Department of Veterans Affairs

Office of Inspector General

Healthcare Inspection

Review of the Care and Death of a Veteran Patient
VA Medical Centers
St. Cloud and Minneapolis, Minnesota

Report No. 07-01349-127 **May 10, 2007**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Executive Summary

Introduction

On January 16, 2007, a veteran of the United States Marine Corps (USMC) and Operation Iraqi Freedom (OIF) committed suicide in a friend's home. This patient had received extensive health care over the previous 20 months from the VA Medical Center (VAMC) in Minneapolis, Minnesota. He received general medical care there, primarily for infectious conditions and musculoskeletal injuries, and he was also the recipient of psychiatric care at the Minneapolis VAMC, predominantly for post-traumatic stress disorder (PTSD).

Although a patient of the Minneapolis VAMC, the patient visited the St. Cloud VAMC, 75 miles to the northwest of Minneapolis, for the first time 5 days before his death. At that time, he was accompanying his father who was a veteran patient of that facility, and who had a prescheduled January 11, 2007, doctor's appointment. While at the St. Cloud VAMC with both his father and his stepmother, the patient started the process to be admitted to a St. Cloud VAMC elective residential treatment program. This program is a non-emergency program described by the Veterans Health Administration (VHA) as "appropriate for veterans…who require additional structure and support to address multiple and severe psychosocial deficits, including homelessness and unemployment."

Two processes were to occur before elective residential treatment program admittance could be arranged. The first was a pre-screening evaluation in which patients applying for the program are asked if there are legal or medical issues that would prevent program completion. The second is for prospective program participants to answer a more detailed screen administered by a nurse or social worker. These steps occurred on January 11 and 12 respectively, and the patient was advised by the screening social worker that he had been accepted for the program.

Four days later, the patient committed suicide. In the aftermath of the patient's suicide the patient's father and stepmother claimed that at the time of both screenings, the patient had told St. Cloud VAMC staff—an intake nurse on January 11 and the screening social worker on January 12—that he was suicidal. This declaration, if true, should have prompted a far more thorough evaluation than simply the residential treatment program admission screens that had been administered.

At the request of VA's Secretary and members of Congress, VA's Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) performed a comprehensive inspection of the Minneapolis and St. Cloud VAMCs' health care provided to the patient. This included the 2 days in question, as well as in the 20 months prior; OHI also examined the circumstances of the patient's death. Both the prior VA health care and circumstances of death were critical in order to understand the patient's mental state and actions after his

January 12 screening telephone call with the St. Cloud VAMC social worker, and to reconstruct and understand what transpired on January 11–12.

Additionally, in the aftermath of the above allegations, others arose. One was that much of VA's medical care for the patient was inadequate, the thrust of these allegations being that VA displayed an overall indifference to, and lack of understanding of, the patient's needs, including, in particular, his PTSD. Another was that the reason the patient was not admitted emergently to the St. Cloud VAMC on January 11–12 was that a bed was unavailable. Still another appeared to be that VA should have recognized the patient's suicidality in time to prevent it. These allegations, too, are addressed in this report.

Results

OHI found that the patient received extensive quality medical care at the Minneapolis VAMC, consisting of intensive treatment for infections as well as somewhat more routine care for orthopedic conditions. He was hospitalized on May 9, 2005, 1 month after discharge from the USMC, due to lip swelling and inflammation of his superficial abdominal wall, both caused by soft tissue infections. He required intravenous antibiotic therapy and surgical debridement and was ultimately discharged in stable condition 11 days later on May 20. He was hospitalized again from June 12–16, 2005, with abscess-like infections in his groin, buttocks region, and lower extremities, and again required intravenous antibiotic therapy and surgical intervention. The patient's failure to fight infection well was both troubling and perplexing in an apparently healthy 25-year-old. An immune system evaluation was performed, which found no abnormalities.

During the patient's May 9–20, 2005, Minneapolis VAMC admission, his attending physician elicited the history that the patient had been diagnosed by his family physician with PTSD. Arrangements were made for a Minneapolis VAMC evaluation. On May 13, the patient was seen by a Minneapolis VAMC social worker to whom he told that he suffered anxiety symptoms associated with combat exposure including panic attacks, nightmares, flashbacks, and hypervigilance. A more detailed evaluation was performed a week later by a Minneapolis VAMC nurse clinician and a Minneapolis VAMC psychiatrist. A PTSD treatment plan was formulated with the patient's approval consisting of prescription medications, counseling, and group therapy. However, in the following weeks and months, these measures could not be implemented successfully because the patient frequently did not keep follow-up appointments. The patient's mental health treatment was further complicated by the patient's reluctance to fully disclose the extent of his problems with alcohol. Overall, we found that his medical and psychiatric treatment were often impeded by not providing a complete and accurate medical history or complying with follow-up recommendations.

In the face of missed appointments, Minneapolis VAMC caregivers called the patient, offered care after daytime work hours, and when he "no-showed," reviewed his medical chart and assessed his risk for suicidality and homicidality. These assessments were

negative. Despite the patient's clear underlying illness, however, he was not delusional or an imminent risk to himself or others such that he could be committed under Minnesota law.

In the latter part of 2006, when legal problems related to a Driving While Intoxicated (DWI) conviction were an issue for the patient, the Minneapolis VAMC formulated a care plan. The patient was scheduled for March 2007 entry into a Minneapolis VAMC program, which is an elective, non-emergent program.

In January 2007, the patient considered other VA program options that met his needs, including pending legal requirements. On or about January 4, a friend telephoned the Minneapolis VAMC because the patient was in distress. The staff there advised to bring him to the VAMC, and a friend offered to take him, but the patient declined. On January 11, he accompanied his father and stepmother to the St. Cloud VAMC because his father had an appointment there with his own doctor. At the St. Cloud VAMC, the patient began the application process for an elective non-emergent residential program. OHI could not substantiate the allegation that the patient stated he was suicidal at the St. Cloud VAMC that day or in a telephone screening interview the next day. We did not find evidence of attempts made to seek help at a non-VA facility, or to contact other sources of help such as the police or 911 in reaction to a purported statement of suicidality. Further, OHI found that the patient did not express suicidal ideation from January 13–15. On January 16, the day he committed suicide, evidence indicates that the patient had heavy alcohol intake after a period of abstinence. Either deliberately or inadvertently, the patient fatally asphyxiated himself, and the Regional Medical Examiner ruled the patient's death a suicide by hanging.

OHI found that this patient's VA medical care met or exceeded community standards. The patient's medical record contemporaneously documents care provided for PTSD. However, although extensive PTSD care was offered, it was never fully engaged in. The patient was also offered care for other disclosed mental health issues. The St. Cloud VAMC had inpatient psychiatric beds available on January 11–12, 2007, to hospitalize a patient, if acutely suicidal. The patient was not turned away from the St. Cloud VAMC due to lack of an acute psychiatry bed. He was placed on a waiting list for elective residential care, the program for which he had been screened. During his VAMC care, he was repeatedly assessed for suicidality and these evaluations were always negative.

Recommendations

OHI's recommendations concern the screening process for the St. Cloud VAMC's elective residential program. Because patients diagnosed with PTSD and co-morbid conditions have an elevated risk for self-destructive behaviors, we believe that screening for entry into VA mental health programs, even non-emergent elective programs such as in this case, should entail a more comprehensive and detailed assessment process. We recommended that the St. Cloud VAMC screening questionnaire be reviewed and that a multidisciplinary

process be considered. As discussed in the body of this report, we found that the patient was asked to contact the St. Cloud VAMC regarding follow-up, both for evaluation and information. We believe that it would be a superior approach for a VAMC to initiate the contact with patients and provide updates as required instead of placing this onus on patients.

Comments

The VISN Director and St. Cloud Medical Center Directors agreed with the findings and provided acceptable improvement plans. (See Appendix B, pages 36–37 for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Services Network 23 (10N23)

SUBJECT: Healthcare Inspection – Review of the Care and Death of a Veteran Patient, VA Medical Centers St. Cloud and Minneapolis, Minnesota

Purpose

The Department of Veterans Affairs (VA) Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) was requested by VA's Secretary and members of Congress to review the care of a Marine Corps veteran of Operation Iraqi Freedom (OIF) who, on the evening of January 16, 2007, committed suicide. This act was completed in a friend's home in a suburb of Minneapolis, Minnesota. Although specific allegations are numerous and varied, they all have as their essential core the assertion that in a time of need and crisis an OIF veteran reached out for help from the VA only to be met with indifference. The purpose of this review is for OHI to perform a review of this veteran's VA care, the circumstances surrounding his death, and to identify and discuss issues that such an examination raises.

Background

The patient was a 25-year-old United States Marine Corps (USMC) veteran and native of Minnesota who served in the USMC from March 12, 2001, to April 7, 2005. His 4-year service in the USMC entailed rotations through Okinawa, Iraq (OIF), and Camp Pendleton, California. During his service he was awarded the Combat Action Ribbon, Global War on Terrorism Service Medal, Sea Service Deployment Ribbon (w/1 star), Global War on Terrorism Expeditionary Medal, National Defense Service Medal, Navy Unit Marksman and Rifle Badge, and the Sharpshooter Pistol Badge.

While in the USMC, he received extensive medical and psychiatric care provided primarily by the U.S. Navy Medical Corps. As a veteran, the patient received medical, surgical, and psychiatric care from the Minneapolis, MN, VA Medical Center (VAMC), a primary and tertiary care urban medical center that provides a full range of acute and long-term care health care services. Among the patient's medical and psychiatric conditions, he carried a diagnosis of post-traumatic stress disorder (PTSD).

On January 11, 2007, the patient presented to the St. Cloud VAMC, located in central Minnesota, 75 miles to the northwest of Minneapolis to request admission to an elective residential program. It is alleged that the patient had finally decided to take steps to deal with mental health issues and that when he came in contact with a St. Cloud VAMC intake nurse, he stated that he was suicidal. It is further alleged that, despite such an assertion by the patient, rather than being immediately admitted to the medical center for inpatient psychiatric treatment, he was told that a screener for mental heath admittance was unavailable and that he (the patient) should come back the next day for screening or that, alternatively, he could be screened by telephone.

The next day, the patient was screened by telephone. It is alleged that in this telephone screening, the patient again stated he was suicidal, but, as on the previous day, neither provisions, actions, nor arrangements were made for immediate admission to the St. Cloud VAMC or elsewhere; nor was advice given to take the patient to an ER. Rather, the patient was allegedly told that he was 26th on a waiting list for admission to the St. Cloud VAMC. The patient was allegedly told to check back periodically to ascertain his place on this waiting list. It was alleged that the patient was placed on a waiting list because the St. Cloud VAMC did not have an available residential bed.

The overall underlying allegation(s) are that VA was indifferent to the needs of this veteran. Further, when it became public that the patient had received extensive care at the Minneapolis VAMC, it was opined in the media that caregivers at Minneapolis VAMC should have recognized and taken steps to treat an obviously suicidal patient.

