Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Denial of Care and Quality of Care Issues
Veterans Health Care System of the Ozarks Fayetteville, Arkansas

Report No. 09-02987-60 **January 13, 2010**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time, Monday through Friday, excluding Federal holidays

E-Mail: vaoighotline@va.gov

Executive Summary

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding the quality of mental health care received by a patient at the Gene Taylor Community Based Outpatient Clinic (Mt. Vernon CBOC), in Mount Vernon, Missouri.

The Honorable Jo Ann Emerson, Representative from the 8th Congressional District of Missouri, requested the VA OIG review allegations that a constituent was denied care at the Mt. Vernon CBOC. Specifically, the complainant alleged the Mt. Vernon CBOC denied a patient's repeated requests for hospitalization when he presented to the CBOC with complaints of anxiety, depression, a belief his current medications were not working, and a recent history of handling his handgun in a way that concerned his spouse. In addition, the complainant alleged inadequate monitoring of the patient's mental health condition. He died of a self-inflicted gunshot wound the following day.

Although the patient was not hospitalized, we determined that bed availability at the Fayetteville VAMC was not the driver for the provider's decision to not admit the patient to a mental health unit. However, we could not find evidence in the medical record documentation that the provider sufficiently explored relevant aspects of the patient's recent suicidal thoughts and or further inquired about the location of the patient's gun. Finally, the CBOC primary care service did not provide the patient with a mental health consult within the required timeframe and did not facilitate further assessment of the patient's mental health when he presented to the CBOC for unscheduled visits with mental health issues. Although we identified these patient care issues, given all the facts in this case, including those relating to the care provided to this patient both at VA and at non-VA facilities, we cannot conclude that these deficiencies impacted the patient's outcome.

We recommended that the VISN Director ensures that the Medical Center Director: 1) requires documented discussion in the patient's medical record regarding access to lethal weapons for patient's determined by the evaluating clinician to be at heightened risk for suicide; 2) requires newly hired providers are initially monitored through chart review to assure new staff are sufficiently adept with use of CPRS, 3) assures patients seen in the primary care clinic and who have mental health needs receive timely referrals; and assures that clinical staff facilitate further assessment of patient's mental health care needs for patients who present to primary care for unscheduled visits where mental health issues are central to the visit.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable corrective actions. (See Appendixes A and B, pages 19–21, for the full text of the Directors' comments.) We will follow up on the planned actions until they are complete.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, South Central VA Health Care System (10N16)

SUBJECT: Healthcare Inspection – Alleged Denial of Care and Quality of Care Issues, Veterans Health Care System of the Ozarks, Fayetteville, Arkansas (2009-02987-HI-0166)

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding the quality of mental health care received by a patient at the Gene Taylor Community Based Outpatient Clinic (Mt. Vernon CBOC), in Mount Vernon, Missouri.

Background

The Honorable Jo Ann Emerson, Representative from the 8th Congressional District of Missouri, requested the VA OIG review allegations that a constituent was denied care at the Mt. Vernon CBOC. Specifically, the complainant alleged the Mt. Vernon CBOC denied a patient's repeated requests for hospitalization when he presented to the CBOC with a suitcase and complaints of anxiety, depression, a belief his current medications were not working, and a recent history of handling his handgun in a way that concerned his spouse. In addition, the complainant alleged inadequate monitoring of the patient's mental health condition. He died of a self-inflicted gunshot wound the following day.

The Mt. Vernon CBOC is one of four CBOCs associated with the Veterans Health Care System of the Ozarks, Fayetteville, Arkansas (Fayetteville VAMC). The Fayetteville VAMC is part of the South Central VA Health Care Network – Veterans Integrated Service Network (VISN) 16. It is categorized as a very large CBOC and it serves over 15,000 unique patients. Provided services include primary care and outpatient mental health, referred to as the Behavioral Health Service (BHS).

