she misses an appointment. VHA leaders have made a concerted effort to ensure staff follow up with patients who miss appointments. The Deputy Under Secretary for Health for

²³ For this report, we defined appropriate MH care as treatment for those diagnoses that were identified as active and the treatment addressed goals set by the veteran and treatment team.

Operations and Management Memorandum, *Guidance on Patients Failure to Attend Appointments (No Show)*, June 25, 2013, states that

VA policy requires staff members to contact Veterans who miss scheduled mental health or substance use disorder appointments. Follow-up can be completed in most cases by any staff member. However, if the patient is on the high-risk list, a qualified mental health provider must make the contact. Follow-up will be by telephone in most cases. At least three attempts should be made to reach the Veteran and this must be documented in the Veteran's medical record.

In addition, facilities are required to "...develop or amend local policies to ensure consistency with this requirement. The policy must include a requirement for supervisors to audit compliance with the policy by performing chart reviews."²⁴

The system's policy requires Medical Support Assistants (MSA) to note when a patient failed to attend an appointment in the appointment management system, print a no-show letter, reschedule the missed appointment, and notify a case manager or designee for all patients, except those on the high-risk for suicide list.²⁵ For those on the high-risk for suicide list, system policy requires that a qualified health provider²⁶ make contact.²⁷ However, system MH staff reported variations to their actual practice including having a MH clinician make one attempt to call patients who miss an appointment and, if unable to reach the patient, leave a message. The MSA then attempts to call the patient and, if unable to reach the patient after two attempts, sends a no-show letter to the patient.

In the last several months of his life, the patient had many outpatient MH appointments scheduled, of which he canceled or failed to attend about one-third. The system canceled a few group therapy appointments; because these groups meet on a regular schedule, the facility did not need to reschedule the cancelled appointments.

Documentation in the EHR confirms that MH clinical staff spoke with the patient following about one-third of the missed appointments. Following several other missed appointments, MH clinical staff documented that they were unable to reach the patient and left a voice message. The EHR and appointment management system lack documentation recording a second or third attempt to call the patient or send a letter for these appointments. We were unable to locate evidence of actions taken by staff following the remaining missed appointments.

While we are unable to retrospectively determine the impact for this particular patient had the process been followed and he received additional calls or letters for each of his missed appointments, we were able to determine that the system's policy, actual

²⁴ Deputy Under Secretary for Health for Operations and Management Memorandum, *Guidance on Patients Failure to Attend Appointments (No Show)*, June 25, 2013.

²⁵ Iowa City VA Health Care System MCM 14-240, *Processing No Shows in Outpatient Clinics*, December 17, 2014.

²⁶ A qualified health provider is defined as a licensed clinician.

²⁷ Iowa City VA Health Care System MCM 14-240, *Processing No Shows in Outpatient Clinics*, December 17, 2014.

practice, and documentation in the EHR were not in alignment with VHA's Office of Mental Health Operations guidance that all veterans who miss MH appointments are called three times and that each attempt is documented in the EHR.

Treatment Planning

VHA guidance regarding treatment plans includes the coordination and development of a treatment plan that incorporates input from the patient, and is monitored and revised when necessary.²⁸ The JC requires that plans be modified in accordance with progress towards goals and changes in needs and preferences. Reassessment occurs for a variety of reasons, including the need for an evaluation of a patient's response to care, treatment, or services, and/or in response to a significant change in status, diagnosis, or condition.

A facility policy defines treatment planning as "a natural outcome of the assessment process. It is a fluid system that requires continuous monitoring. If monitoring is carried out effectively and efficiently, there should be no dramatic surprises during the course of treatment." The goal of treatment planning is to provide "individualized, planned, and appropriate interventions."²⁹

Between 2013 and 2015, the staff developed four separate treatment plans with the patient; however, these plans were not updated following a number of significant events. Although the patient's original treatment plan discussed depression and PTSD, clinicians did not update the treatment plan when the patient expressed significant changes in mood during MH appointments. From the time the patient called the VCL, various clinicians entered multiple notes into the patient's EHR indicating he was struggling and experiencing increased depression. The psychologist documented the patient saying "I haven't felt this depressed in a couple years." This note has no co-signers on it and indicates the plan is for the patient to contact the psychologist if he wants individual therapy and to return to the clinic on an as-needed basis.

