PODCAST TRANSCRIPT

Deficiencies in Inpatient Mental Health Care Coordination and Processes Prior to a Patient's Death by Suicide, Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri

Introduction

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Dr. Amber Singh:

This is Dr. Amber Singh. I am an associate director of mental health programs within the VA Office of Inspector General. With me today is Meggan MacFarlane, a mental health system specialist. Meggan, we are here to revisit the January 2021 report titled, *Deficiencies in Inpatient Mental Health Care Coordination and Processes Prior to a Patient's Death by Suicide at the Harry S Truman Memorial Veterans' Hospital in Columbia, Missouri*. Can you start by telling us what prompted the OIG to look into this patient's care and death by suicide?

Meggan MacFarlane:

Hello, Amber. Thank you inviting me here today. The OIG received a complaint regarding a patient who died by suicide after being seen at the Harry S Truman Memorial Veterans' Hospital. According to the complainant, the patient was admitted to the inpatient mental health unit and was sent home prematurely with what was described as a suicide packet. An additional allegation was that mental health staff did not reach out to the patient after discharge from the inpatient unit.

Dr. Amber Singh:

When did the patient die by suicide after being seen at the VA?

Meggan MacFarlane:

The patient died within three days of being discharged from the facility's inpatient mental health unit. We substantiated that the patient was sent home with prescriptions for medication and discharge instructions that included suicide prevention materials, as required by the Veterans Health Administration. However, we identified deficiencies in care coordination and discharge planning.

Dr. Amber Singh:

Let's discuss the timeline of care that the patient received prior to their death.

Meggan MacFarlane:

Certainly. In late 2019, the patient was in counseling at the vet center in Columbia, Missouri. Later that year, the patient established primary care at the Truman Memorial Veterans' Hospital. At that time, the patient denied suicidal ideation and told staff about a suicide attempt and psychiatric hospitalization approximately three years earlier.

Dr. Amber Singh:

What else did you learn?

Meggan MacFarlane:

In early 2020, the patient came to the VA hospital's emergency department with suicidal ideation, and staff admitted the patient to the inpatient mental health unit.

Dr. Amber Singh:

Ok, so in this situation, the patient first received counseling at the vet center in Columbia then later established care at the medical center. Can you tell me more about vet centers? Are they affiliated with VA medical centers?

Meggan MacFarlane:

Originally established in 1979 to respond to Vietnam era veterans with readjustment problems, vet center eligibility was expanded in the 1990s to include all veterans who served during armed hostilities before and after Vietnam. Vet Centers are aligned under the Veterans Health Administration and provide counseling to help veterans transition from military to civilian life. Vet Center staff can access patients' VHA electronic health records. However, VHA medical center staff need a written release of information to access a patient's Vet Center health records.

Dr. Amber Singh:

Why is the patient's history of counseling at the vet center relevant to this case?

Meggan MacFarlane:

The patient told facility emergency department and inpatient unit staff about receiving counseling at the vet center, and staff documented a plan to obtain the Vet Center medical records. However, no one ever requested the patient's permission to obtain the vet center records. This was a missed opportunity to gather important clinical information, to facilitate the patient's engagement with outpatient counseling and supportive resources, and to ensure timely follow-up by vet center clinicians already familiar with the patient.

Dr. Amber Singh:

Sounds like the patient's clinical information from the vet center may have assisted hospital staff in their care for the patient. Safety planning is another important aspect of patient care. Can you share why safety planning is important?

Meggan MacFarlane:

Of course. VHA requires that inpatient mental health unit staff collaboratively develop a safety plan with patients at risk for suicide prior to discharging the patient. Safety planning should include working with the patient to identify warning signs, coping strategies, social and professional contacts, and ways to reduce lethal means. VA specifically instructs clinicians to ask patients directly about the means they might use for self-harm and to identify ways to secure or limit access to lethal means.

Dr. Amber Singh:

Did staff collaborate with the patient we are discussing to develop a safety plan prior to discharge?

Meggan MacFarlane:

No, they didn't. One inpatient nurse provided the patient with a hard copy of the safety plan form, and the next day another nurse briefly reviewed the form and entered it in the patient's electronic health record. But no staff member asked the patient directly about access to lethal means or discussed ways to secure or limit access to lethal means.