At the CBOC, 13 teams comprised of a physician, a registered nurse (RN), and a clerk, provide primary care services. New patients are randomly assigned to a primary care team. Because offering some mental health treatment in the primary care setting may reduce stigma and may facilitate acceptance and transition of care if needed to the mental

health clinic setting, local policy at the CBOC allows primary care physicians to treat mental health diagnoses with up to two trials of antidepressants if they feel comfortable doing so. They may also refer patients with mental health needs to an Advanced Practice Nurse (APN) for consultation and primary care. APNs at the CBOC are Mental Health Clinical Nurse Specialists who may prescribe a variety of medications including those to treat depression and anxiety. The APN sees the patient for one to four visits to determine if the patient should remain under treatment with primary care or if they would benefit by further assessment and treatment by the BHS. CBOC primary care physicians and APNs are privileged to refer patients for inpatient mental health admission if needed. Finally, patients may self refer and primary care physicians may refer patients immediately to the BHS. The services BHS provides include general mental health, substance abuse, post traumatic stress disorder (PTSD), suicide prevention, and mental health intensive case management (MHICM).[1]

The Fayetteville VAMC is a 72 bed facility that provides acute medical, surgical and psychiatric care. Located approximately 100 miles from the CBOC, it has a 15 bed psychiatric unit and is the CBOC's main referral hospital. If a practitioner determines a patient requires medical or psychiatric inpatient admission, the patient is transported to the Fayetteville VAMC, another VAMC, or is admitted to a local community hospital. Patient acuity and bed availability determine the final disposition of patients who practitioners determine require admission.

Scope and Methodology

We interviewed the complainant in person. We interviewed the Butler county coroner by telephone. In addition, with permission of the complainant, we obtained and reviewed the coroner's report and related laboratory test results. We conducted site visits at the Mt. Vernon CBOC August 18–20, 2009 and at the Fayetteville VAMC on September 1, 2009. We interviewed medical center management, psychiatrists, RNs, APNs, pharmacists, the Suicide Prevention Coordinator, and administrative clerks. We reviewed policies, procedures, directives, and the patient's medical records. We also reviewed practitioner personnel files, credentialing and privileging folders, peer reviews, and background checks. We reviewed the patient's VA electronic medical record and, with the complainant's permission, we reviewed records from an outside community hospital at which the patient had previously been treated. In addition, the complainant provided us with copies of the police report related to the patient's death, and with copies of an evaluation and notes by a private therapist who had briefly seen the patient earlier in the year.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

[1] An intensive case management program for patients with severe mental illness.

Case Summary

The patient was an Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veteran who, between 2004 and 2006, served two, 1-year tours in Iraq with a 4-month break between the two tours. A 30-year military Veteran who retired from the National Guard in 2008, he was in his mid-fifties, lived with his wife, and had no documented service related disabilities.

Summary of Events Prior to Receiving Care at the Mt. Vernon CBOC

Prior to receiving care at the Mt. Vernon CBOC, the patient received medical and mental health care between March and September 2007, at the Marion Illinois VA Medical Center (VAMC) and at the Paducah CBOC, one of seven CBOCs associated with that VAMC. Because he was an Iraq war Veteran, the Marion VAMC conducted screening for PTSD, depression, and alcohol abuse;[2] the PTSD screen was positive. He received mental health evaluations from a social worker, an APN, a psychiatrist, and a therapist. He was diagnosed with anxiety, depressed mood, and possible PTSD during this time. He was prescribed an antidepressant that is also used for anxiety. In October 2007, he cancelled a follow-up mental health appointment scheduled at the Paducah CBOC. He did not reschedule the appointment. He had no further mental health related appointments at any VA facility until April 2009. In July 2008, he had coronary artery bypass surgery at a non-VA hospital.

In October 2008, the patient received a flu immunization at a CBOC in Branson, Missouri, one of the four CBOCs associated with the Fayetteville VAMC and located approximately 70 miles from Mt. Vernon. Two weeks later, he presented to the Branson CBOC without an appointment and requested a prescription refill for stomach upset. Around that time, he and his wife were moving and he was transferring his care to the Mt. Vernon CBOC, where a new patient evaluation appointment was scheduled for early November. Because it is VHA policy to accommodate Veteran needs during times of travel, [3] a Branson CBOC physician reordered the prescription as requested. After receiving the stomach upset prescription refill, the patient cancelled the Mt. Vernon appointment and one that was subsequently rescheduled for mid-November.