Another note from a counseling session after the patient reported depression indicates that the patient "was agreeable to seeking VHA support and preventing things from becoming worse" and that the patient agreed to speak with his psychiatrist regarding medications to help treat depression. Other than having the psychiatrist co-sign the note and noting an appointment over a month away, the EHR does not contain documentation of plans to ensure the patient connected with his psychiatrist to address his depression. Several days later, during a nurse's visit to the patient's home, the patient shared that he was "not in a good place." Despite repeated expressions of despair to individual clinicians, the treatment team was not brought together to discuss the patient and/or update his treatment plan.

²⁸ VHA Handbook 1160.01, *Uniform MH Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

²⁹ Iowa City VA Health Care System Addictive Disorder Services Standard Operating Procedure (SOP), June 13, 2016.

A treatment plan created at the time the patient transitioned from one IOP location to another within the system recognized both the IOP and Extended Outpatient level of care³⁰ as therapeutic activities in the patient's treatment, and the plan was cosigned by the members of the treatment planning team. Upon graduation from the IOP program in 2016, the therapist noted that the patient met the requirements for program completion and encouraged him to continue with the continuing care program. At this critical juncture in the patient's recovery, the treatment plan was not updated, and a counselor was the only member of the MH treatment team to sign this note.

Although much information was available in the EHR through various notes, it was not centralized into a treatment plan. Without an updated treatment plan, the team was denied a single place to go for a comprehensive look and coordinated plan of care. It is impossible to know whether the information being in a centralized location would have changed the actions/clinical decisions of any one provider.

Clinical Assessments

A clinical assessment involves evaluating a patient through history taking, physical exam, and/or an analysis of conditions, disorders, data, and a patient's overall state, including social factors.³¹

A suicide risk assessment is a clinical evaluation tool designed to assist in the identification and documentation of necessary information to help determine a patient's current risk level and care needs. MH providers are responsible for assessing suicide risk at every clinical encounter using a standardized template to assist with documentation. Exceptions to this requirement include when the patient is seen in a group setting that does not allow for an individualized discussion/assessment or if another provider completes the risk assessment earlier on the same day.

This patient was well known to the team and, according to staff members, was doing very well in the several months before his death. He demonstrated success in treatment and graduated from IOP, a significant point where the patient was to increase his role in creating the structure for his ongoing recovery. About a year had passed since his last inpatient admission, a significant improvement compared to the year before when he had been an inpatient several times. Clinicians described him as committed to treatment, and noted that he had successfully navigated difficult situations in the past.

We found that mood and PTSD were routinely assessed at the patient's MH visits. Other than the last appointment when the patient left prior to a suicide risk assessment being completed, we found that clinical staff completed suicide risk assessments as required. Notes in the EHR document the recurrence of the patient's depression. While

³⁰ Extended Outpatient is the term used by the system to describe the level of care that is recommended following graduation from the IOP. It indicates a recommended treatment level of 1 – 8 hours of treatment per week.

³¹ Stedman's Medical Dictionary, 28th Edition (2006).

he had a remote history of anti-depressant use for mood disorder and anxiety, he had not been on medication for depression for about a year. His last prescription for an anti-depressant was mailed in early 2015. A review of the record found that in the last few months of the patient's life, his psychiatrist and psychologist assessed his mood at each of their visits and noted a downturn in the patient's mood. Before that, the patient consistently reported a positive mood. About a month prior to his death, the patient reported an exacerbation of depression and told his psychologist, "I haven't felt this depressed in a couple of years." His psychiatrist explained that in complex cases such as this, it is difficult to sort out depression versus symptoms of PTSD. The psychiatrist stated his intention to address the patient's depression if the truncated final appointment had continued.

Although assessments occurred, documentation in the EHR does not go into depth demonstrating that contributing factors were fully explored. For example, the patient's relationships with his child and girlfriend were listed as protective factors but little evidence is documented of conversations about the time he spent with each and the status of those relationships. In interviews, the patient's ex-wife told us that the patient had canceled visits with their child over the last few weeks of his life. The treatment team did not know, or had not documented, that the patient had not seen his child during this time.