Minneapolis and St. Cloud VAMCs

The Minneapolis VAMC[1] is a teaching hospital providing a full range of patient care services, as well as education and research. Comprehensive health care is provided through primary care, tertiary care, and long term care areas in medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics and extended care. The Minneapolis VAMC is designated as a Polytrauma VA Medical Center and receives active duty servicemen and servicewomen as well as veterans for rehabilitation of injuries such as traumatic brain injury, amputation, and blindness.

The St. Cloud VAMC[2] provides primary medical and mental health services, acute psychiatry, and an array of outpatient specialty services. Additionally, the St. Cloud VAMC operates a number of "special emphasis programs," including residential substance abuse, PTSD, Psychosocial Residential Rehabilitation Treatment Program (PRRTP), dual diagnosis, outpatient programming for seriously mentally ill, vocational rehabilitation, extended care, adult day health care, rehabilitation and ventilator care. There are no acute medical beds at the facility.

[1] http://www1.va.gov/minneapolis/about/abou_mission.html
[2] http://www1.va.gov/directory/guide/facility.asp?ID=127&dnum=ALL&map=1

Outpatient mental health services at the St. Cloud VAMC are organized around a general psychiatry focus. The facility does not run specialized outpatient psychiatry clinics. The clinic is organized into three interdisciplinary care teams which provide mental health and primary care services to patients. Team members include psychiatrists, nurse practitioners, physician assistants, clinical nurse specialists, registered nurses, licensed practical nurses, social workers, and counseling or clinical psychologists. The facility offers PTSD groups. The three teams operate Monday to Friday from 8 a.m. to 4:30 p.m., with some therapy clinics and group activities available during evening hours.

The St. Cloud VAMC does not have an emergency room or urgent care area. Patients who spontaneously walk in to the mental health clinic are seen by one of three triage nurses. If needed, local policies call for an immediate visit with a clinical nurse specialist, nurse practitioner, or psychiatrist to take place.

The acute psychiatry unit has 15 operating beds and is a secure inpatient psychiatric unit. The medical center operates 148 residential rehabilitation program beds. Forty-five of these beds are designated for patients in the PRRTP program. Of these 45 beds, 25 are designated for a specialized PTSD cohort. The facility has 103 beds designated for patients in the Domiciliary Residential Rehabilitation and Treatment Program (DRRTP). These 103 beds include 34 beds for extended rehabilitation patients. An extended care building houses a small geriatric psychiatric unit, a dementia unit, nursing home beds, and a unit for patients who are ventilator dependent. For the first 7 days of their admission to rehabilitation programs at the Medical Center, patients are required to stay on grounds.

Although 45 beds are categorized as PRRTP and 103 total beds as DRRTP, the Medical Center's Chief of Mental Health reported that these are not firm lines. That is, the number of beds attributed to each category is adjusted based on need. Therefore, if the number of patients needing PRRTP programming exceeds the number of PRRTP beds, these patients would be housed in available DRRTP beds but would receive PRRTP programming.

VA established the PRRTP bed level of care in 1995. This level of intensity of residential mental health care is appropriate for veterans with mental illnesses and other disorders who require additional structure and support to address multiple and severe psychosocial deficits including homelessness and unemployment. PRRTP provides for psychiatric and psychotherapeutic treatment and symptom reduction of mental and other disorders, opportunities to improve functional status, and psychosocial rehabilitation.

PRRTP is a residential level of bed care, distinct from acute inpatient psychiatry beds, which provides a 24-hour therapeutic setting for veterans. PRRTP beds are distinct from sub-acute or intermediate psychiatry beds that are co-located or integrated with an acute unit for short term discharge planning. PRRTP is considered hospital care for purposes of eligibility determinations. Each patient is assessed as independent or semi-independent for self medication. Medications are kept in a locked cabinet accessible only to that veteran and designated staff. Patients assessed as independent self-administer their medications.

Staff administers or monitors medications for patients who are assessed as semi-independent. Treatment and/or therapeutic activities must be provided at least 4 hours per day, 7 days per week. In order to be eligible for PRRTP care, patients must be clinically stable and able to function outside of a medium or high-intensity hospital setting and must be capable of self-preservation in case of a disaster. Patients in a PRRTP who develop an acute psychiatric or medical condition are moved to a medium or high-intensity psychiatric setting or medical unit.

The St. Cloud VAMC has a PTSD cohort for patients in the PRRTP program. The cohort is divided into a combat track and a non-combat track. Patients in the program receive individual and group therapy focused on teaching them how to cope with the trauma they have experienced. Patients in the residential programs who previously were receiving outpatient treatment at the facility continue care with their outpatient psychologist and/or therapist during their stay in the program.

According to Veterans Health Administration (VHA) Handbook 1162.03[3] on PRRTP, PTSD focused PRRTP programs are targeted for patients whose PTSD and concomitant mental health diagnosis are sufficiently under control to allow effective participation in both the treatment and residential rehabilitation services. In addition, patients must be able to refrain from harm to self and others, self-preserve in case of an emergency, and demonstrate motivation for treatment and rehabilitation.

Most patients seeking to be pre-screened for the PRRTP or DRRTP programs at the St. Cloud VAMC do not spontaneously walk in to the facility; they are usually referred from another program such as an inpatient unit or are pre-screened via telephone. A few patients per month walk in to the facility for seeking PRRTP or DRRTP care. Reportedly approximately 50 percent of veterans screened are admitted into the program.

Scope

This review focuses on care provided by the Minneapolis and St. Cloud VAMCs. We also determined the whereabouts of the patient and reviewed his physical and mental state during the 4-day period from his telephone call with a St. Cloud VAMC social worker on January 12, 2007, to his death 4 days later on January 16, 2007. This was critical in order to gain insight into the patient's mental state and actions after that telephone call, as well to enable a better understanding of what transpired at the St. Cloud VAMC on January 11 and during the telephone call of January 12. While we summarized the patient's relevant military medical and private sector medical care, assessment of those aspects of the patient's medical history was not within our jurisdiction.

[3] VHA Handbook 1162.03, *Psychosocial Residential Rehabilitation Treatment Program (PRRTP)*, issued October 19, 2006.

A key allegation is the lack of acute psychiatric beds at the St. Cloud VAMC. Accordingly, we reviewed the facility's Mental Health and Behavioral Services (MH&BS) Program and its relevant statistics.

We also identified and discussed changes implemented by the Minneapolis and St. Cloud VAMCs in the aftermath of the patient's death.

The issue of suicide and system-wide implementation of suicide prevention efforts are reviewed in a separate VA OIG report, *Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention*.[4]

Methodology

On February 22, 2007, OHI inspectors visited the St. Cloud VAMC. From March 6–9, we visited both the St. Cloud and Minneapolis VAMCs and interviewed family members and friends of the patient; on March 13, we traveled to Florida to interview a marine comrade of the patient; and from March 19-22, we revisited the St. Cloud and Minneapolis VAMCs, as well as conducted further interviews with family and friends of the patient.

At each VAMC we interviewed clinical, clerical, and administrative staff. We inspected each hospital, paying particular attention to the area to which the patient came at St. Cloud VAMC on January 11. We interviewed clinical quality assurance staff from both VAMCs and obtained extensive programmatic information. At the St. Cloud VAMC in particular, and focusing on the dates of January 11–12, we obtained and reviewed medical center census information, telephone logs, and bed and program occupancy information.

VHA, which operates the system of VA medical centers and clinics, conducted three reviews of the patient's care and his suicide. These reviews were performed at VHA local, regional, and national levels by the involved VAMCs, Veterans Integrated Service Network (VISN) 23, and the VA Office of the Medical Inspector, respectively. We obtained and studied these reviews and interviewed team members from each review group.

Many of the patient's family members were interviewed, including both biological parents, both stepparents, the patient's sister, and his brother. All of these individuals were able to provide insight into the patient's physical and mental state throughout the course of his VA care and to provide detailed information about events occurring in January 2007, the month of the patient's suicide. Several of these individuals spoke with or saw the patient in the days immediately preceding his death, and on the day he died.

[4] *Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention*, Report No. 06-03706-126, issued May 10, 2007.

We interviewed several friends of the patient who were able to provide information about the patient's health care after discharge from the USMC. Additionally, they were able to provide specific information about events occurring from January 4, 2007—when a friend telephoned the Minneapolis VAMC on his behalf, stating that the patient was in distress—through his visit to the St. Cloud VAMC on January 11; to a telephone screening interview by the St. Cloud VAMC on Thursday, January 12; to the days over the course of the ensuing Martin Luther King Day holiday weekend; to the time of the patient's death on Tuesday, January 16.

The patient was on probation at the time of his death from a DWI conviction. The terms of that conviction played a key role in regard to the patient's actions at both the Minneapolis and St. Cloud VAMCs. Accordingly, we interviewed the supervisor of three Scott County, MN, probation officers who had charge of the patient's case.

We obtained and reviewed relevant police reports concerning the patient's death and the events of January 16, 2007. We interviewed the police sergeant who was at the scene of the patient's death. We interviewed and reviewed forensic evidence with the Minnesota Regional Medical Examiner in Hastings, MN, who performed a limited post-mortem examination for forensic purposes and in accordance with Minnesota State law requiring autopsies in cases of unnatural death (suicide, homicide, accident).

We obtained and analyzed the patient's relevant USMC administrative and medical records. We interviewed the patient's family physician who had diagnosed PTSD, prescribed therapy, and recommended further therapy. We reviewed private sector medical records, particularly documentation from Private Hospital A, where the patient was taken on January 16 after being found unresponsive by the police and emergency medical technicians.

We reviewed relevant medical and psychiatric literature regarding suicide, PTSD, dual diagnosis, and substance abuse. We reviewed relevant VA initiatives concerning suicide prevention. We also reviewed relevant medical literature regarding immune system compromise from anabolic (bodybuilding) steroid use and neutrophil function, and clinical issues relevant to this patient's case.

We interviewed patients at the St. Cloud VAMC to better understand the processes of their admission to that facility. We examined the medical record of a patient who was evaluated at the St. Cloud VAMC for suicidal ideation at or about the same time that the patient in this report presented to the St. Cloud VAMC.

This inspection was performed in accordance with the *Quality Standards for Inspections* published by the President's Counsel on Integrity and Efficiency.

Inspection Results

Case History

The patient was a 25-year-old man who had served in the USMC from March 12, 2001, to April 7, 2005. He received a general discharge at the rank of private. During his 4-year tour of duty in the USMC, the patient spent 1 year in Okinawa, Japan; approximately 2.5 years total in California; and 7 months in Iraq. He was deployed to Kuwait on February 19, 2004, and into Iraq on March 6, 2004. A marine friend and family reported that while in Iraq, the patient experienced heavy fighting and received shrapnel injuries. Although the patient was not service-connected at the time of his first VA medical center presentation at the Minneapolis VAMC in 2005, he was ultimately awarded a 70-percent total service-connected rating for bronchial asthma (30 percent); post-traumatic stress disorder (50 percent); and a knee condition (10 percent).[5]

The patient had several issues related to mental health care that pre-dated his military service. Military records indicate that the patient had adolescent alcohol problems prior to enlistment. Approximately 9 months after the patient began his service with the USMC in 2001, and prior to deployment to Iraq in 2004, the patient was command-referred for underage drinking and received treatment at the Naval Addictions Rehabilitation and Education Department (NARED) at Camp Pendleton, CA. At or about that time, he was also diagnosed as having PTSD based upon trauma that pre-dated his military service. According to records, the patient completed alcohol treatment but he was said to have a "poor prognosis." Exit diagnoses were alcohol dependence and PTSD. The incident in which his brother sustained third-degree burns was felt to meet the trauma criterion for the diagnosis of PTSD.