In late October and early November 2008, the patient was seen by a private, non-VA therapist for uneasiness, mild depression, and life changes. He reported feeling somewhat lost, not knowing what to do with himself since his retirement from a military career. He reported anxiety related to estranged family relationships. He also reported becoming frequently agitated for no apparent reason and marital problems. He denied

[2] VHA Directive 2005-005, *Implementation of the National Clinical Reminder for Afghan and Iraq Post-Deployment Screening*, December 1, 2005.
[3] VHA Directive 2007-016, *Coordinated Care Policy for Traveling Veterans*, May 9, 2007.

suicidal or homicidal ideation,[4] but reported spending a lot of time thinking about his time in Iraq, ruminating on friends he had lost in his unit. He told the private therapist that re-adjustment had been very hard. He denied prior ongoing mental health treatment, but reported that he was seeing a counselor at the Mt. Vernon CBOC in addition to his primary care physician. He received a provisional diagnosis of major depression - mild, and generalized anxiety disorder. The therapist noted that PTSD could not be ruled out and further assessment was needed. It was the therapist's assessment that the patient might need medication as well as cognitive behavioral therapy. The therapist encouraged the patient to see a physician to determine the need for an antidepressant.

The patient was seen again by the private therapist in late November 2008. During this appointment, he recalled having had panic attacks at some point in the remote past that was treated with the anti-anxiety medication chlordiazepoxide (Librium). He said he was currently experiencing anxiety, but believed he could control it himself. He told the therapist he would go to the VA clinic in Mt. Vernon to address medication issues.

Summary of Events After Beginning Care at the Mt. Vernon CBOC

The patient's next encounter with a VA healthcare facility occurred at the Mt. Vernon CBOC in early April 2009, where he received a comprehensive, new patient evaluation. He did not see his assigned primary care physician because she was on leave. He was evaluated instead by a recently hired physician who had worked at the CBOC for approximately 1 month. He received required screening for PTSD, depression, and alcohol abuse; the PTSD and depression screens were positive. He told the physician he did not believe his current antidepressant was effective and he was feeling depressed. He denied thoughts of suicide. The physician's impression included a diagnosis of depression and she changed his antidepressant to one he had experienced success with in the past. She documented the positive PTSD and depression screening results and noted he should receive a mental health consult within 14 days; however, she did not properly order the consult through the Computerized Patient Record System (CPRS). [5]

Three days after the Mt. Vernon CBOC evaluation, the patient left the couple's home and went to a local motel. He was gone for 5 days before he called his wife. He asked her to come get him because he said he could not drive. When his wife arrived he became angry, told her to call the police, and drove away in his truck. She called 911 on her cell phone and the police pulled the truck over. The police reportedly found a gun and ammunition in a plastic bag in the truck and the patient was transported by ambulance to a community hospital emergency department for evaluation.

[4] Thoughts of killing self or others.
[5] An electronic medical record application used to enter orders and manage all information connected to any patient in the VA healthcare system.

Emergency department documentation related to this event does not make reference to the patient having left the couple's home for 5 days, the interaction with the police, or the presence of the gun/ammunition in his truck. Documentation did include that the patient reported depression, "doing things that I don't understand," increasing irritability, and arguing with his wife. He reportedly stated that he wanted to make it work, but was feeling like he did not feel in control of the situation. The notes indicated that the current episode had started more than a week earlier and had gotten progressively worse. Over the prior month, the patient reported that he had gradually become increasingly argumentative and was easily agitated. He endorsed depression and memory loss. He denied suicidal ideas, insomnia, and psychotic symptoms. His speech and behavior were described as normal and his affect as blunt.[6] He told the clinician that, although he had been prescribed anti-depressant medication, he had not been taking an anti-depressant for 1.5 months. (He reportedly told his wife that he had forgotten.)

The emergency department evaluation also included blood analysis and an electrocardiogram (EKG), which were largely unremarkable. The emergency department physician noted his thyroid stimulating hormone level[7] was slightly above the reference range, so he was advised to follow this up with his primary care doctor. He was also advised to take his anti-depressant medication. The hospital's mental health unit screener also evaluated the patient while he was in the emergency department. The patient reportedly stated he was feeling better and he was discharged from the emergency department to his home with instructions to follow up at the VA.

Three days after the emergency department evaluation, the patient sought unscheduled care at the Mt. Vernon CBOC where he requested an EKG, which was performed and determined to be normal. During this encounter, he told the triage[8] nurse he had a "panic attack" and was taken to an emergency room by ambulance. Documentation does not reference or indicate mention of the events that led to the non-VA hospital emergency department visit 3 days earlier. The patient told the triage nurse that he had not filled or started taking the new antidepressant prescribed by the Mt. Vernon physician in early April. He denied suicidal ideation. He was discharged to home with the advice to get the antidepressant prescription filled and to call if he continued to have problems.