We identified additional information during our review that, if known to VHA providers, may have altered the course of care. Interviews with clinical staff and a review of the EHR revealed that the patient's caregiver/girlfriend was aware of, but had not informed VHA providers that the patient had been talking about suicide³². In addition, although documentation noted that the patient mentioned suicidal thoughts, it does not indicate that he had formulated the intent/plan to harm himself in the last weeks of his life. The EHR indicates that a few weeks prior to his death, the patient's caregiver/girlfriend shared her concern regarding his money management but declined to specify the cause of his financial difficulties. Although the team was aware of the caregiver/girlfriend's concerns over the patient's money management, they did not know the extent of his financial problems. When the psychiatrist asked him about financial concerns during his final appointment, the patient became very upset and left. The MH team was also unaware that the patient had canceled his visits with his child, a previously recognized protective factor, for the few weeks prior to his death.

We noted multiple visits to MH providers and various approaches to treatment documented in the patient's EHR that indicated numerous attempts to help the patient. One provider spoke of how out-of-character he felt suicide was for this patient, since this patient always found a way to get through difficult times and continued to talk about future plans. The team's ability to address the patient's problems in general, and particularly in the weeks leading up to his death, was complicated by the fact that the team was not aware of all the psychosocial struggles the patient was experiencing.

³² These details were shared with the police following the patient's death.

MH Treatment Coordination

In an effort to ensure care coordination and integration, every veteran seen for MH services is to be assigned a principal MH provider.³³ This individual must be made clear to the patient and identified on a patient tracking database. The principal MH provider is responsible for, among other things, ensuring regular contact is maintained with the patient as clinically indicated, psychiatric medications are reviewed and reconciled on a regular basis, implementation of the patient's treatment plan is monitored and documented, revision of the treatment plan is made as necessary, and collaboration with the SPC occurs to support the identification of patients at high risk and to ensure that they are provided with increased monitoring and enhanced care.

The system's practice was to assign a Registered Nurse Case Manager as the principal MH provider, called the MH Treatment Coordinator (MHTC). According to the patient's MHTC on record, as explained during an interview, the MHTC receives his/her direction from the provider(s) at the clinic and handles medication refills, appointment scheduling, follow-up calls requested by a provider, and crisis intervention in the event that concerning information is shared about or by the patient. The MHTC reports inconsistencies throughout the system as to when a new MHTC is to be assigned following patient movement within the system or when an MHTC should intervene without physician direction. Additionally, an MHTC is only notified of a patient's graduation from the IOP if the patient plans to establish care at the clinic where that coordinator is located, even if the MHTC is still assigned as the patient's primary MH provider.

We found that the patient had an MHTC assigned in 2013. The coordinator was located at CBOC #1. Between the initial assignment and 2015, the MHTC was routinely involved in the patient's care primarily through phone calls and the coordination of information between various providers. Topics the MHTC addressed included suicide risk and whether or not the patient was on a high-risk status, patient medications, welfare checks to see how the patient was doing, and calls to schedule appointments when the patient had been absent for a period of time. The last communication between the patient and the MHTC was in early 2015, at the point the patient enrolled in the IOP program at CBOC #2. At no point throughout the subsequent course of the patient's care was a different MHTC assigned to oversee his care. We found that the original MHTC was unaware of the continued assignment as the patient's current MHTC, therefore leaving the patient without a coordinator active in the patient's treatment.

Issue 3: MH Admission Practices

We reviewed the system's policy and procedures for admitting patients for MH care to assess whether there was a trend of improperly turning away patients seeking inpatient

³³ VHA Handbook 1160.01, *Uniform MH Services in VA Medical Centers and Clinics*, September 11, 2008 (amended November 16, 2015).

MH care. We found that the system followed VHA admission guidelines, including processes for when the system beds were unavailable, and that MH admissions met utilization management³⁴ (UM) criteria.

MH Admission Policy and Practices. VHA requires that admission to inpatient MH care be available for all patients who require hospital level care for a MH condition, either in the VA facility, a nearby VA facility, or through non-VA care. If appropriate treatment facilities are not available at the site where the patient is receiving the evaluation, MH leaders at facilities must have a plan in place to ensure patients have access to the needed level of care.³⁵

A licensed provider with admitting privileges must determine whether a patient needs to be admitted, regardless of a patient's desire to be admitted. The provider is to base the admission decision on a thorough evaluation and clearly document justification.

