



# DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

## PODCAST TRANSCRIPT

### Deficiencies in the Administration of Emergent Mental Health Services at Coatesville VA Medical Center in Pennsylvania

July 9, 2020

Dr. Terri Julian:

This is Dr. Terri Julian, Director of Mental Health Programs within the VA Office of Inspector General. I'm here with Dr. Amber Singh, Associate Director of Mental Health Programs.

Dr. Singh, we are here to discuss the report *Deficiencies in the Administration of Emergent Mental Health Services at Coatesville VA Medical Center in Pennsylvania*. This report discusses the case of a patient with an other than honorable discharge from the military who received 90 days of emergent mental health treatment from VA. Can you tell us what emergent mental health care means and how the OIG came to be involved?

Dr. Amber Singh:

Sure. The VA allows patients not otherwise eligible for VA health care to receive emergent mental health treatment to stabilize a patient's mental health conditions. The treatment can include outpatient, residential, or inpatient mental health services. The OIG hotline received a complaint alleging that facility staff and leaders denied the patient's request for an additional 90 days of emergent mental health services and failed to coordinate the patient's transition to non-VA care. The complaint also raised ethical concerns that the facility's medical emergency procedures were disparate based on a patient's military discharge status in the Grant and Per Diem Program, which is a supportive housing program for veterans experiencing homelessness that is funded by VA and run by community agencies. Based on these allegations, the OIG's Office of Healthcare Inspections opened a hotline inspection.

During the course of the inspection, the OIG team identified an additional concern related to staff follow-up with patients who are discharged from 90-day emergent mental health services and who are also identified through the REACH VET program. REACH VET stands for the Recovery and Engagement and Coordination for Health—Veterans Enhanced Treatment. The program aims to enhance treatment for veterans identified at a statistically increased risk for suicide, deaths from other causes such as accidents and overdoses, and hospitalizations for mental health or medical conditions.

Dr. Terri Julian:

There were many aspects to this hotline. Let's take some time to discuss each of these issues in turn. Can you explain the 90-day emergent mental health services eligibility?

Dr. Amber Singh:

Sure. In 2017, the Veterans Health Administration expanded mental health services eligibility to former servicemembers with other than honorable administrative discharges, who would otherwise not be eligible for VA services. These individuals are eligible for 90 days of emergent mental health services for stabilization. During that period of eligibility, patients can receive a range of mental health services including inpatient, residential, and outpatient mental health care.

Over the course of a patient's 90-day VA treatment, facility staff should be assisting the patient with obtaining referrals to continue treatment in the community once the 90 days of VA eligibility ends.

A staff member can also request, on behalf of the patient, an extension for an additional 90 days of VA eligibility.

Dr. Terri Julian:

And in this case, the patient received 90 days of emergent mental health services?

Dr. Amber Singh:

Yes. The patient arrived at the Corporal Michael J. Crescenz VA Medical Center in Philadelphia, Pennsylvania, in crisis and was admitted to a mental health inpatient unit for 10 days. The patient was then transferred to the Coatesville VA Medical Center's Substance Abuse Residential Rehabilitation Treatment Program. While in the residential program, the patient received comprehensive treatment including the medication Suboxone® to treat opioid addiction. Further, facility staff coordinated continuing care for the patient that included intensive outpatient treatment and Grant and Per Diem Program housing following discharge from the residential program. While in the residential program, through the REACH VET program, the patient was identified as at a statistically elevated risk for suicide or other adverse outcomes.

Dr. Terri Julian:

Did the patient request an extension of emergent mental health services eligibility?

Dr. Amber Singh:

Nineteen days before the patient's eligibility ended, the patient's outpatient psychiatrist submitted an extension request for an additional 90 days of treatment to the Coatesville VA Medical Center Chief of Staff. The Chief of Staff denied the extension request, recommended transferring the patient to non-VA treatment as soon as possible, and allowed one appointment before eligibility ended.

Two days prior to the end of the patient's eligibility, the patient approached a nurse and inquired about the status of the extension request. The nurse called executive leaders and learned that the request was denied, and then informed the patient of the denial.

Dr. Terri Julian:

So, the patient was notified just two days before eligibility ended. Did that cause any problems for the patient?