The following week, the patient's assigned primary care physician noted a possible concern related to cholesterol and hypertension medications. The patient was receiving medications for these conditions from the VA and the physician was concerned that he was also taking similar medications prescribed by a private physician. The matter was resolved that day when the clerk called the patient, who reported he would finish the non-VA prescribed medications before starting the VA prescribed medications. At the end of April and again towards the end of May, CBOC staff also called to remind him to

[6] A severe reduction in emotional expressiveness.
[7] A blood test to detect problems affecting the thyroid gland.
[8] A nurse assigned to assess patients who present to the clinic, without a scheduled appointment, requesting care.

complete and mail a colorectal screening card. There is no indication that mental health concerns were raised during these telephone contacts.

At the end of May, the patient again sought unscheduled care at the Mt. Vernon CBOC. He told the triage nurse he had been experiencing more anxiety and had increased his new antidepressant medication without consulting a physician. He also told her he was "good at this time." The triage nurse contacted his assigned primary care physician who increased his prescribed anti-depressant to the dosage the patient was then taking and directed the triage nurse to advise the patient to not increase the dosage again on his own. The patient was instructed to call with any problems. The physician also wrote, "Does he need to see MHC?"[9] There is no documentation this question was presented to the patient during this interaction.

Three days after requesting the antidepressant dosage increase, the patient called the Mt. Vernon CBOC and requested to see someone in the mental health clinic. He said he was "reverting back to his old ways" and he wanted to have someone to talk to about his problems. His assigned primary care physician ordered a mental health consult that day and the following day a BHS psychiatrist telephoned the patient to perform an initial assessment. The purpose of this call was to assess the patient's safety and to determine if his needs were urgent or routine. During this assessment, the patient told the psychiatrist he needed help with his mood and depression. He said his current medications were no longer effective. She noted he did have access to a gun, but that he denied any suicidal or homicidal ideation. Based on this telephone assessment, the psychiatrist determined the patient's mental health needs were not urgent. She scheduled a comprehensive mental health consult to be performed in 3 business days.

A mental health APN assigned to the primary care clinic performed the scheduled mental health consult. The patient was neatly dressed, he made good eye contact, and he was personable. He said he had had a coronary bypass and was advised he might experience problems with anger. He acknowledged he was angered easily, and that he was experiencing marital and family problems. He said he had experienced anxiety problems 10 years before due to a marital crisis. He told her he had received mental health care at the Paducah CBOC and that he had also seen a non-VA mental health clinician earlier in the year, but he could not recall the provider's name or the visit dates. He denied other psychosocial stressors or serious health problems. He told her he had a gun in the home, but denied suicidal or homicidal ideation. Finally, he reported good social support, feelings of economic security, and the ability to enjoy everyday experiences. The APN completed a suicide risk assessment and noted the patient did not appear to be a danger to himself or others. She noted that he denied feeling hopeless, of having thoughts of taking his life, of any prior history of suicide attempts, or of a family history of suicide attempts or mental illness. Her impression during this visit was that the patient was depressed.

[9] Mental Health Clinic.

She continued his prescribed antidepressant, and added a prescription for an anti-anxiety medication - buspirone (Buspar). She also scheduled appointments for him to see a BHS psychologist in 2 weeks and to follow up with her in 6 weeks.

Summary of Events the Day Before and the Day of the Patient's Suicide

Nine days later, the patient phoned the Mt. Vernon CBOC and asked to speak with the APN who had performed his initial mental health evaluation. It was after 3 p.m. and he was in the CBOC parking lot. The clerk told him to come inside and he would be seen. Soon after, the patient and his wife entered the clinic and a triage nurse performed an assessment. He told the triage nurse that he was anxious, depressed, and his medications were not working. He also told her he had taken his pistol out the night before and his wife found him holding the gun. He said he was taking the ammunition clip out and then putting it back in. The patient's wife validated the patient's account of the prior evening. He said he was not sure what he was thinking and he stated he would not hurt his wife. The patient shared that he had always been in control, but now he felt out of control. When asked where the gun was, the triage nurse asserted the patient's wife told her she had removed the weapon. Because she viewed the account of the night before as a possible suicidal gesture, the triage nurse placed the patient on direct observation as a precaution until he could receive further evaluation.