After deployment to Iraq, by his own report and report to family and friends, the patient was involved in heavy fighting and was subjected to numerous traumatic events. Some of these included witnessing a rocket propelled grenade decapitate a friend and having to "tag and bag" this friend; seeing the bloated and misshapen bodies of two marine buddies who drowned in the Euphrates River; and participating in and witnessing violent combat deaths firsthand—of his comrades-in-arms, of enemy combatants, and, apparently, civilians. In short, available records as well as interviews make it clear that the patient was directly involved in high-intensity combat.

After his Iraq service, but while still in the USMC, the patient was treated for PTSD. He received medication treatment from a Navy psychiatrist as well as psychotherapy from a Licensed Clinical Social Worker. The patient was also seen by his family physician, who prescribed Valium® (diazepam), Zoloft® (sertraline), zolpidem, and trazodone for symptoms of PTSD.

[5] Service-connected veterans may be rated in increments of 10% per medical condition. They also receive a "total" service-connected rating. The sum of the individual ratings may or may not equal the total rating.

The patient's USMC Active Duty Statement of Service shows five offenses under the Uniform Code of Military Justice, both before and during deployment to Iraq. The patient was discharged from the USMC on April 7, 2005, and was not recommended for reenlistment.

The patient was in his usual state of health until May 3, 2005, when he injured his superficial abdominal wall in a construction accident. His abdomen became red and inflamed. The area also became increasingly painful, and on May 8, he was seen at Private Hospital B and treated with intravenous vancomycin. He soon developed upper lip swelling and pain, which was treated with Benadryl® (diphenhydramine), ranitidine, and prednisone. This provided only transient relief. He was discharged to home with prescriptions for Keflex®, Bactrim®, antibiotic medications for his abdomen, and an antiviral medication.

The next day, on May 9, 2005, the patient presented to the Urgent Care/Emergency Room (UC/ER) area of the Minneapolis VAMC with complaints of increasing lip pain, swelling, and concern that he might have a fever. This was his first visit to a VA medical facility. His prior medical history at that time was notable for chronic low back pain; bilateral knee injuries; shrapnel injuries; a viral infection; history of motor vehicle and all terrain vehicle accidents; and a history of asthma diagnosed in Japan while in the USMC.

The patient was admitted to the Minneapolis VAMC Medical Intensive Care Unit because of significant concern that his lip swelling was indicative of a serious allergic reaction to the prior day's vancomycin injection and because of severe pain in his lip and abdomen. In particular, because of a possible serious allergic reaction, it was important to closely monitor the patient's respiratory status. The medical record notes that there was a "low threshold for intubation if pt. [patient] develops signs of airway compromise." As this concern abated, he remained hospitalized, due to inordinately slow healing of deep tissue infections of his upper lip and abdominal wall.

A highly complicated hospital course followed over the ensuing 12 days. The patient was treated on the Internal Medicine Service. The General Surgery; Ear, Nose, and Throat; and Infectious Diseases Services were consulted early in the hospitalization and followed the patient during the course of his stay. Further history revealed that the patient had recently received a lip cut, just as he had received a cut or cuts to his left lower abdomen. Both the patient's abdominal pain and his lip swelling were determined to be due to infections and abscesses caused by a methcillin sensitive *Staphylococcus aureus*[6] (MSSA) infection.

[6] *Staphylococcus aaureus*, or *Staph. aureus* is a gram positive bacterium frequently living on the skin or in the nose of a healthy person; it can cause illness ranging from minor to life threatening. Some Staphylococcus species have become resistant to penicillin. B-lactamase resistant penicillins were developed to combat this resistance. Methcillin, introduced in 1959, was the first penicillin in this class to be introduced. Methcillin resistant *Staph. aureus* was first reported 2 years later and has become prevalent in hospital settings over the last decade. Clinicians distinguish methcillin sensitive *Staph. aureus* (MSSA) from methcillin resistant *Staph. aureus* (MSRA) because antibiotic treatment choice depends on the organism's sensitivity or resistance.

Surgical debridements, packing, and close monitoring were performed. A variety of antibiotics, both intravenous and oral, were administered until finally clindamycin was determined to be the most efficacious for this patient.

The first mention of mental health issues occurred on May 10, 2005, when a staff attending physician noted "possible PTSD: pt [the patient] reports being diagnosed with PTSD as OP [outpatient] by family doc. [He] would like [a] referral to be seen here – will schedule." A note dated the next day by the same physician documents that aftercare referrals were made both for outpatient mental health as well as for outpatient primary care.

On May 13, 2005, the patient was seen by a primary care social worker. He told the social worker that he had been diagnosed with PTSD by a community physician. The patient endorsed[7] anxiety symptoms associated with combat exposure including panic attacks, nightmares, flashbacks, and hypervigilance. Noting that the staff physician had placed a Psychiatry Service referral for PTSD and alcohol assessment, the social worker contacted the nurse in Psychiatry Urgent Care who had been assigned to evaluate the patient. In addition, the primary care social worker gave the patient contact information for the social worker assigned to case manage Minneapolis VAMC OIF veterans.

From a medical standpoint, the patient's hospital course was complex and unusual. The patient had developed significant abscesses and axillary lymphadenitis[8] from relatively superficial injuries. He, in turn, had an inexplicably muted response to intensive antibiotic and surgical treatment. The severity of the infections in a young person considered in good health and the patient's apparent inability to fight off these infections rapidly despite intensive intravenous antibiotic therapy, surgical debridement, and abscess incision and drainage were perplexing. Although the patient had a history of self-administering intramuscular injections of anabolic steroids for bodybuilding, it appears that this data was not elicited by his caregivers or shared by the patient until late in the hospitalization.

However, despite his slowness to heal, the patient did gradually improve, and his infections came under control to the point at which he was able to be discharged. As he was approaching discharge, a nurse case manager gave the patient her card and noted that the patient "can contact me if he has any questions regarding his follow up appts [appointments] or any concerns after discharge." Her note was also copied to the Primary Care Social workers who had seen the patient on May 13, 2005, as well as to the social worker assigned to case manage Minneapolis VAMC OIF veterans.

The patient was ultimately discharged on the morning of May 20, 2005, with two aftercare appointments scheduled for that same afternoon at the Psychiatry Urgent Care area of the Minneapolis VAMC, as well as a medical follow-up appointment scheduled for a subsequent date.

[7] "Endorsed" means that he stated that he had or experienced.
[8] Lymphadenitis is the inflammation of a lymph node. It is often a complication of a bacterial infection of a wound, although it can also be caused by viruses or other disease agents.

Later that afternoon the patient was initially evaluated by a nurse clinician at Psychiatry Urgent Care. This clinician noted that the patient had been seen by an active duty Marine Corps psychologist and his private physician and told that he (the patient) has PTSD and "The veteran is requesting evaluation and treatment here [at] the VA." The patient reported waking 3–7 times per night with nightmares. He endorsed anxiety when having nightmares or when exposed to unexpected loud noises. The patient denied depression, loss of interest or pleasure, diminished appetite, energy level, or concentration, and he reported that he was able to function well at work and play. In addition, the patient reported that he drank rarely, that he drank 2–3 beers a month earlier, that he had never been much of an alcohol drinker, and he denied any history of DWI or other alcohol related legal issues. A very detailed mental health assessment is documented with the following impressions:

> Veteran returned from Iraq this past September where he saw combat and was wounded. Initially he reports being very anxious and isolated which caused concern for his family. The veteran reports he is much improved over when he first returned as he is social, happy and functioning well on the job ect [*sic*[9]]. He continues however to have frequent nightmares and anxiety. Sleep continues to be interrupted waking several times each night. Education given to the veteran regarding acute stress reaction as opposed to PTSD. Also education given regarding reintegration following wartime experiense [*sic*]. The veteran agrees to be followed here in PUC for more assessment and supportive contact prior to referal [*sic*] to another team.
> Dx: per Dr. [psychiatrist]:
>
> ASSESSMENT: AXIS I: r/o [rule out] acute stress reaction
> AXIS II: Deferred
> AXIS III: recent staff [*sic*] infection in lip
> AXIS IV: none [*sic*] specific
> AXIS V: 65[10]

[9] The Latin word "*sic*" means "thus" or "so" and is used to indicate that a quoted passage, especially one containing an error or unconventional spelling, has been retained exactly as shown in its original form.

[10] From the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Washington DC, American Psychiatric Association, 1994, pp. 25,32. A multiaxial assessment involves an assessment on several axes, each of which refers to a different domain of information used to facilitate comprehensive and systematic evaluation.

Axis I	Clinical Disorders Other Conditions That May Be a Focus of Clinical Attention
Axis II	Personality Disorders Mental Retardation
Axis III	General Medical Conditions
Axis IV	Psychosocial and Environmental Problems
Axis V	Global Assessment of Function (GAF)

Axis V is for reporting the clinician's clinical judgment of the individual's overall current level of functioning. The GAF may be particularly useful in tracking the clinical progress of individuals in global terms, using a single measure. A GAF score of 60–70 would be consistent with having some mild symptoms or some difficulty in social,

An initial treatment plan was formulated consisting of the patient seeing a psychiatrist, prescription of the sleep aid zolpidem 10 mg orally every night for sleep, and supportive therapy every 1–2 weeks at the Minneapolis VAMC's mental health clinic. The nurse clinician noted that he would contact the patient on the following Monday for an appointment and to assess the effectiveness of the zolpidem.

The patient was evaluated by a Minneapolis VAMC staff psychiatrist that same day. The patient reported that he (the patient) generally felt that he was doing well. The psychiatrist noted that after returning home from deployment, the patient had been prescribed the anti-anxiety medication Valium® by a family physician but did not like how he felt on it and, thus, discontinued it. At a later date, the patient had been on the antidepressant medication Zoloft® (sertraline) for approximately 4 months with some benefit in terms of anxiety but without improvement in nightmares. The Zoloft® had been discontinued by the patient. Prior to hospitalization the patient had been taking the medication trazadone as a nighttime sleep aid. The patient endorsed good mood and denied other past mental health history or history of alcohol use. The psychiatrist concluded:

> Appears to initially had [*sic*] an acute stress reaction and still with some residual symptoms of nightmares occurring very frequently. He is also hypervigalent [*sic*] at times but not interfering with his relationships and work. We discussed trying some ambien for sleep instead of trazadone and will have pt follow [*sic*] with [psychiatric urgent care nurse clinician] weekly for therapy. But if symptoms do not get better in the next few weeks will consult to PTSD for additional treatment options.

