PODCAST TRANSCRIPT

Healthcare Inspection: Review of Two Mental Health Patients Who Died by Suicide, William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin

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Lauren Olstad:

This is Lauren Olstad, Associate Director in Office of the Healthcare Inspections. I'm speaking today with Dr. Alan Mallinger, a board-certified psychiatrist and Medical Director of the Office of Healthcare Inspections' Mental Health Program. We are discussing an OIG report that reviews the care and management of two mental health patients who died by suicide while under treatment by the Madison, Wisconsin, VA facility.

Dr. Mallinger, this report identified, among other issues, deficiencies in the outpatient mental health care provided to these two patients by VA psychiatric clinical pharmacists. The report also describes important differences between psychiatrists and psychiatric clinical pharmacists in respect to the length, type, and focus of training received for addressing mental health disorders.

Given that psychiatrists have more extensive training, why are psychiatric clinical pharmacists providing patient care?

Dr. Alan Mallinger:

Lauren, the answer to that relates to some pragmatic issues faced by the VA, specifically, a shortage of psychiatrists. In June 2018, we published the report *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages [for] Fiscal Year 2018*. In that report, we found the William S. Middleton Memorial Veterans Hospital in Madison ranked psychiatry second in the overall staffing shortages for medical specialties. Only primary care ranked higher than psychiatry. To help meet the need for mental health services, psychiatric clinical pharmacists at this facility were enlisted as care providers in the outpatient mental health clinic.

Lauren Olstad:

And how does the staffing shortage situation at this particular VA facility in Madison compare with the picture nationally?

Dr. Alan Mallinger:

In that same staffing report, we found that psychiatrists were identified as the number one ranked occupational shortage in the VA nationwide. Specifically, 98 of the 141 VA healthcare facilities (or nearly 70 percent) identified psychiatry staff shortages. Thirty-nine facilities reported that nurse practitioners, who can also prescribe medications, were likewise in short supply. These nurse

practitioners work in multiple specialty areas, not just mental health, but it seems unlikely that sufficient numbers of nurse practitioners would be available to alleviate the psychiatrist shortage.

Lauren Olstad:

So, it sounds like VA facilities across the nation are having challenges in providing psychiatric services. Can other mental health providers help ease these occupational shortages?

Dr. Alan Mallinger:

Psychiatrists are licensed independent practitioners who may perform a variety of mental health services. Because of their extensive training, they can perform a broad range of clinical functions, such as establishing diagnoses and analyzing the influence of co-occurring medical problems on patients' mental health conditions and treatment. In addition, they can manage patients' medication, something that is outside the permitted practice for most other mental health providers, such as psychologists or social workers. However, psychiatric clinical pharmacists can provide medication management services, although collaborative arrangements are necessary because they are not licensed independent practitioners. From this perspective, psychiatric clinical pharmacists can provide very valuable medication management services that would otherwise need to be provided by psychiatrists, advanced practice nurses, or physician's assistants.

Lauren Olstad:

So, the staffing of psychiatric clinical pharmacists to provide needed medication treatment sounds like a useful strategy. But the report noted there were deficiencies in the mental health care provided by psychiatric clinical pharmacists to the two patients that the OIG reviewed. Does this raise concerns about the safety of providing care using this approach for other patients with mental health care needs?

Dr. Alan Mallinger:

Certainly, we need to assure that care provided to veterans is safe and effective. This applies to all care providers. In the case of Madison, OIG staff identified system failures that contributed to the deficiencies found.

Lauren Olstad:

And what specifically were the system failures that were identified?

Dr. Alan Mallinger:

We identified two major areas of concern. First, the OIG determined that the William S. Middleton Memorial Veterans Hospital in Madison did not have a sound methodology for assigning patients based on their mental health care needs. Therefore, patients with unstable major psychiatric illnesses, complex presentations, or significant risk of dangerousness were assigned arbitrarily to either a psychiatric

clinical pharmacist or a psychiatrist. The OIG inspection team asserted that a psychiatrist would have been the more appropriate choice for these types of patients.

A second area of concern was that the facility did not provide a policy or guidance for collaboration between psychiatric clinical pharmacists and psychiatrists when patient care management was beyond the pharmacist's permitted practice, the patient's condition changed, or when a patient needed a higher level of care. Although some of the facility's psychiatric clinical pharmacists described having an informal collaboration with psychiatrists, the OIG determined that the psychiatric clinical pharmacists independent decision-making without sufficient psychiatrist collaboration or supervision may have contributed to deficient mental health care.

Lauren Olstad:

So how could these areas of concern be addressed?

Dr. Alan Mallinger:

The OIG made recommendations to VA for addressing these system problems. We asked the facility director to ensure a methodology is developed so that patients with complex mental health care needs, including patients flagged as high risk for suicide, are assigned to psychiatrists. We also asked the director to ensure the development of a collaborative agreement that would detail the specific conditions that require oversight of psychiatric clinical pharmacists by psychiatrists in the Mental Health Service.

Lauren Olstad:

And so, psychiatric clinical pharmacists could be an important part of the solution to the shortage of psychiatrists in VA, assuming appropriate systems are in place to ensure they practice safely?

Dr. Alan Mallinger:

Yes, psychiatric clinical pharmacists have considerable training related to psychiatric medications. However, they have less rigorous training in the mental health field. For example, they are not considered qualified to enter a mental health diagnosis in the medical record. This is where effective oversight and precision in defining which licensed independent practitioner will team with the pharmacist assigned to a patient can hopefully prevent situations that result in less than satisfactory medical care.

Lauren Olstad:

Dr. Mallinger thank you for discussing this report today.

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