The APN whom the patient had requested was with another patient and was not available to see him, but another mental health APN volunteered to see him. That APN came to the triage area to meet the patient and to take him to her office for evaluation. The patient was accompanied by his wife. The APN recalled the patient as pleasant and calm and said his wife was tense and appeared to be holding back tears. The APN reported having understood from the triage nurse that the patient was there because he had a pistol out the night before. He thought his wife was in bed, but she got up and found him with a gun which had subsequently been removed. The APN did not further inquire about the current location of the gun with either the patient or his wife during this encounter.

During the APN evaluation, the patient's wife told the APN about events surrounding his April visit to the emergency department at the non-VA hospital. The APN assessed the patient for symptoms of depression and explored whether he had experienced prior or recurrent episodes of depression in the past. She then assessed him for anxiety symptoms and surmised that he was anxious and possibly had PTSD. The patient told her his medications were not working, and he had daily thoughts about Iraq. He reportedly indicated that he had been to a counselor, but had stopped going because the counselor would break appointments. He reportedly declined to provide the APN with the name of the counselor when asked. The APN asked the patient if he had thoughts of hurting himself to which he replied "No."

At some point during the interview, the patient's wife got up and left the room. The APN closed the door and continued the interview with the patient. The APN asked the patient if his wife was alright to which the patient replied "I guess." Once alone with the patient, the APN asked what the patient had been thinking about when holding his gun the night before and he replied that he did not know. The APN asked what he was thinking when the gun was in his lap. Again the patient replied "I don't know." When asked what he was doing with the clip, the patient reportedly said he "was putting it in and taking it out." He denied pointing the gun at any part of his body. He said his wife was his soul mate, but he did express concern that he "gets angry with her." He denied thoughts of harming her or getting angered with others.

The patient also told the APN that he had not been truthful about suicidal ideation with the APN he had seen for the mental health evaluation 9 days earlier. In addition, he told the APN that he had "scammed" the military about PTSD (under-reported symptoms) after he returned from Iraq. The patient was described as hesitant to disclose too much. The APN told him during this encounter that he needed to be honest with her and from that point on she believed their interactions were honest and truthful.

During this assessment, the APN reportedly asked the patient "What do you want me to do for you?" to which the patient replied that he wanted to get back in control of his feelings. He said he felt more sad than happy, but that he was sleeping and his appetite was good. He denied current thoughts of suicide, but reported that when he did have these thoughts he felt worthless, helpless and hopeless. He did not display psychotic symptoms. She diagnosed the patient with major depression, recurrent, moderate; panic disorder; and rule out PTSD. They then discussed a plan for medication changes and reportedly he seemed agreeable with the new plan.

The APN reviewed medication changes with the patient which included tapering his present antidepressant (citalopram); beginning a different antipressant, venlafaxine (Effexor); and beginning clonazepam (Klonopin) up to twice a day to manage his anxiety and panic. The patient was asked but reportedly denied having previously been treated with venlafaxine. She also reviewed the importance of taking the medications as ordered, of coming to appointments, and of calling the clinic if problems or concerns should arise. She advised him to call the clinic or the suicide hotline if he became suicidal. She reminded him that he had an appointment in 5 days with a Mt. Vernon CBOC therapist and with her in 1 month to follow up with his medication management and to allow time for the medication change to have an effect.

After reviewing the plan with the patient, the APN went to the waiting area and brought his wife back to the office to discuss the plan with her. After returning to the APN's office, the APN reported stating "your husband and I have discussed a plan and want to see what you think of it." The APN reviewed the medication changes with his wife present and the wife agreed to keep control of the medications. The APN told them he

was to return for a follow-up appointment in 4 weeks to allow time for the medication change to have an effect. She also reminded them that he was already scheduled to see a psychologist at the CBOC in 5 days. The APN documented that she had discussed the benefits, alternatives, and rationale of the treatment plan and that the Veteran participated in and agreed to the plan. She also noted she did not think he was a danger to himself or others at that time. The APN reported that the patient and his wife seemed agreeable with the plan to go home. This evaluation lasted 25 minutes.

As the patient and his wife were checking out with the clerk, the APN maintained that she told the patient "if you think this is not a good plan in the morning, I will personally arrange a hospital stay." The clerk also reported hearing the APN tell the patient that if he decided the next morning that he would like to be admitted, he should call the APN who would personally arrange his admission to the Fayetteville VAMC. After scheduling the patient's follow-up appointment, the clerk reported telling the patient he did the right thing by coming in and that he could call the office any time he felt like talking or had any issues he wanted to discuss.