As promised, the nurse clinician followed-up by phone on May 23, 2005. The patient reported that the zolpidem was effective in promoting sleep and that he was not experiencing any side effects. An appointment was scheduled for Thursday, May 26 for supportive contact. The next entry on June 7 reveals a "no-show,"[11] and therefore a referral to the Post-Traumatic Stress Recovery Team (PTSR) program was not made. The nurse clinician noted that he would contact the patient in an attempt to re-schedule.

Late in the evening on June 7, 2005, the patient presented to the UC/ER of the Minneapolis VAMC with a pruritic, non-pustular, maculopapular, left groin rash of 1 week's duration appearing 1 week after a camping trip. The patient also reported left groin pain which he rated as 6 out of 10 in intensity. The patient was without fever, and no evidence of infection was noted. The rash was felt to be fungal in origin and the patient was given a prescription for nystatin (an antifungal drug) and the antihistamine Atarax® (hydroxyzine) for itching.

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occupational, or school functioning, but generally functioning well, including having some meaningful interpersonal relationships.

[11] A "no-show" is a term used for a patient who missed an appointment; it is also used as a verb, as in "the patient no-showed."

On June 12, 2005, the patient was seen at the UC/ER of the Minneapolis VAMC with complaints of multiple painful carbuncles associated with follicles around the lower extremities, groin, and buttocks region. The patient stated that these lesions were different then those he had had at the previous UC/ER visit. He was again hospitalized at the Minneapolis VAMC from June 13–16, 2005, for intravenous antibiotics and pain medication. Cultures were positive for MSSA. Treatment was similar to that of his May hospitalization, consisting of intravenous clindamycin and abscess incision and drainage. During this episode of care, the General Surgery, Infectious Diseases, and Occupational Therapy Services were consulted. The patient was responding well after 3 days of intravenous antibiotics and was discharged on oral antibiotics.

The two separate episodes of severe, pustular infections in a young man considered to be in good health were further explored by Minneapolis VAMC clinicians. An underlying primary or secondary immune deficiency disorder was considered. The patient's medical team conferred with a specialist in neutrophil (a type of white blood cell vital in fighting infection) disorders at the University of Minnesota. In addition, immunoglobulin levels, a sedimentation rate, serum complement levels, a viral test, and other tests were ordered and the results were not indicative of an underlying immunological disease. A nasal culture for *Staphylococcus* colonization was pending at the time of discharge.

An aftercare appointment was scheduled with the Infectious Diseases Clinic for June 24, 2005, but the patient did not show. The Chief, Infectious Diseases asked support staff to re-schedule the appointment. The lead medical support assistant contacted the patient and the appointment was re-scheduled for July 22.

Soon thereafter, the patient presented to the Minneapolis VAMC UC/ER on July 14, 2005, complaining of a presumed viral infection. The episode had lasted longer than previous outbreaks prompting the patient to seek care. The emergency room physician noted that the patient had an upcoming appointment with the Infectious Diseases Clinic and prescribed an antiviral medication.

On July 22, 2005, the patient was seen at the Infectious Diseases Clinic for follow-up of the cutaneous staphylococcal skin infections that had led to his two recent Minneapolis VAMC hospitalizations and to evaluate other lesions. The Infectious Diseases fellow noted that the recurrent MSSA infections had resolved. A nasal swab was positive for colonization with S*taphylococcus* and the patient was prescribed mupirocin ointment to be applied to each nostril for 5 days. The patient was referred to the Dermatology Clinic for further evaluation of his present lesions. A follow-up appointment with the Infectious Diseases Clinic was scheduled for 3 months.

Later that evening of July 22, 2005, the patient presented to the Minneapolis VAMC UC/ER for a groin rash. The UC/ER physician noted several healing lesions, that the patient had already been treated with a course of therapy, and that the patient had an upcoming appointment with the Dermatology Service. The patient was treated

symptomatically with hydrocortisone cream and Vicodin® (hydrocodone) for burning pain.

On October 21, 2005, the patient did not show for follow-up appointment with the Infectious Diseases Clinic.

On November 2, 2005, the patient presented to the Minneapolis VAMC UC/ER with complaint of severe back and neck pain, and headache associated with heavy lifting and digging footings in his backyard. He reported trying ibuprofen and Vicodin®, which he had from a previous prescription, without relief. Tenderness and muscle spasm were noted on examination, and he was treated with Ativan® (lorazepam) by intramuscular injection and ketorolac with improvement, given prescriptions for Percocet® (oxycodone and acetaminophen), etodolac, and methocarbamol and advised to follow-up with his primary care physician if he was not better. The patient did not show for a clinic appointment on November 4 at the Minneapolis VAMC. Later that afternoon, he returned to the Minneapolis UC/ER with ongoing back pain, neck pain, and headache. Extremity strength, reflexes, and sensation were noted to be intact. Imaging studies were obtained that proved negative for cervical or thoracic spine fractures. The patient was diagnosed with a likely muscle tear. Ibuprofen, Flexeril® (cyclobenzaprine), and Percocet® were prescribed with follow-up to be arranged by the Primary Care Clinic in 2 weeks.

After discussion with the patient's assigned primary care physician, a nurse from the Primary Care Clinic attempted to reach the patient by telephone on November 17, 2005, to follow-up on the UC/ER visit. A voicemail message was left for the patient to call back.

On January 31, 2006, the patient presented to the UC/ER of the Minneapolis VAMC with an ankle sprain after a slip on the ice. He also reported anxiety, severe shakiness, blackouts, short temper, poor concentration, and stomach pains to an UC/ER staff nurse. He denied suicidal thoughts, intent, or plans. He endorsed drinking 10 drinks on Friday and Saturday, 3 days earlier. The patient was seen by a physician in the UC/ER. The patient reported that he had fallen a week earlier and the swelling had subsided but the pain continued. The physician noted that the patient reported otherwise feeling well. The patient was without fever, with normal pulse, respiratory rate and diastolic blood pressure. On exam, the ankle was swollen. An x-ray was performed and showed swelling but no ankle or leg fractures. The patient was diagnosed with an ankle sprain to be treated with non-steroidal anti-inflammatory drugs, rest, and minimal weight bearing.

The patient next presented to the UC/ER of the Minneapolis VAMC on February 9, 2006. The patient was examined by a medical physician who noted that the patient had:

> …a plethora of medical concerns and flashback PTSD problems. 1. Bright red blood with stools off and on for two months. 2. Mid epigastric abd [abdominal]

> pains so severe that he stopped bimge [*sic*] drinking ETOH[12] 100% for two months. No hx [history] of emesis or hematemesis. He denies any use of street drugs such as cocaine or marijuana. Urine tox [toxicology] screen ordered. 3. Panic attacks with hyperventilation to point of "passing out" on occasion. 4. Recurrent [infection]… and has been using bacitracin oint [ointment] locally which he is intructed [*sic*] to DC [discontinue] and replace with sparing use of mycostatin cr. [cream] as directed.

He was found to have an anal fissure. Citrucel® (methylcellulose) and sitz baths were prescribed. A blood test for *Helicobacter pylori*[13] was obtained and sent to the lab and omeprazole was prescribed. A urine drug screen was also ordered by the ER physician which subsequently tested positive for cannabis and the *H. pylori* test was negative. The patient was also referred for psychiatric evaluation and treatment.

At about 7:30 p.m. that same evening of February 9, 2006, a fee basis psychiatrist moonlighting in the UC/ER also saw and evaluated the patient. This psychiatrist's note is somewhat confusing in that it is labeled as a telephone contact note, but it contains a physical examination, and overall, is consistent with the patient having been evaluated in-person. According to this note, the "Pt would like to establish care with our psychiatry clinic." In her note, the psychiatrist reiterated many of the psychiatric symptoms the patient had complained of to the medical physician and to the nursing staff such as severe anxiety, poor sleep, flashbacks, nightmares, and worsening panic attacks. Additionally, she (the physician) noted that the patient complained of anger and irritability, low mood, and hopelessness. The psychiatrist noted that the patient denied suicidal and homicidal ideation. She reported that the patient stated, "I did not want to admit I could not handle it - but now my life is falling apart." This note states that the patient was taking trazadone 200 mg every night that he reported was not helpful, and Zoloft® 200 mg prescribed by a non-VA physician that the patient also did not feel was helpful. The patient denied use of street drugs and reported having discontinued alcohol 2 months earlier due to having severe stomach pain. The psychiatrist's impression was "PTSD, Major Depressive D/O [disorder], r/o [rule out] panic attacks," and her plan was as follows:

1) Continue Zoloft for now - will need psychiatry eval; likely will need antidepressant change
2) Will give 10 day supply of Ambien [zolpidem] for sleep, stop trazadone
3) Will also give hydroxazine [*sic*] (Vistaril) prn [as needed] for panic attacks
4) Instructed pt on deep breathing techniques for panic/anxiety
5) Pt is to call Psychiatry Clinic in am to schedule eval. His phone number is […]
6) Medical eval [evaluation] and follow-up per ER MD
7) Pt to call POD [Psychiatrist on Duty] if feels unsafe.

[12] ETOH is the symbol for ethanol, commonly referred to as alcohol. In the context of this quotation, 100% does not refer to the concentration of alcohol but refers to complete (100%) abstinence from binge drinking.
[13] A bacterium associated with the development of gastric ulcers.

As a result of the emergency room visit, the nurse clinician who had previously seen the patient in May 2005 was contacted; he (the nurse clinician), in turn, made a referral to the PTSR program for an intake evaluation that was scheduled for February 15, 2006.

In the interim, the patient was seen the next day, February 10, 2006, by a staff psychiatrist at the Minneapolis VAMC. He reported mild success with use of the zolpidem the evening prior. The psychiatrist noted that the patient had lost his driver's license related to a DWI. The patient reported that he had stopped drinking in November 2005. That morning (February 10) he had planned to take his brother's truck, but his mother intervened fearing that if he got caught he would be in more legal trouble. There was some talk that he would "mow down" anyone who tried to arrest him. The psychiatrist noted that there were no guns in the house. The patient subsequently went into a rage, reportedly screaming, yelling, and frightening his mother and older brother who intervened. His mother reported that he had been having rage attacks, particularly since he had been laid off from construction work. The psychiatrist spoke with the patient individually and with his mother and offered admission to the facility's PPH (partial psychiatric hospitalization) program.[14] The patient declined the PPH program because he was concerned about financial stressors and wanted to work. The psychiatrist noted that the patient and his mother felt safe that he would never harm himself and would not harm anyone in the home but "it is frightening when he explodes but she feels safe in returning him home." An in-person appointment was offered for the ensuing Monday, but the patient had an appointment with a chiropractor scheduled and also wanted to go to a temp agency to seek employment. The psychiatrist noted "both the patient and mother felt he was safe and the family was safe and could access the VA system emergently and he would check in with me Monday and mother has my card as well." The zolpidem was increased in dosage. The patient reported having been on the Zoloft® consistently for 2 months without much success; consequently, the psychiatrist recommended gradually tapering the dose in advance of his upcoming evaluation by a psychiatrist in the PTSR program.