Dr. Amber Singh:

VHA also requires that all patients admitted to an inpatient mental health unit are assigned a mental health treatment coordinator. The coordinator is responsible for ensuring continuity of care during care

transitions, collaborating with the suicide prevention coordinator, and assisting with a patient's engagement in treatment. Did staff assign the patient a mental health treatment coordinator?

Meggan MacFarlane:

No, inpatient staff did not assign the patient a mental health treatment coordinator prior to discharge, and this may have resulted in the patient not receiving support during the discharge process. This support can be critical to a patient's successful transition to outpatient care. We also found that facility leaders did not establish a policy to guide identification and assignment of mental health treatment coordinators, as VHA requires. The lack of a policy may have contributed to staff not being aware of this requirement and mental health treatment coordinator assignment processes.

Dr. Amber Singh:

Following a patient's death by suicide, VHA requires completion of an issue brief, which provides information about the death, reviews clinical care, and evaluates compliance with policy. Was an issue brief completed following this patient's death?

Meggan MacFarlane:

Yes, three days after the patient's discharge, the local police notified facility staff of the patient's death, and the facility's suicide prevention coordinator completed an issue brief. However, the suicide prevention coordinator did not note in one section of the issue brief that the patient scored positively on a suicide risk screening in the emergency department. The absence of this information may have compromised facility leaders' ability to accurately evaluate the staff's compliance with suicide risk assessment policy.

Dr. Amber Singh:

Can you tell me more about issue briefs and why they are important?

Meggan MacFarlane:

Facility leaders review issue brief information to determine whether to conduct an institutional disclosure. An institutional disclosure is when facility leaders inform a patient or family member about a potentially harmful incident that might have contributed to a patient's risk of serious health issues or death.

Dr. Amber Singh:

Did facility leaders complete an institutional disclosure with the patient's family?

Meggan MacFarlane:

No. The facility director told us an institutional disclosure was not completed because they believed staff completed an appropriate discharge plan. However, as I mentioned earlier, the issue brief was not fully accurate, which may have influenced facility leaders' decision to not conduct the disclosure.

Dr. Amber Singh:

Facility leaders completed an internal review as required when a patient dies by suicide within 72 hours of an inpatient discharge. But you identified an important deficiency in the process, didn't you?

Meggan MacFarlane:

Yes. In 2017, the VHA Office of Mental Health and Suicide Prevention and vet centers established a memorandum of understanding that required medical center staff to invite vet center staff to serve on the internal review team for shared patients who died by suicide. The purpose of the memorandum is to enhance shared responsibility for suicide prevention; however, many facility leaders told us that they were not aware of this requirement.

Dr. Amber Singh:

Did you identify other gaps in awareness about the 2017 memorandum of understanding? What are the possible consequences of these gaps?

Meggan MacFarlane:

Yes, we did. VHA National Center for Patient Safety leaders were also unaware of the 2017 memorandum of understanding. VHA leaders failed to disseminate written guidance to all stakeholders regarding the role of vet center staff in medical center internal reviews. We concluded that a lack of broad stakeholder awareness of this internal review requirement may lead to failure to include vet center staff on internal review teams for shared patients, such as in the review of the patient we have been discussing. The failure to include all stakeholders who have knowledge of the patient whose care is the focus of the internal review can really put leadership at a disadvantage in trying to understand any deficiencies or gaps in care that might prevent a negative outcome for another patient.

Dr. Amber Singh:

Absolutely agree Meggan. Increasing the awareness of the vet center role in internal reviews is an important takeaway. I know your team recommended this to the Under Secretary for Health. What other recommendations did you make?

Meggan MacFarlane

In addition to the recommendation on strengthening the processes for collaboration between inpatient mental health unit staff and vet center providers, we also made six recommendations to the facility director to address each of the facility-level problems identified, including collaboration with vet center staff, safety planning, suicide risk assessment and evaluation, mental health treatment coordinator assignment, and internal review processes.

Dr. Amber Singh:

What is the current status of the recommendations we made?

Meggan MacFarlane:

Less than a year after the report was issued, I can report that the VA successfully closed all seven associated recommendations.

Dr. Amber Singh:

Meggan, that's great news. Thank you for exploring the issues related to this patient's care and the inspection with me. Listeners can find the full report on our website as well as other companion podcasts on recently published reports.

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