The triage nurse saw the APN bring the patient and his wife out to the reception area after their appointment. She also reported hearing the APN advise the patient and his wife to call in the morning if they changed their minds and she would arrange hospitalization for him. Because the clinic normally closes at 4:30 p.m. and the doors were locked, the triage nurse escorted the patient and his wife to the pharmacy to get a prescription filled. The triage nurse reported that neither the patient nor his wife were crying or appeared visibly upset during this time.

That evening the patient and his wife reportedly stayed at a motel in the Mt. Vernon area. The patient took the new medications and initially told his wife that he felt calmer. The rest of the night and the following day he seemed quiet and withdrawn. The following afternoon, they drove home after stopping to visit family on the way. Shortly after their arrival home, the patient committed suicide with a handgun.

According to the police report (Butler County Sheriff's Department) from the date of the patient's death, the patient's wife told the Sheriff's deputy that after leaving the CBOC the day before, she asked the patient about his comment of having suicidal thoughts and why he had never said something to her about it. She said that he told her "that he only said that because he knew it was a quick way of getting the hospital to do something in an attempt to get faster help for his depression."

The coroner determined the Veteran's death was a suicide. The toxicology results that accompanied the report indicated high levels of the antidepressant venlafaxine, its metabolite norvenlafaxine, and the antidepressant citalopram.

Introduction

Suicide is a major public health problem. In 2006, it was the eleventh leading cause of death in the U.S., accounting for 33,300 deaths. The overall rate was 10.9 suicide deaths per 100,000 people. An estimated 12 to 25 attempted suicides occur per every suicide death.[10] Data from 2002 through 2007 indicated a rising rate of suicide attempts and suicides among members of the Armed Forces; firearms were the most common method employed.[11] In a study of suicide mortality among individuals receiving treatment in the Veterans Health System for a diagnosis of depression, during the period from 1999-2004, researchers found that 0.21 percent of the Veterans meeting study criteria committed suicide.[12]

Suicidal ideation occurs in about 5.6 percent of the general U.S. population, with about 0.7 percent of the general population attempting suicide. The incidence of completed suicide is lower, at 0.01 percent. Mental illness is a major risk factor, present in 90–95 percent of suicides.[13]

According to the American Psychiatric Association's Practice 2003 *Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors*, "this rarity of suicide, even in groups known to be at higher risk than the general population, contributes to the impossibility of predicting suicide."[14] Mental health clinicians do not have a foolproof mechanism for preventing suicides, and even with good treatment, some people still commit suicide. For instance, 5 percent of all suicides occur in hospitals, so inpatient care is not absolutely preventive.[15] It is therefore important to highlight the distinction between a good decision and a good outcome.

Clinical decisions are made on the basis of information that is available at the time of evaluation and clinical disposition. In the practical reality of patient care, a good outcome may result from a poor decision and conversely a poor outcome may follow thorough evaluation and sound clinical decisions. Sources of information may include the history elicited from the patient; the mental status exam; the electronic medical record; collateral sources (e.g., family, friends) and external records both subject to the

[10] Centers for Disease Control and Prevention National Center for Injury Prevention and Control Web-based Injury Statistics Query and Reporting System (WISQARS) : www.cdc.gov/ncipc/wisqars
[11] Concerns mount over rising troop suicides, CNN.com/US, February 3, 2008.
[12] Kara Zivin, PhD, H. Myra Kim, PhD, John F. McCarthy, PhD, Karen L. Austin, MPH, Katherine J. Hoggatt, PhD, Heather Walters, MS and Marica Valenstein, MD, MS, Suicide Mortality Among Individuals Receiving Treatment in the Veterans Health Affairs System: Association with Patient and Treatment Setting Characteristics, American Journal of Public Health, Vol.97, No. 12, December 2007.
[13] Kanapaux, William, Guidline to Aid Treatment of Suicidal Behavior, Psychiatric Times, Volume 21. No.4, July 1, 2004.
[14] Practice Guidline for assessment and treatmentof patients with suicidal behaviors, American Psychiatric Association work group on suicidal behaviors, American Psychiatric Association, 2003, Washington D.C.
[15] Kanapaux, William, Guidline to Aid Treatment of Suicidal Behavior, Psychiatric Times, Volume 21. No.4, July 1, 2004.

patient's consent; relevant laboratory and radiologic studies; and prior interactions and experience with the particular patient.