A PTSR team intake evaluation was completed on February 15, 2006. Based upon a 2-hour interview with the patient that included the Clinician Administered PTSD Scale (CAPS-DX), and review of his VA medical records, the patient's DSM-IV diagnoses were noted as follows:

Axis I:	PTSD, Mod-Severe
	Alcohol Abuse in early full remission (since around 11/05)
Axis II:	None
Axis III:	low back pain, h/o [history of] bilateral knee injuries, …,
	s/p[15] MVA [motor vehicle accidents] and

[14] The Partial Psychiatric Hospitalization program provides day hospital treatment for patients Monday to Friday from 8 a.m. to 3 p.m. Patients typically go home at the end of each day and return each morning for treatment.
[15] The abbreviation "s/p" for *status post*, means "status following."

	ATV [all terrain vehicle] accidents, s/p staph infection in lip, s/p boil/lesion removal
Axis IV:	Trauma history, isolation, laid off from work (construction) but started new job 2/14/06
Axis V:	Current GAF: 60

Targeted treatment goals included:

GOAL 1:	Pt will report improved quality and quantity of sleep, obtain more than 2 hours of sleep/night at least 15 nights/month.
GOAL 2:	Pt will report at least "some" improvement in sense of closeness in relationships and decreased social isolation.
GOAL 3:	Pt will report at least "some" improvement in ability to manage/regulate negative emotional states (i.e. anger and anxiety) and decrease in maladaptive avoidance behaviors.

The psychiatric therapy and interventions that were to be employed to achieve these goals included case management to enhance anger management skills and provide increased social support, concurrent medication management overseen by a psychiatrist, and referral to a Minneapolis VAMC OIF re-adjustment/psychoeducational group. The patient's medical record notes the patient was "fully involved in the treatment planning process."

The patient reported primary concerns with temper, anxiety, flashbacks, sleep, and endorsed re-experiencing, avoidance, and hyper-arousal symptoms of PTSD. This caused problems in social relationships, isolation and feeling a sense of anger inside all the time, with occasional rage reactions where he would hit walls and cars, but he denied aggression toward people. He reported 1–2 hours of sleep per night despite the use of zolpidem and abstinence from alcohol since November 2005. The patient reported disciplinary problems on two occasions related to alcohol use while in the military, a DWI in the fall of 2005, and occasional social use of marijuana with the last use in December 2005. He denied a previous history of treatment for substance abuse.

A detailed addendum was entered into the medical record 6 days later, on February 21, 2006. This note indicates that:

> The veteran presented to the intake because his life has become "unmanageable" since returning from Iraq in September 2004. He noted that, since that time, he has developed a "violent temper." He stated that something will set him off (e.g., seeing a person of Middle Eastern descent) and he will start shaking and feel extremely upset. On a daily basis, his temper will lead him to punch windows and holes in the walls. He also frequently has verbal outbursts during his episodes of anger. In

> addition, he reported that when he becomes upset it will typically take him over an hour to calm down. As a result of his temper, the veteran indicated that his friends no longer want to be around him and his family is scared of him. The veteran further reported that several times per day he will experience uncontrollable episodes of extreme anxiety that are triggered by military reminders. During these episodes, his anxiety will peak within several minutes and it often takes him at least 30 minutes to calm down. He reported experiencing the following symptoms during these episodes: racing heart, chest pain, choking sensations, sweatiness, shakiness, shortness of breath, fear of losing control, and hot flashes. He has experienced these episodes of anxiety since returning from Iraq. The veteran also reported experiencing intrusive military-related sounds (e.g., hearing Middle Eastern religious ceremonies; hearing combat sounds) and images several times per day since returning from Iraq. Finally, the veteran endorsed experiencing significant sleeping disturbances. He indicated that he has "severe" nightmares every night where he wakes up with extreme anxiety. In addition, he noted obtaining only 2 hours of sleep per night as a result of initial insomnia (i.e., takes him approximately two and a half hours to fall asleep) and middle insomnia (i.e., awakens 3 to 5 times per night and takes him up to 30 minutes to return to sleep). The veteran endorsed the following additional life stressors: financial debt due to unemployment (7000$) [sic] and legal problems. He indicated that he received a DWI in October 2004. As a result, he lost his license for six months. During this time (October 2005), he was caught driving without a license and his license was suspended for another six months.

During the evaluation, the patient also reported having used anabolic steroids on a daily basis for 2 months each year from 2001–2004. He indicated that his friendships were strained because many of his friends drank heavily but he no longer was using alcohol. In addition, he reported that he was not currently involved in a romantic relationship. He indicated that he had been involved in a romantic relationship after returning from deployment, but his girlfriend had left him because of his steroid use.

The Axis I diagnosis included PTSD (with panic features) and a co-morbid mental health condition. A medication evaluation by a PTSR program psychiatrist was forthcoming, and the next appointment with his case manager was scheduled for March 3, 2006.

On February 28, 2006, the patient was seen by the psychiatrist who would be overseeing the patient's medication treatment. A detailed evaluation ensued and is documented in the medical record. In this evaluation similar symptoms of nocturnal panic attacks, sleep disturbance, feelings of anger and irritability, hypervigilance, intrusive thoughts, scanning of his surroundings, and nightmares related to his combat experience were elicited. He denied frank paranoia, or symptoms of anhedonia (loss of the capacity to experience pleasure), guilt, or depressive mood. He endorsed a satisfactory appetite and reported that his energy level and concentration were fine. He continued to enjoy hunting, fishing,

bodybuilding, and going out with friends. The patient endorsed an "okay" mood but was noted to be tense throughout the interview. He denied any suicidal or homicidal ideation. He indicated that zolpidem, which he had been taking for the previous month, was helping him with his sleep. In addition, he reported that he had restarted Zoloft® in November 2005 but had stopped a month prior to this appointment because of no effect.

The plan of care included initiation of the antidepressant Celexa® and continuation of zolpidem for insomnia. The psychiatrist noted that the patient expressed interest in the anger management group, was scheduled for PTSD education group, and had a follow-up appointment scheduled with the PTSR case manager on March 3, 2006. The psychiatrist "strongly encouraged the patient to attend these sessions, in particular if he opts to do anger management classes, as I think this part will be equally important as taking medication itself."

The patient did not show for his first follow-up appointment with his PTSR staff case manager on March 3, 2006. When contacted by his case manager, he reported having worked until 3:00 a.m., asked if he could reschedule this appointment to March 28, the day he was scheduled to follow-up with his psychiatrist. However, he again "no-showed" on March 28. His PTSR case manager left a voice mail message and mailed a "no-show" letter to him.

The patient was next seen in UC/ER at the Minneapolis VAMC on April 6, 2006, when he presented with sore throat, congestion, and fatigue. He reported that others on the construction crew had something similar going around. He was diagnosed with an acute viral illness, and a compete blood count and Monospot Test (a blood test for infectious mononucleosis) lab tests were drawn.

On April 21, 2006, his PTSR case manager wrote, "Given pt has not been seen in PTSR clinic since intake in Feb due to no-showing for f/u [follow-up] appts, I again attempted outreach and called his home today, his mother answered and said he was not home so I left [a] message for him to return my call."

On April 26, 2006, the patient was seen at the Minneapolis VAMC by the Audiology Service in the course of a VA Compensation and Pension (C&P) examination with a claim and complaint of bilateral hearing loss and tinnitus (ringing in the ears). However, normal hearing was found to be present bilaterally, and it was felt that the patient probably did not have tinnitus. A week later, at a general medical C&P examination, the patient reported continuous knee pain and severe low back pain. He noted a history of carrying heavy combat gear. He also reported right hand arthritic pain that he attributed to falling off a cliff while in the military. He stated that he used an albuterol inhaler for his asthma on a daily basis.

Medical record notes indicate a "no-show" for mental health appointments on May 12, May 19, and May 26, 2006.

Typically, after the patient "no-showed" for mental health appointments at the Minneapolis VAMC, a risk assessment would be performed, for example, to make sure the patient was not an imminent danger to himself or others. These assessments were documented and indicated that he was considered not at imminent risk.

The patient next presented to the mental health section of the Minneapolis VAMC on June 21, 2006, when he was seen for psychological testing in conjunction with his C&P examination.

In the late morning on September 14, 2006, the patient was seen in the UC/ER of the Minneapolis VAMC with a complaint of right arm injury secondary to breaking a window to get into his house. He was initially seen at a non-VA hospital and had sutures placed in this arm. He told staff at the Minneapolis VAMC that his right arm pain and swelling were increasing and that the ibuprofen that he was using was both ineffective and appeared to be causing gastrointestinal upset. He had received a Toradol® injection at the non-VA hospital and had been told to have the sutures removed in 1 week. He also complained of bilateral knee pain for which he reported taking ibuprofen. The UC/ER nurse called the Primary Care Clinic and arranged an appointment for that same day.

He was seen in the early afternoon in the Primary Care Clinic. A clinic nurse performed various physical and mental health screening items. The nurse documented a negative score on the PRIME-MD PHQ depression screen[16] and positive PTSD screen, and noted that the patient was already working with mental health. The patient was seen by an internal medicine resident physician and discussed with a Clinic attending physician. The internal medicine resident noted the patient's right arm pain, abdominal pain, and hematochezia (bright red rectal bleeding) of a few days duration. The plan of treatment included arm elevation and Vicodin® (hydrocodone) for arm pain; renal function tests and an acetaminophen level due to concern about analgesic overuse; omeprazole for possible esophagitis/gastritis; increase in antiviral medication; and a Colorectal Surgery Service consultation for evaluation of rectal bleeding.

On September 27, 2006, the etiology of the bleeding was identified by the Colorectal Surgery Service. A surgical treatment was recommended. Pre-operative education was provided, and this operation was scheduled for November 14.

On October 2, 2006, his PTSR case manager noted having received a message from the Minneapolis VAMC PTSR coordinator indicating that the patient had recently been in

[16] The Primary Care Evaluation of Mental Disorders Screen Patient Health Questionnaire is a nine-item screening tool. The PRIME PHQ-2 is a shorter two item version which asks: During the last two weeks how often have you been bothered by any of the following problems? 1. Little interest or pleasure in doing things? 2. Feeling down, depressed or hopeless? Patients choose among responses of "Not at All," "Some Days," "More than Half of the Days," and "Nearly Every Day."

contact with the ACC[17] and related treatment programs. As he had already been seen, evaluated, and accepted in the PTSR program, the matter was referred to the patient's already assigned case manager, who called the patient and scheduled a PTSR clinic appointment for October 11.