VHA requirements for inpatient MH care include severity of symptoms and the potential for danger to self or others as elements determining eligibility for admission. Anyone who presents with verbal or physical aggression, suicidal or homicidal thoughts or intent, and is considered a danger to self or others will not be turned away.³⁶ A system MH leader explained that all MH admissions should have the patient's safety as a primary reason for admitting a patient. Other patient's MH needs may be addressed through outpatient care.

The system's inpatient MH unit has 15 beds with an average daily census of 13. When beds are not available and a patient needs admission for MH care, the system has a process in place to ensure patients receive the needed care. In the event that a bed is not available, the primary back-up is the system's academic affiliate, but the system also partners with other community resources. When a patient receives inpatient MH care in the community, the requesting provider obtains approval and enters an appropriate Non-VA Care consult into the EHR, relevant medical information is provided to the community provider, travel is arranged for the patient, and Care Management nurses follow the patient's non-VA care until the patient's care returns to the system.

The system's psychiatry diversions report showed that between January and June 2016, the system placed 98 MH patients in non-VA facilities due to lack of bed availability. The monthly number of MH patients transferred to the community during that time ranged from 2 to 26 and resulted from the MH unit being full, not having enough staff, and being closed to additional admissions due to a Norovirus outbreak.

Inpatient MH Services. We did not identify a trend in the system improperly turning away patients seeking inpatient MH care. To determine whether or not this was an

³⁴ Utilization Management is a review process used to manage health care use by influencing patient care decision-making through individualized assessment of the appropriateness of care prior to care delivery.

³⁵ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

³⁶ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

isolated incident, we reviewed all reports submitted to the system's patient advocate in 2015 and 2016 that involved MH admission practices or decisions, and other VA OIG Hotline complaints regarding the system and the denial of care/admission to the inpatient MH unit.

During a 12-month period reviewed, the patient advocate received 14 reports regarding MH admission practices or decisions. Nine of the 14 reports were from patients already admitted to the inpatient MH unit. The other five were unrelated to MH access to the inpatient MH unit. No other complaints have been made to the VA OIG Hotline regarding the system and the denial of care/admission to the inpatient MH unit.

System MH admission practices were in alignment with VHA and system policies. We did not find evidence of a trend in inappropriately denying patients' request for admissions. Additionally, our review of patient advocate data and other VA OIG Hotline reports did not identify that the system was improperly turning away patients seeking inpatient MH care.

Issue 4: System Review/Response to the Case

We reviewed system employees' responses to the patient's death from suicide in order to ensure that the system not only met VHA requirements, but also identified aspects of the care delivery system that could be improved in the future. In addition, we spoke with the Director, Field Operations, Office for Suicide Prevention, regarding national policies, practices and guidance given to local suicide prevention teams following a veteran suicide. He agreed that facility staff should make efforts to include all relevant information in their post suicide reviews.

Suicide Reporting. VHA requires that SPCs report all veteran suicides. The reporting process includes completion of a Suicide Behavior Report, Issue Brief,³⁷ Behavioral Health Autopsy,³⁸ and data entry into the national Suicide Prevention Application Network. We found the SPC complied with these reporting requirements.

Reviews of Clinical Care. Three reviews of the primary MH physician's care of the patient were completed; two by VHA psychiatrists outside of the system and one by a psychiatrist outside of VHA. Although the reviews complied with requirements, they were limited to information in the EHR and did not include interviews and other documents relevant to the case. During a discussion with a VHA Suicide Prevention program office representative, he agreed that facility staff should make efforts to include all relevant information in their post suicide reviews.

³⁷ An Issue Brief provides fact based information to leadership within the organization regarding a situation/event or issue. Examples of events that may trigger an issue brief include homicide on VA property, all veteran suicides/attempts, and internal or external disasters affecting a VA site of care.

³⁸ A Behavioral Health Autopsy is a process used within VHA to provide a post-mortem review of the EHR for quality improvement purposes.

Root Cause Analysis. VHA requires VHA Patient Safety staff to conduct a Root Cause Analysis³⁹ (RCA) following all suicides that occur while an inpatient or within 7 days following an inpatient discharge. Completion of an RCA following an outpatient suicide that did not follow a recent inpatient admission, as was the case for this patient, is optional. Following the patient's death, the system initiated an RCA and completed it in 2016.⁴⁰

The JC. The system's Behavioral Health program is accredited by The JC.⁴¹ As part of the oversight process, The JC reviews the response by VHA facilities to patient safety events that are brought to their attention or reported by the facilities. The JC reviewed information provided by the system specific to this event and conducted an onsite visit to meet with system staff. They did not issue any findings.