Clinical decision making takes place under varying levels of uncertainty. Decision making under uncertainty is particularly salient in mental health. Some patients are unable or unwilling to articulate their symptoms or intentions due to the nature of the illness they are experiencing (e.g., the psychotically depressed patient who is experiencing paranoid delusions). Stigma and the existence of perceived cultural and social norms may play a role in the patient-clinician interchange (e.g., the elderly patient who grew up in an era when sharing suicidal thoughts was considered taboo). Other patients may purposefully conceal or disguise their thoughts and intentions. Finally, some patients, particularly those with labile mood, mercurial temperament, or co-morbid substance use issues, may be absent thoughts of self harm or suicide at the time of evaluation; however, they may develop suicidal thoughts a few hours later with shifts in mood, reaction to subsequent life events or while under the influence of alcohol and other substances.

Key components in the decision making process include appreciation of the multiple factors that may contribute to suicidal behaviors, a thorough mental health evaluation, a specific suicide inquiry, determination of level of risk, determination of a treatment plan, and relevant documentations.[16]

Because all patients are unique individuals, evaluation and management must occur on an individual basis. Patients may present with a spectrum of suicide related symptoms. Some present with suicidal ideation, which varies in measure depending on the specificity of suicide plans and the degree of intent. Patients may have active suicidal ideation with thoughts of harming themselves without a plan, with a vague plan, or with a detailed suicide plan. Patients may report passive death wishes or passive suicidal ideation (e.g., "I wish I could crawl into a hole and die"), but without active intent or plan. A patient may deny suicidal ideation at the time of evaluation, but may acknowledge having felt suicidal much of the previous week. Occasionally, patients may even report having had chronic ongoing suicidal thoughts for several years with or without a history of prior suicide attempts. Other patients report a history of deliberate self harm, such as repetitive cutting behaviors (willful self-inflicting of painful, destructive, or injurious acts without intent to die), with or without a history of suicidal thoughts or prior attempts.

Inherent in the evaluation and management process is also the assessment of suicidal intent (subjective expectation and desire for a self-destructive act to end in death) and the lethality of suicidal behavior (objective danger to life associated with a suicide method or action). The lethality is distinct from and may not always coincide with an individual's

[16] Jacobs, Douglas MD, Brewer, Margaret, RN MBA, APA Prctice Guideline provides recommendations for assessing and treating patients with suicidal behaviors, Psychiatric Annals, 34:5, May 2004, p.373-380.

expectation of what is medically dangerous. A patient may report plans to die for which the lethality may be low, but if the patient is intent on dying, then the clinical scenario is as concerning as if the plan were of greater lethality. Thus, even a patient with a low-lethality suicide plan or attempt may be at high risk in the future if intentions are strong and the patient believes that the chosen method will be fatal. At the same time, a patient with low suicidal intent may still die from suicide by erroneously believing a particular method is not lethal.[17]

"Direct questions about suicide are an essential tool in suicide assessment. The psychiatrist should ask specifically about suicidal thoughts, plans, and behaviors. Simply asking the patient about suicidal ideation and accepting a negative response may not be enough to determine actual suicide risk, however. Inconsistencies between a denial of suicidal ideation and the patient's presentation or depressive symptomatology may indicate a need for additional questioning or collateral sources of information."[18]

"The goal of the suicide risk assessment is to identify factors that may increase or decrease a patient's level of suicide risk, to estimate an overall level of suicide risk, and to develop a treatment plan that addresses patient safety and modifiable contributors to suicide risk."[19]

Formulation of a treatment plan and a decision as to whether hospitalization is indicated is predicated on evaluation of multiple factors including: those listed in the preceding paragraph, absence or presence of prior suicide attempts, presence of acute stressors, the underlying psychiatric diagnosis, the presence of pain and other co-morbid, non-psychiatric medical conditions, the presence of protective factors including familial and external supports, the clinician's assessment of patient coping skills, resilience and vulnerabilities, the nature, presence, context, and severity of suicidal intent and suicidal plans, the perceived reliability of the patient, and the patient's level of function, among others. After consideration of the overall scenario, the decision whether or not to hospitalize ultimately rests on clinical judgment.