The patient was seen for case management and supportive therapy on October 11, 2006. He stated that symptoms similar to those previously articulated had been worsening:

> He stated when he starts to feel upset/angry about something, he then becomes "panicky" and [has] difficulty breathing, stated he passed out at least once from the panic, stated he cannot catch his breath and had to use an inhaler in order to breathe, stated he went to Urgent Care in community and was given some anti-anxiety pills, tried them, but did not like the feeling they gave him. He reported that his prescription from VA provider for Ambien ran out and he did not follow up for renewal, stated the medication worked "great" for his sleep and wants to continue with medication management of sleep and also willing to consider other medication options for tx [treatment] of the PTSD/anxiety symptoms.

The case manager coordinated an appointment with the PTSR psychiatrist for November 6, 2006. The patient had not attended anger management group and indicated that he now wanted to participate. The case manager informed him that the next cycle would start on October 16, and the patient stated he would attend the 10-session group. The case manager developed a plan for additional mental health care that comported with the patient's symptoms and requests. Also this note indicates that:

> Pt asked for assistance with managing his anxiety so we reviewed coping skills of acceptance, grounding in the present, deep breathing, relaxation skills and I provided him with handouts on grounding skills and 3 relaxation exercises. I assessed current substance use and pt reported he has one glass of wine wiht [*sic*] girlfriend with meals about 3 times per week, denied any recent abuse of alcohol, denied recent use of marijuana.

In mid-2006, the patient was sentenced for a DWI occurring in Scott County, MN. Conditions of his sentence included probation and random urinalysis drug testing.

The patient attributed many of his missed VA appointments to work obligations. He reported having started a new job with hours from 6 a.m. to 2 p.m. and that he would need late afternoon or evening sessions because his new employer might object to his absence for anger group sessions. The case manager told the patient that a referral could be made to a Minneapolis VAMC clinician who had evening hours for therapy addressing anger, PTSD, and anxiety.

[17] ACC is an acronym for Assessment, Consultation, and Crisis. Mental Health clinicians on the ACC service provide mental health consultation on medical/surgical floors and to the emergency room.

The patient did not keep his appointment for an October 16, 2006, treatment program assessment, nor his afternoon Anger Management Group. After learning that he had missed the treatment program assessment, his case manager contacted the patient by telephone, and the patient indicated that he had not been told about the October 16 treatment program assessment because he had been out of town and had just returned that day. He indicated that he would call to re-schedule an assessment and would attend next week's Anger Management Group session. The treatment program assessment was subsequently rescheduled for October 24.

On October 23, 2006, the patient received an influenza immunization and attended an Anger Management Group session. The medical record notes that:

> This member was rather quiet but at times spoke without prompts. He appeared to be an attentive participant today. His responses were appropriate. His verbal responses indicated that he was incorporating the material presented.

The following day, October 24, 2006, the patient was seen at the Minneapolis VAMC for mental health care. The patient was a no-show for his October 30, 2006, Anger Management Group session. However, he returned the call from his psychologist on November 3 and left a message. The psychologist, in turn, then returned the call and left a message.

On November 6, 2006, the patient called to cancel appointments that day with his case manager and with his psychiatrist. He agreed to meet with his psychiatrist on November 13 but did not keep that appointment. Likewise he did not attend the November 13 Anger Management Group meeting and was dropped from that program for non-attendance.

His psychiatrist left a phone message inquiring how he was and inviting him to call back and reschedule. The psychiatrist noted that on review of the records he did not appear at imminent safety risk and was able to seek help when in distress.

The patient had also been scheduled for pre-operative testing that day, for which he did not show. The pre-operative testing was re-scheduled for the following morning prior to his reporting to the outpatient surgery area.

When the patient came in the following morning, he admitted that he had been out drinking the night prior and his blood alcohol level was 0.125 g/dl[18] at 8:45 a.m. The patient also reported having had some oral intake early that morning but was noted to be anxious to proceed with the surgery. In response, the surgery was moved to the end of the operating room schedule and the procedure was performed later that afternoon under local monitored

[18] Metric system units: grams per deciliter. A normal blood alcohol level would be zero.

anesthesia care[19] without complication after discussion with the patient, physical examination, and review of the patient's lab work and vital signs.

The patient met with his case manager for supportive therapy, life skills, and case management on December 4, 2006. The patient reported that he had been struggling with PTSD and anxiety symptoms and had not attended the weekly anger management group due to transportation problems. He indicated that he wanted to try medication for his symptoms and reported that he had started exercising more which was helping with anger management. The patient reported that he was recommended to attend a program that meets "one hour per week for 3 months but that it will not start until Feb [February]." Assessment and treatment plan remained largely similar to previous visits cited above. The treatment plan is documented to include case management/therapy every 3–8 weeks and, as needed, psychiatric evaluation with medication management; referral to the Anger Management Group, noting that the patient attended only one session of the previous cycle's group due to problems with transportation; referral to a Wednesday evening coping skills classes; and continued care as required by his primary care provider.

The patient called Outpatient Surgery on December 5, 2006, to re-schedule his colorectal surgery follow-up appointment from December 6 to December 13. At the follow-up appointment, he denied pain; reported doing well; the surgical site appeared to have healed nicely without evidence of recurrence; and the plan was for the patient to follow up in 4 months.

On December 14, 2006, he saw his psychiatrist in a follow-up visit. She noted interval changes since she had last seen him in February 2006 (see above). She indicated that his PTSD symptoms continued and that since the February visit there had been no improvement and some worsening of his symptoms with more panic attacks and nightmares. The patient had not started the Celexa® and zolpidem that had been prescribed at the February visit. He reported that he had not been drinking since mid-October, was socializing with some friends but had alienated most of his family and friends, and that he did not date as he did not feel ready for a relationship. Her assessment and plan included:

> Pt continues to struggle. He has recently quit ETOH on his own….He is now at the point that he wants to start meds, and seems to have connected w Dr. [the case manager].
> - Start Celexa 20 mg qd [once a day]. Plan to taper up as needed. Discussed SE [side effects], pros and cons, including sexual SE
> - Start Ambien 10 mg qhs [at bedtime] (was on it in the past and helped).
> - As far as nightmares, I suggested he brings this up w Dr. [the case worker] and works with her on techniques for dealing with nightmares.

[19] Monitored anesthesia care is moderate (conscious) to deep sedation; less sedation than general anesthesia.

> - Encouraged attendance of group Tx in March. In the meanwhile, I think he would benefit from seeking safety.[20] I encouraged him to bring this up w Dr. [the case worker].
> - Also anger management group would be beneficial - but now pt has issues w transportation (b/c [because of] revoked driving license) and it is a problem. He has discussed this w Dr. [the case manager] before.

The patient denied suicidal or homicidal ideation, intent, or plan, was considered stable and safe, and follow-up was scheduled for 6 weeks.

During the first week of January 2007, several important events occurred. The patient was asked to leave an apartment that he had been renting because of his drinking and outbursts, and his friends offered him a temporary place to live. Second, the patient spoke with his probation officer in the context of not appearing for two random alcohol and drug urinalysis screens in accordance with the conditions of his DWI sentence in August 2006. Third, he contacted the intake counselor at the Minneapolis VAMC who had performed an assessment on October 24, 2006. The medical record indicates that the patient was interested in specialized elective mental health treatment at the Minneapolis VAMC that would not begin until March. He inquired about elective treatment at the St. Cloud VAMC, but the interviewer was not optimistic about his being admitted at St. Cloud VAMC any sooner.

The following day, the patient moved into a vacant house in a suburb of Minneapolis that was owned by a friend ("Friend 1"). Another friend ("Friend 2") stated that the patient was going to look into elective treatment but did not want to wait until March to begin a specialized program at the Minneapolis VAMC.

The next day, January 4, 2007, when the patient visited friends ("Friend 3, Friend 4"), they described him as being depressed and crying all night. At approximately 9:30 p.m., they called the Minneapolis VAMC UC/ER and told a female employee they were with a veteran with PTSD who was in "bad shape." Friend 3 said that the employee told them to bring the veteran in to the Minneapolis VAMC UC/ER. Friend 3 offered to drive the patient to the ER, but he refused to go.

In a January 24, 2007, letter to the Director of the Minneapolis VAMC, the patient's father wrote:

> On January 11 of this year, [the patient] agreed to come along with [the step-mother] and I as I had an appointment to see a doctor, [name of father's doctor] at the St. Cloud VA. [The patient] was ready and willing to seek help once again as an inpatient for his problems.

[20] Seeking Safety at the Minneapolis VAMC is a time-limited group therapy program.

Thus, on Thursday, January 11, 2007, the patient went to the St. Cloud VAMC with his father. The veteran walked into the VAMC's domiciliary care unit with his parents (father and stepmother) and was met by a nurse. The veteran's father had a medical appointment scheduled for himself on that day, and the patient accompanied his father and stepmother to the VAMC. The nurse inquired as to why the patient had visited the domiciliary care unit. The patient told her that he was seeking specialized rehabilitation treatment. She subsequently took him to an intake area where she conducted a pre-screen evaluation for acceptance to the residential program. The nurse stated that his parents stood behind him throughout the pre-screening process but did not speak to her.

The patient's parents later reported that the patient told the nurse he was suicidal. According to the family, the nurse did not seem to acknowledge or respond to this and continued through the pre-screen questions in a matter of fact manner, reportedly prompting the patient's stepmother to step forward and yell, "He is an Iraqi veteran!"

When we interviewed the nurse who interviewed the patient, she denied that the patient stated he was feeling suicidal. At the time of the veteran's interview, a second screening nurse was sitting on the opposite side of a divider between their desks. When the second nurse was interviewed, she said she only heard two voices, the first nurse and a male voice.

Patients applying for the St Cloud VAMC residential program are required to be independent in their living skills, free from legal problems that would prevent their attending, and capable of completing the program. The nurse conducted the pre-screening process by asking the veteran if he had any legal or medical issues that would prevent him from completing the program. He responded that he did not. She telephoned one of the three screeners assigned to the program who were responsible for conducting a full admission screen. The nurse called and spoke with the screener, a clinical social worker, to inquire about his availability for conducting the admission screen that day. The social worker told her that he was unable to conduct the screening that day and offered to schedule an appointment for the patient to be screened the following day.

Because the patient lived far from the VAMC, an appointment was set up for the patient to be screened by telephone at 2:00 p.m. the following day. The nurse stated that she wrote the telephone number to the nursing station for the veteran to call back the following day. The patient was to call that number which would then be transferred to the screener who would conduct the admission screen. Neither the nurse nor the social worker spoke to family members about the veteran's application for the elective treatment program.

On January 12, 2007, at approximately 2 p.m., the patient called the screening social worker. He (the patient) was told the social worker would call back in about 20 minutes. When the call was returned, the screening questionnaire for the residential rehabilitation treatment program was administered by the screening social worker. The patient's stepmother told OHI that she could hear the patient's end of the conversation. She stated the following:

> He [the St. Cloud VAMC social worker] gave his name, and then I guess he said you have to fill out a questionnaire, you know, and I heard, "Yes, yes," you know, to questions he was asking, "Yes, yes. Yes. No. Yes," and he had to have asked him, I guess, suicidal, homicidal, and [he] said, "Yes, I am. Yes, I am."