Communications. After the patient's death, the family complained about the system's lack of clear, direct communication regarding the circumstances surrounding the patient's death. We shared the family's request for a meeting with system representatives. A month after the patient's death, clinical staff and representatives from the system's privacy office and quality management met with members of the family to answer questions from the family, discuss the patient's care, and assist with the processing of the release of the patient's records to the family.

Members of Congress advocating for the care of their veteran constituents closely followed this case and contacted the system for information. The system responded to written requests for information and the System Director and Public Affairs Officer held meetings with three of the five interested Members of Congress.

Conclusions

We found that the patient requested inpatient MH admission and that the patient was not admitted. However, the psychiatrist made a good faith effort to re-engage the patient after he abruptly left the clinic, and followed appropriate medical decision making practices based on the limited information available to him at the time.

We determined that the patient had access to and participated in extensive MH care appropriate⁴² for his diagnoses and needs. We found that the patient did not take advantage of all of the services available to him and that his clinical team was unaware

³⁹ Root Cause Analysis (RCA) is a process to find out what happened, why it happened and to determine what can be done to prevent it from happening again. RCA teams investigate how well patient care systems function.

⁴⁰ OIG reviewed the findings developed during the RCA; however, this information cannot be released in a public report pursuant to 38 U.S.C. § 5705.

⁴¹ The Joint Commission is an independent, not-for-profit organization that accredits and certifies VA and non-VA health care organizations and programs in the United States. Accreditation is granted when an organization meets performance standards. <https://www.jointcommission.org/about-us/about-the-joint-commission-main.aspx>. Accessed November 22, 2016.

⁴² For this report, we defined appropriate MH care as treatment for those diagnoses that were identified as active and treatment that addressed goals set by the veteran and treatment team.

of some essential circumstances that emerged in the month preceding the patient's death.

We identified some deficiencies in patient care by the system. The system's No-Show policy, actual practice, and documentation for missed appointments was not in alignment with VHA guidance regarding communication following a no-show, the patient did not have an updated treatment plan, and an MHTC was not actively involved in the patient's care. However, it is difficult to determine the degree, if any, to which the system's shortcomings contributed to the patient's death from suicide.

We reviewed the system's policy and procedures for admitting patients for MH care and found that the system followed VHA admission guidelines, including having a plan to provide care when system beds were unavailable. MH admissions met UM criteria. A review of patient advocate data and other VA OIG Hotline complaints did not identify other individuals who contended they were wrongly denied admission to the inpatient MH unit. We did not find evidence of a trend in the system improperly denying inpatient MH admissions.

We reviewed the system's employees' responses to the case. Although the reviews completed by system staff complied with requirements, they were limited to the contents of the EHR and interviews with clinicians and the identified next of kin. We found information from the police report and interviews beyond the patient's next of kin to be critical in understanding the situation and circumstances leading up to the event. During a discussion with a VHA Suicide Prevention program office representative, he agreed that facility staff should make efforts to include all relevant information in their post suicide reviews. We also noted opportunities for the system to proactively plan for the management of communications in similar future cases. Confusion, frustration, and speculation may have been mitigated had there been a pre-determined approach that allowed system managers to reach out to the patient's family immediately.

We made four recommendations.

Recommendations

1. We recommended that the Acting Under Secretary for Health ensure that facility staff conduct thorough post suicide reviews to include all information that provides valuable context and details related to the event.
2. We recommended that the System Director ensure that the system No-Show policy and practice for mental health patients is in alignment with the expectations of the Office of Mental Health Operations and that system leaders monitor compliance.
3. We recommended that the System Director ensure that clinicians update outpatient mental health treatment plans according to applicable requirements and guidance and that system leaders monitor compliance.

4. We recommended that the System Director ensure that the Mental Health Treatment Coordinator program complies with Veterans Health Administration requirements and guidance, and that system leaders monitor compliance.