Dr. Amber Singh:

Yes, we found that the burden of not knowing whether the extension request was granted and having to seek out the information with two days left before discontinuation of VHA mental health services may have caused the patient emotional distress. The absence of national guidance regarding timeframes and notification processes may impose stress on a vulnerable population and contribute to patients' increased risk of adverse outcomes.

Additionally, we found that the Chief of Staff did not conduct a thorough review of the patient's electronic health record prior to denying the request and did not submit the request to the Veterans Integrated Service Network Chief Medical Officer for approval as required by policy.

Dr. Terri Julian:

And what did you learn about the allegation that facility staff also failed to coordinate the patient's transition to non-VA care?

Dr. Amber Singh:

We didn't substantiate this allegation. The patient's outpatient psychiatrist continued to prescribe medications beyond the eligibility period and the patient established treatment at a non-VA program. While the patient was in the Coatesville VA residential program, facility staff also assisted the patient in obtaining housing assistance through a Grant and Per Diem Program.

Dr. Terri Julian:

And there was an allegation related to emergency procedures in the Grant and Per Diem Program, correct? What did the inspection find?

Dr. Amber Singh:

Yes, the complainant alleged that Grant and Per Diem Program staff were instructed to call 911 for medical emergencies involving patients with other than honorable discharges rather than alerting a facility "Code Blue." A Code Blue alert would call for a local facility emergency medical team, which would likely provide faster care than calling 911. Our concern with this approach was that patients would potentially receive disparate emergency medical care based on the type of military discharge they had, and not what might be fastest. This raised obvious ethical concerns.

Dr. Terri Julian:

You mentioned an additional concern that the OIG team identified?

Dr. Amber Singh:

I did. Each month, the facility REACH VET coordinator receives a list of patients identified at an elevated statistical risk for suicide or other adverse outcomes. The REACH VET coordinator is supposed to assign a provider for each identified patient, and the provider's job is to ensure the patient receives appropriate care according to his or her treatment plan.

We reviewed the five patients who received 90-day emergent mental health services at the facility in 2017 and who were also identified as at an elevated statistical risk of suicide through the REACH VET program. One patient did not receive the required REACH VET outreach and that patient died by suicide about five months after transfer to non-VA care.

Dr. Terri Julian:

That sounds very concerning. Can you say more about that case?

Dr. Amber Singh:

This patient initially sought treatment at the facility in fall 2017, was granted eligibility for 90-day emergent mental health services, received inpatient and residential mental health services, and was identified through REACH VET over the course of VA treatment. While receiving VA mental health services, facility staff completed all REACH VET documentation including status reviews, patient care needs, and care coordination with non-VA providers. Subsequent to the patient's eligibility ending, however, the patient was twice identified as at risk for suicide through REACH VET—first approximately two weeks after eligibility ended and again about two-and-a-half months after eligibility ended. The OIG found no evidence that facility staff attempted to contact the patient in response to identification through REACH VET. Approximately five months after the patient's emergent mental health services eligibility ended, the patient died by suicide.

Dr. Terri Julian:

What guidance does VHA provide the field regarding the responsibilities of REACH VET coordinators and providers for patients who are no longer eligible for VHA mental health services?

Dr. Amber Singh:

On a VHA internal website, suggested actions included that REACH VET coordinators “do their best to help the individual engage in other community care” and attempt to contact the patient, obtain a release of information, and inform non-VA providers about the REACH VET program. VHA does not, however, have a written policy to clearly direct staff actions when a REACH VET patient is no longer receiving or not eligible for VHA care. The OIG found that this absence of policy may result in a failure

to outreach, assess risk, and offer resources to patients identified as at statistically elevated risk for suicide and other adverse outcomes.

Dr. Terri Julian:

Dr. Singh, thank you for exploring the issues related to this patient's care and the inspection. The OIG team made two recommendations to the Under Secretary for Health related to emergent mental health services and the REACH VET program and two recommendations to the Facility Director related to emergent mental health services and medical emergency procedures. VA has submitted actions plans to address each of the identified deficiencies, and the OIG will follow up on the planned actions until they are completed.

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