In the January 24, 2007, letter to the Director of the Minneapolis VAMC, the patient's father described the screening process as follows:

> Unfortunately, he was told that he would not be able to get in that day but he would have to go thru a screening process the next day by telephone. During the next day's screening by telephone, [the patient] expressed his emotional instability and suicidal thoughts. He was told that he was number 26 on the waiting list for getting help.

On January 12, 2007, the social worker completed the screening and accepted the patient for the residential rehabilitation program. He told the patient that he was accepted to the residential program, put him on hold, and attempted to contact the admission clerk. She was unavailable, so the social worker left a voice mail with the patient's name and telephone number so that she would contact him. The social worker also gave the veteran the clerk's telephone number, so that he could check with her about his admission date. The social worker stated that he did not know whether the clerk was able to contact the veteran or whether the veteran was able to contact the clerk. Moreover, the social worker did not speak with family members during the screening process.

When we interviewed the social worker about the screening process, the social worker reported that he was aware the patient had received care at the Minneapolis VAMC, and he attempted to access the patient's Minneapolis VAMC record electronically. However, he was unsuccessful due to a computer problem, which has since been resolved. In the OHI interview, his description of asking the veteran about suicide was as follows:

> OHI Inspector: I've read your template, but tell me how you assessed him for safety.
> Social Worker: The only way that I can [*sic*] assess him for safety was by asking him the question about "Have you had or are you currently having suicidal thoughts?" to which he answered "No." That was the end of it.
> OHI Inspector: What was the following question?
> Social Worker: "Have you had any suicide attempts?"
> OHI Inspector: Okay.
> Social Worker: And again, his answer was "No." I have no information to compare with. All I had was what he told me on the phone and what I entered into the progress note.

After completion of the telephone screening for the elective residential treatment program, the patient told his parents he was number 26 on a waiting list and wrote down a telephone number for the St. Cloud VAMC, which he was to call approximately every half week to mark his progress on this waiting list.

We interviewed the medical technician who functions as the admission clerk for the VAMC's elective residential program. The clerk stated that she assumed that the screener had left her a voice message with the patient's name and telephone number indicating that the veteran had been screened and accepted and that he (the patient) would be contacting the clerk for an admission date. The clerk stated that she did not keep the voice message recording and did not recall contacting the veteran. Moreover, the clerk did not have a copy of the roster of veterans accepted to the program because the handwritten roster is destroyed and a new roster started as the patient list changes.

That day, the patient also spoke with Friend 5 and told him that he would wait it out for residential treatment. Friend 5 told him that he could stay at Friend 1's home in a Minneapolis suburb for as long as he needed. The patient also called Family Member 1 and said that he was number 26 on the waiting list for admission to the St. Cloud VAMC's program.

On Saturday, January 13, 2007, Friend 2 picked up the patient from his parents' home and took him back to Friend 1's home. Friend 2 also stayed overnight at the home, then left the next day (January 14). That same day, the patient had repeated phone conversations with Friend 2. The conversations were described as normal.

Late Monday night, January 15, 2007, Friend 2 received a call from the patient and described the patient as sounding happy and making many optimistic forward looking statements. Friend 5 also spoke with him and said that the patient stated that he (the patient) was doing pretty well. Additionally, he told Friend 5 that he had resolved a dispute with Friend 2 and that he felt good about that. However, the patient also called Family Member 2 and said that he should have stayed at his parents' house. Family Member 2 offered to have the patient picked up, but this never happened.

On January 16, 2007, Friend 5 and the patient had approximately five conversations via telephone discussing the patient's relationship with another friend. The patient called Friend 3 that morning, and during their conversation he reported having gone jogging, seemed "really happy" and "fine." Friend 2 spoke with the patient around 12:30 p.m. and described that he [the patient] was "pretty much in the dumps." The patient called Friend 3 again in the afternoon and told the friend that he was drinking and "didn't like how his life was." About an hour later, the patient called Family Member 2, further discussed personal matters, and agreed to call back at 4:00 p.m.

Between 5:30 p.m. and 6:30 p.m., Friend 2 went to visit the patient. Friend 2 found him alone at the house, ascertained that he had been drinking, stayed briefly, and told the patient to call the next morning.

By approximately 7:30 p.m., Family Member 2 had still not heard back from the patient, became worried, and called him. The patient stated that he had resumed drinking, that he planned to leave Minnesota and go to Oklahoma, and that he found a blue cord and made a noose, and apparently expressed suicidal ideation. The family member conversed with the patient and felt they had been able to lift his spirits and dissuade the patient from such an action and told the patient that Family Member 3 would be home shortly and wanted to speak with him. Family Member 2 hung up after obtaining assurance from the patient that he would answer the phone.

Approximately 8 p.m., the patient called Family Member 1 and asked if Family Member 4 could get him (the patient) a ticket to Oklahoma as he had marine buddies he wanted to visit. Family Member 1 reported that from the way the patient was talking it was apparent that he was inebriated. Family Member 4 spoke with the patient and promised to check on this the next morning. The patient asked Family Member 4 if he could call the next day and was told he could give Family Member 4 a call at work in the morning. Upon transfer of the phone from Family Member 4 back to Family Member 1, the patient had apparently hung up.

About 5 minutes later, Family Member 1 called the patient back and was told by the patient that he had a noose or was going to put a cord around his neck. The patient stated that nobody could help him and that nobody was able to help him. Family Member 1 told the patient to stop saying things like that or the police would have to be called. Family Member 1 hung up the phone, to quickly call Family Member 5, and explained the call that had just transpired. Family Member 5 instructed Family Member 1 to hang up and call the police. Family Member 1 called 911.

The patient called Friend 5 and said that he (the patient) was wrapping a cord around his neck and tying it to a cross beam in the basement. The patient spoke briefly with Friend 5 and dropped the phone. When the line went dead, Friend 5 called 911.

The police made an emergency visit to the patient's home. No one answered the door, but they noticed the patient through a window; he was motionless, in a sitting position, and semi-suspended by an electrical cord. The police broke into the house, started cardiopulmonary resuscitation (CPR), and summoned paramedics. The patient was transported by ambulance to Hospital A. Although CPR was continued at the hospital, the patient was unresponsive. CPR was ultimately discontinued, and the patient was pronounced dead at 9:12 p.m. on January 16, 2007.

A limited post-mortem examination was performed by the Minnesota Regional Medical Examiner's Office. This office holds forensic jurisdiction over Scott County, Minnesota,

where the patient died. The cause of death was determined to be hanging, the manner of death to be suicide, and other significant conditions were noted to be acute and chronic alcoholism and post-traumatic stress disorder. Significant toxicology findings were a urine ethanol of 0.28 gm/dl[21] and a vitreous[22] alcohol of 0.25 gm/dl.

Findings and Conclusions

Allegation: A Patient Claiming Suicidal Ideation Was Not Admitted to the St. Cloud VAMC.

This allegation could not be substantiated.

The patient's medical record showed that, while a patient of the Minneapolis VAMC from 2005–2006, he denied suicidal ideation on all visits.

On January 11, 2007, the pre-screener nurse met the patient, his father, and stepmother as she was walking past them in the hallway of Building 28. She asked the patient if she could help him and his response indicated that he was interested in one of the facility's elective residential programs. The nurse then guided the patient and his family to the pre-screening area where veterans are interviewed for the programs. The nurse took some information, and asked the patient the pre-screening questions used to determine suitability for non-acute residential programs (that is, whether the patient was medically stable and free of legal issues which would prevent him from completing the program).

The patient's parents reported that the patient told the nurse he was suicidal. The nurse according to the family did not seem to acknowledge or respond to this and continued through the pre-screen questions in a matter of fact manner, reportedly prompting the patient's stepmother to step forward and yelled "He is an Iraqi veteran!"

On completion of the pre-screening interview, the nurse then called a screening social worker to report that a patient interested in the rehabilitation program had come in as a walk-in. The nurse asked the screening social worker if he was available to help the patient at that time. The screening social worker reported that he was busy and that he couldn't but offered to set up an appointment for the following day. Initially this was accepted by the patient, but after speaking with his father who expressed frustration with having to come back because they drove from out of town, the nurse offered to have the veteran call the their office at a certain time and conduct the interview over the telephone. The patient's father said something to the patient who then agreed with this arrangement. The nurse wrote down the telephone number that the patient was to call, and the patient and his family left the pre-screening area.

[21] Metric system units: grams per deciliter.
[22] Vitreous is the fluid in the eye.

Our review found that St. Cloud VAMC staff interviewed asserted that the expressed procedure of the St. Cloud VAMC is to be highly attuned to and reactive to any expression of suicide. In fact, during one of our visits to Building 28 at the facility, one of the patients sought us out because he wanted us to know that he had come to the facility on January 12 to begin the rehabilitation program; this was the day following the patient's first contact with St. Cloud VAMC. The patient we spoke to reported that he told staff he had been having passive death wishes, with thoughts of wishing he could go to sleep and not wake up, but he denied have active thoughts of harming himself. This patient told us that several staff members descended upon him in response. He reported that he had to verbally "fight" to not get taken upstairs to the locked unit, and that it was only because a therapist who had cared for him on a previous admission intervened on his behalf that he was not taken to the locked ward. With this other patient's permission, we checked the electronic medical record and verified that he was admitted on January 12, 2007.

On January 12, the day following the patient's visit to St. Cloud VAMC with his parents, he called the screening social worker at 2:00 p.m., as had been arranged. The screening social worker relayed to a staff member that he would call the patient back in 20 minutes, which he did. The patient was at the home of his father and stepmother. The patient's stepmother reported that she was present in the room at the time of the conversation. The patient was asked questions from a screening template. She reported that she could hear the patient's part of the conversation but not the other half of the conversation. The patient's stepmother reported that at some point during the conversation she heard the patient say or respond "yes I feel suicidal" to a question that she believed concerned suicidal ideation.

When we interviewed the nurse who interviewed the patient, she denied that the patient stated he was feeling suicidal. At the time of the veteran's interview, a second screening nurse was sitting on the opposite side of a divider between their desks. When the second nurse was interviewed, she said she only heard two voices, the other nurse and a male voice. The documentation suggests that the patient presented to the St. Cloud VAMC to be admitted to an elective program, as opposed to there being a psychiatric emergency.

When OHI interviewed the screening social worker and reviewed his notes, he stated both to OHI and in his note that the patient denied suicidal ideation.

Friend 3 recalled speaking with the patient by phone on January 11 and asked the patient "I thought you got checked in this morning." The patient told the friend that his dad had driven him to the hospital, that he had gone in and been evaluated, and put on a waiting list. The friend reported stating "Well, that's ridiculous. They need to take you in because, you know, you're suicidal. You should not be by yourself." The friend asked "did you tell them you were suicidal?" and said that the patient reportedly stated yes and "said that he told them everything, that he was suicidal and about all his depression, and he said they put him on a waiting list." Friend 3 also spoke with the patient by phone on January 16, at which time the patient seemed happy and stated he would never kill himself.