Recent OIG Reports

Facility/System Reports

In the past 5 years, OIG completed the following reviews of the system:

- **Report No. 12-02263-269, Healthcare Inspection: Review of Quality of Care, Management, and Operations, Iowa City VA Health Care System, Iowa City, Iowa, August 29, 2012.**
- **Report No. 14-01261-03, Healthcare Inspection: Follow-Up of Quality of Care, Management, and Operations, Iowa City VA Health Care System Iowa City, Iowa, October 21, 2014.**
- **Report No. 15-01968-424, Healthcare Inspection: Alleged Poor Quality of Care and Refusal to Pay for Lung Transplantation, Iowa City VA Health Care System, Iowa City, Iowa, July 9, 2015.**
- **Report No. 15-00602-425, Combined Assessment Program Review of the Iowa City VA Health Care System Iowa City, Iowa, July 14, 2015.**

Topic Related Reports

OIG has conducted a number of recent relevant reports involving MH access, opioid use and treatment, factors that contributed to patient suicide, and the VCL:

- **Report No. 14-04530-414, Healthcare Inspection: Mental Health-Related Deficiencies and Inadequate Leadership Responsiveness, Central Alabama VA Health Care System, Montgomery, Alabama, July 29, 2015.**
- **Report No. 13-04038-521, Healthcare Inspection: Alleged Suicides and Inappropriate Changes to Mental Health Treatment Program, Coatesville VA Medical Center, Coatesville, Pennsylvania, September 30, 2015.**
- **Report No. 14-04897-221, Healthcare Inspection: Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California, March 30, 2016.**
- **Report No. 15-02627-386, Healthcare Inspection: Alleged Poor Mental Health Care Resulting in a Patient Death at VA Central Iowa Health Care system, Des Moines, Iowa, June 10, 2015.**
- **Report No. 14-03540-123, Healthcare Inspection: Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York, February 11, 2016.**

Acting Under Secretary for Health Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 21, 2017

From: Acting Under Secretary for Health (10)

Subj: Healthcare Inspection—Alleged Inadequate Mental Health Care,
Iowa City VA Health Care System, Iowa

To: Assistant Inspector General for Healthcare Inspections (54)
Director, Seattle Office of Healthcare Inspections (54SE)

1. Thank you for the opportunity to review and comment on the draft report, Alleged Inadequate Mental Health Care Iowa City VA Health Care System. The Veterans Health Administration (VHA) is strongly committed to developing long-term solutions that mitigate risks to the timeliness, cost-effectiveness, quality and safety of the Department of Veterans Affairs (VA) health care system. VHA is using the input from VA's Office of Inspector General, and other advisory groups to identify root causes and to develop critical actions. As VHA implements corrective measures, we will ensure our actions are meeting the intent of the recommendations. VHA is dedicated to sustained improvement in the high risk areas.
2. The recommendations in this report apply to GAO high risk areas 1 and 4. VHA's actions will serve to address ambiguous policies and inconsistent processes and inadequate training for VA staff.
3. I concur with the draft report content and OIG's recommendations. I provide the attached action plan to address recommendation 1. The Iowa Health Care System Director will provide action plans for recommendations 2, 3, and 4.
4. If you have any questions, please email Karen M. Rasmussen, M.D., Director, Management Review Service at VHA10E1DMRSAction@va.gov.

(original signed by:)
Poonam Alaigh, M.D.

Acting Under Secretary for Health Comments

The following Acting Under Secretary for Health comments are submitted in response to the recommendation in the OIG report.

Recommendation 1. We recommended that the Acting Under Secretary for Health ensure that facility staff conduct thorough post suicide reviews to include all information that provides valuable context and details related to the event.

Concur

Target date for completion: May 2017

Facility response: VHA Office of Mental Health and Suicide Prevention obtains information for post suicide review on the characteristics and outcomes of suicide from multiple sources, as available, including root cause analyses, issue briefs, Suicide Behavior Reports, VHA administrative records, and mortality data obtained from the National Death Index.

Beginning in 2012, we expanded efforts to collect information about Veterans' suicides in a methodical way by implementing the Behavioral Health Autopsy Program (BHAP). BHAP is a quality improvement initiative that systematically collects comprehensive quantitative and qualitative information for all Veteran deaths by suicide reported to VHA clinicians and Suicide Prevention Coordinators (SPC) at each VA medical center or large community based outpatient clinic.