None of the patient's other friends and family interviewed by OHI recalled the patient stating during the January 13–16 (Saturday through Monday) time period that he had told the VA that he was suicidal on January 11–12. Also, the patient's parents wrote a letter dated January 24, 2007, to the St. Cloud VAMC director in which they make the allegation that the patient, "expressed his emotional instability and suicidal thoughts" over the telephone on January 12. However, there was no claim in that letter that the patient stated he was suicidal the day before (January 11) while at the St. Cloud VAMC.

Family members ascribed the patient's use of alcohol to attempts at self medication for his PTSD symptoms such as nightmares. During the January 13–16 time period, family and friends did not describe the patient as having a pervasive depressed mood nearly ever day or markedly diminished interest or pleasure in activities in the absence of alcohol use. However, family members and friends did describe a history of prominent disturbances in mood and behavior prior to the January 13–16 time period most frequently related to alcohol use. Family members and friends detailed instances during the year and a half prior to his death in which the patient displayed anger and depressed mood and/or made suicidal comments in the context of heavy drinking. One family member stated that the next day, when he was sober, it was as if it had never happened the night before. Verbalization of suicidal thoughts appeared to be typically associated with recent alcohol use.

Interviews with the patient's friends indicated that he maintained sobriety for almost a 2 week period during early January until the day of his death. During a phone conversation with Friend 3 on the morning of January 16, the patient reportedly appeared happy and fine. However, while inebriated later that afternoon, he began experiencing and displaying a roller coaster of emotions and in the evening began verbalizing suicidal thoughts.

Allegation: The Patient Was Denied Admission to the St. Cloud VAMC Due to Lack of an Acute Psychiatric Bed.

The allegation is not substantiated.

The hospital has mental health units designed for elective programs and units designed for acute mental health treatment. A patient at acute risk for suicide would be admitted to an acute unit, not an elective mental health unit. There were acute psychiatry beds available for the patient on both Thursday, January 11, and Friday, January 12. The Acute Psychiatry Unit of the St. Cloud VAMC is a secure 15-bed unit. On January 11, 2007, there were six beds occupied on the acute inpatient psychiatry unit and, thus, nine were vacant. During the course of the ensuing 24-hour period, four more beds were filled, one was vacated, and there were six beds available on the unit. Lack of an acute bed was not a factor in not admitting the patient.

Other Key Findings

The Patient Received Extensive Quality Medical and Psychiatric Care at the Minneapolis VAMC.

Review of this patient's medical records shows that he received extensive medical, surgical, and psychiatric care at the Minneapolis VAMC in 2005 and 2006. That medical care is detailed above in this report. Both the patient's medical care as well as his psychiatric care was found to be detailed and compassionate. For example, when faced with a young patient who seemed abnormally slow to heal from infections, a detailed immunologic evaluation was initiated and staff conferred with an authority on neutrophil cells at the University of Minnesota.

In regard to the patient's psychiatric care, contemporaneously written notes document thorough assessments, treatment plans, and recommended follow-up care. While follow-up was routinely arranged, the medical record revealed repeated "no-shows" for further evaluation and treatment recommendations. Notwithstanding these "no-shows," the Minneapolis VAMC mental health staff made repeated attempts to reach out to the patient.

The patient's medical and psychiatric care met or exceeded community standards.

A Social Worker Was Available To Screen the Patient When He Presented to the St. Cloud VAMC on January 11, 2007.

We found that when the patient presented to the St. Cloud VAMC seeking admission into its residential rehabilitation program, the social worker stated that he was busy when called by the intake nurse to screen the patient. The social worker reported telling the nurse that he would interview the patient and perform the screening interview with the patient by telephone the next day.

We found that the social worker was not engaged in any activity that should have taken precedence over seeing the patient that same day. We found no evidence that he was seeing another patient at that time or occupied with an emergency. Screening patients by telephone for the residential rehabilitation program was an accepted practice. In fact, sometimes seeing a patient in person is not even an option, such as when an incarcerated individual is applying for the program.

However, we concluded that it would have been the best practice to have screened the patient in person on January 11 when he was present at the St. Cloud VAMC. This criticism is not meant to suggest that "in person screening" vs "telephone screening" would have led to a different clinical outcome in this case.

Changes Implemented by the St. Cloud and Minneapolis VAMCs in the Aftermath of the Patient's Death.

St. Cloud VAMC

Since the time of this patient's visit and death, patients who present to the St. Cloud VAMC unannounced and unscheduled seeking admission to its residential programs are directed to the St. Cloud VAMC's Mental Health Clinic Triage unit. This provides for an on-the-spot screening of a patient's psychiatric state and immediate needs. Additionally, the RRTP admission screening documentation template, that is, the form filled out by the St. Cloud VAMC social worker on January 12 is being re-evaluated.

A National Veteran Suicide Prevention Awareness Day Action Plan including staff education has been completed.

Minneapolis VAMC

An index of mental health services and program descriptions is being created to educate providers, patients and family members about the different programs.

The appropriate responses towards patients in need of mental health services is a topic of continuing discussions and re-evaluation.

Recommendations

We concur with the steps taken by the Minneapolis and St. Cloud VAMCs thus far. We also believe that the following additional steps should be taken:

Recommendation 1: We recommend that the VISN Director ensure that the St. Cloud VAMC Director requires that elective residential rehabilitation programs utilize a multidisciplinary approach, with active clinical assessment, in determining admission suitability.

Recommendation 2: We recommend that the VISN Director ensure that the St. Cloud VAMC Director requires that the St. Cloud VAMC is responsible for timely communication with patients and updates of all aspects of applicants' status for elective residential rehabilitation admissions and for maintaining documentation thereof.

Appendix A

Glossary

ACC – Assessment, Consultation, and Crisis. Mental Health clinicians on the ACC service provide mental health consultation on medical/surgical floors and to the emergency room.

AXIS I/AXIS II/AXIS III/AXIS IV/AXIS V — As defined by *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition., Washington DC, American Psychiatric Association, 1994:

Axis I:	Clinical Disorders
	Other Conditions That May Be a Focus of Clinical Attention
Axis II:	Personality Disorders
	Mental Retardation
Axis III:	General Medical Conditions
Axis IV:	Psychosocial and Environmental Problems
Axis V:	The clinician's clinical judgment of the individual's overall current level of functioning. Often the GAF (see below) is used.

CAPS-DX – Clinician Administered PTSD Scale.

C&P – Compensation and Pension (a Veterans Benefits Administration program).

DCU – Domiciliary Care Unit.

DWI – Driving While Intoxicated

DSM-IV – *Diagnostic and Statistical Manual of Mental Disorders*. Washington DC, American Psychiatric Association.

Dual Diagnosis – Persistent serious mental illness with substance abuse disorder.

GAF – Global Assessment of Function. The GAF may be particularly useful in tracking the clinical progress of individuals in global terms, using a single measure. A GAF score of 60–70 would be consistent with having some mild symptoms or some difficulty in social, occupational, or school functioning, but generally functioning pretty well, having some meaningful interpersonal relationships.

Hx – history.

Mg/dl and gm/dl – metric system units for milligrams per deciliter and grams per decileter.

MSSA – Methcillin sensitive *Staphylococcus aureus*.

OIF – Operation Iraqi Freedom.

OIG – Office of Inspector General.

OHI – Office of Healthcare Inspections, an office within VA's OIG.

OT – Occupational Therapy. A type of rehabilitative therapy emphasizing skill teaching and creative activities.

POD – Psychiatrist on Duty.

Polytrauma VA Medical Center – Lead Centers: Richmond, VA; Tampa, FL; Minneapolis, MN; and Palo Alto, CA.

PPH – Partial Psychiatric Hospitalization program. The Partial Psychiatric Hospitalization program at the Minneapolis VAMC provides day hospital treatment for patients Monday to Friday from 8 a.m. to 3 p.m. Patients typically go home at the end of each day and return each morning for treatment.

PCC – Primary Care Clinic.

PCP – Primary Care Provider.

Prn – As needed.

PRIME-MD PHQ depression screen – A shorter two item version of the Primary Care Evaluation of Mental Disorders Screen Patient Health Questionnaire (a nine-item screening tool). The PRIME PHQ-2 simply asks: During the last two weeks how often have you been bothered by any of the following problems? 1. Little interest or pleasure in doing things? 2. Feeling down, depressed or hopeless? Patients choose among responses of "Not at All," "Some Days," "More than Half of the Days," and "Nearly Every Day."

PUC – Psychiatry Urgent Care.

PRRTP – Psychosocial Residential Rehabilitation Treatment Program.

Pt – Patient.

PTSD – Post-traumatic stress disorder.

PTSR Team – Post Traumatic Stress Recovery Team.

RRTP – Residential Rehabilitation Treatment Program.

Screening template – Tool used for assessing patients' appropriateness for a treatment program.

SE – Side effects.

Sic – Latin for "thus" or "so" and used to indicate that a quoted passage, especially one containing an error or unconventional spelling, has been retained exactly as shown in its original form.

S/p - The abbreviation for *status post* means "status following."

USMC – United States Marine Corps.

UC/ER – Urgent Care/Emergency Room.

VA – Department of Veterans Affairs.

VAMC – VA Medical Center.

VISN – Veterans Integrated Service Network.

Appendix B

VISN Director's Comments

Department of Veterans Affairs **Memorandum**

Date: May 1, 2007

From: Director, Veterans Integrated Services Network 23 (10N23)

Subject: Healthcare Inspection – Review of the Care and Death of a Veteran Patient, VAMCs St. Cloud and Minneapolis, MN MCI Project No. 2007-01349-HI-0300

To: Assistant Inspector General for Healthcare Inspections (54)

Attached is the Network Director's response to the recommendations of the report.

(original signed by:)

ROBERT A. PETZEL, M.D.
Network Director

Director's Comments to the Office of Inspector General Report

Comments and Implementation Plan

Comments from the Director, St. Cloud VAMC

Recommendation 1: We recommend that the VISN Director ensure that the St. Cloud VAMC Director requires that elective residential rehabilitation programs utilize a multidisciplinary approach, with active clinical assessment, in determining admission suitability.

I concur with the IG's recommendation.

Implementation Plan: Changes to the screen and admission procedures are under revision with expected completion in 90 days.

Recommendation 2: We recommend that the VISN Director ensure that the St. Cloud VAMC Director requires that the St. Cloud VAMC is responsible for timely communication with patients and updates of all aspects of applicants' status for elective residential rehabilitation admissions and for maintaining documentation thereof.

I concur with the IG's recommendation.

Implementation Plan: Communication and documentation processes are under revision to improve the timeliness and documentation of pertinent updates to applicant's admission status with expected completion in 90 days.

Appendix C

OIG Contact

OIG Contact	John D. Daigh, Jr., M.D. Assistant Inspector General for Healthcare Inspections (202) 565-8305

Appendix D

Report Distribution

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