SPCs are required to submit standardized BHAP chart reviews within 30 days of becoming aware of a Veteran's death by suicide. SPCs are instructed to use all available information when completing the chart review component of the BHAP. To facilitate thorough reviews, a BHAP chart review template was implemented in May 2017, to prompt SPCs to obtain and document all data sources used, including: VHA medical records; coroners' and/or medical examiners' reports; death certificates; reports from law enforcement agencies, media, or news outlets; and information provided by family members/significant others. Additionally, BHAP educational and training resources have been developed to offer guidance to SPCs about which sources to utilize when completing the post-mortem BHAP chart analysis.

BHAP chart reviews include documented clinical diagnoses and conditions, as well as SPCs' impressions of the presence or absence of select characteristics. SPCs are advised to submit BHAP chart reviews for all known Veterans who died by suicide, including those with and without history of VHA service utilization.

OIG Comment: We do not consider this recommendation closed and will follow up on the recently implemented actions provided by the Acting Under Secretary for Health to ensure that corrective actions have been effective and sustained.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 21, 2017
From: Director, VA Midwest Health Care Network (10N23)
Subj: Healthcare Inspection—Alleged Inadequate Mental Health Care,
Iowa City VA Health Care System, Iowa
To: Director, Seattle Office of Healthcare Inspections (54SE)
Director, Management Review Service (VHA 10E1D MRS Action)

I have reviewed the Healthcare Inspection-Alleged Inadequate Mental Health Care concerns at Iowa City VA Health Care System.
I concur with the action plans.

(original signed by:)

Janet P. Murphy, MBA
Director, VA Midwest Health Care Network

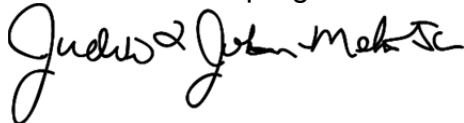
System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 21, 2017
From: Director, Iowa City VA Health Care System (636A/00)
Subj: Healthcare Inspection— Alleged Inadequate Mental Health Care,
Iowa City VA Health Care System, Iowa
To: Director, VA Midwest Health Care Network (10N23)

I have reviewed the Healthcare Inspection-Alleged Inadequate Mental
Healthcare concerns at the Iowa City VA Health Care System.
I concur with the action plans.
I will monitor the progress of the facility responses.



JUDITH L. JOHNSON-MEKOTA, FACHE
Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 2. We recommended that the System Director ensure that the system No-Show policy and practice for mental health patients is in alignment with the expectations of the Office of Mental Health Operations and that system leaders monitor compliance.

Concur

Target date for completion: October 2017

Facility response: The Iowa City VA will rewrite the facility No-Show policy (Medical Center Memorandum 14-240) so that it is in alignment with the Office of Mental Health Operations guidance. The service line will review No Show documentation within the medical record until 90 percent compliance is achieved. The audit will continue on a monthly basis until 90 percent compliance is demonstrated for 3 consecutive months. The results of the audit will be reported on a monthly basis at the Mental Health Service Line Meeting.

Recommendation 3. We recommended that the System Director ensure that clinicians update outpatient mental health treatment plans according to applicable requirements and guidance and that system leaders monitor compliance.

Concur

Target date for completion: October 2017

Facility response: All staff initiating and updating treatment plans will be re-educated on the requirements for individualized plans of care by July 31, 2017.

The facility will review and audit care plans until 90 percent compliance is achieved. The audit will continue on a monthly basis until 90 percent compliance is demonstrated for 3 consecutive months. The results of the audit will be reported on a monthly basis at the Mental Health Service Line Meeting.

Recommendation 4. We recommended that the System Director ensure that the Mental Health Treatment Coordinator program complies with VHA requirements and guidance, and that system leaders monitor compliance.

Concur

Target date for completion: October 2017

Facility response: The facility will review the local policy on MHTC Assignments, revising as needed to ensure it is compliant with the MHTC Assignment DUSHOM Memo dated March 26th, 2012. One-hundred percent of staff will be educated on the revised policy. Confirmation of staff training on the revised policy will be reported monthly at the Mental Health Service Line Meeting until 100 percent compliance has been achieved. The facility will review and audit a sample of medical records monthly for documentation that the MHTCs are coordinating care of the patient, to include: a) review/updating of the mental health plan, and b) notation of mental health services being received at other sites and clinics. The audits will be done until 90 percent compliance is demonstrated for 3 consecutive months. The results will be reported monthly at the Mental Health Service Line Meeting.

OIG Contact and Staff Acknowledgments

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