Treatment settings include a continuum of possible levels of care, from involuntary hospitalizations to partial hospital and intensive outpatient programs to more typical ambulatory settings. In general, patients should be treated in the setting that is least restrictive yet most likely to prove safe and effective. The clinician must weigh the risks and benefits of paternalistic considerations with patient preference regarding treatment venue, patient right to self-determination, and the principle of least restrictive

[17] Practice Guidline for assessment and treatment of patients with suicidal behaviors, American Psychiatric Association work group on suicidal behaviors, American Psychiatric Association, 2003, Washington D.C.
[18] Jacobs, Douglas MD, Brewer, Margaret, RN MBA, APA Prctice Guideline provides recommendations for assessing and treating patients with suicidal behaviors, Psychiatric Annals, 34:5, May 2004, p.373-380.
[19] Jacobs, Douglas MD, Brewer, Margaret, RN MBA, APA Prctice Guideline provides recommendations for assessing and treating patients with suicidal behaviors, Psychiatric Annals, 34:5, May 2004, p.373-380.

environment. The benefits of hospitalization must be weighed against possible negative effects (e.g., disruption of employment, social stigma, fear of being in an acute psychiatric hospital).

For some patients, the specter and stigma of inpatient hospitalization may deter them from otherwise seeking needed outpatient treatment. Other patients may present an imminent danger for which involuntary hospitalization is the most prudent course. Under certain circumstance, even in the presence of some form or degree of suicidal ideation, hospitalization may not necessarily be the most appropriate intervention. Given the multi-factorial nature of the evaluation and decision, choice of a specific treatment setting will not depend entirely on the estimate of suicide risk, but rather will rely on the balance between various factors and elements.[20]

While mild to moderate mental health symptoms are frequently treated in the primary care setting, overall, mental health specialists tend to treat patients with more complex or severe psychiatric symptomotology. Just as many cardiologists daily evaluate and manage patients with angina, mental health clinicians typically assess and treat patients with a range of suicidal thoughts. The presence of uncertainty, the range of clarity and transparence with which patients convey their inner thoughts and intents, and the role of stigma and other cultural factors exclude guaranteeing that the best outcome will always be obtained even in the presence of good assessment and seemingly good judgment. While the best protection against a tragic outcome is a rigorous evaluation and prudent clinical management, a tragic outcome does not in itself imply that a bad decision was made. Consequently, this inspection focused on the availability or denial of mental health care services, compliance with VHA policy regarding specialty referral and consultation, adequacy of monitoring the patient's mental health symptoms, and the mental health evaluation, assessment and management, provided to this patient, rather than on the outcome.

Inspection Results

Issue 1: Denial of Care

The patient presented to the CBOC for an unscheduled visit and was seen in the mental health clinic. Although the APN the patient requested to see was unavailable at the time, another APN in the mental health clinic volunteered to see the patient in order to facilitate a more timely evaluation. Review of that APN's clinical experience reveals she was a licensed, APN and was also a Mental Health Clinical Nurse Specialist. Her resume included over 20 years experience providing mental health care. One of her previous roles was to screen emergency department patients to assess the need for

[20] Practice Guidline for assessment and treatment of patients with suicidal behaviors, American Psychiatric Association work group on suicidal behaviors, American Psychiatric Association, 2003, Washington D.C.

involuntary hospitalization. Her peer reviews and performance evaluations all indicated she was qualified to perform her role at the CBOC and she had no reported disciplinary actions.

The complainant alleged that the patient arrived at the CBOC with a suitcase hoping to be admitted; he told the APN 4–5 times that he was having suicidal thoughts; that his anger was out of control; and that he begged to be admitted. The APN asserted that after the initial inquiry regarding hospitalization, the patient and his wife seemed accepting of the treatment plan and did not further request, beg or insist on hospitalization. The contemporaneous medical record documentation does not indicate multiple requests for hospitalization. The triage nurse and clerk noted that the patient and wife seemed to be pleasant and cooperative, and did not appear distraught after the visit concluded. Although the patient's wife asserted that the patient brought a suitcase with him into the CBOC that day, the clerk, the triage nurse, the APN who evaluated the patient, and the pharmacist who later filled his prescription, denied the presence of a suitcase or any other baggage. The complainant and provider have inconsistent recollection of the details pertaining to the patient's visit with the APN. We could neither substantiate nor refute these allegations.

The complainant also alleged that the APN told the patient and herself that he was "fixable" and that they did not have the resources to admit him. Specifically, the complainant alleged the APN said the 15 bed inpatient mental health unit at the Fayetteville VAMC was full and did not have room for him. The APN acknowledged that earlier in the day she had learned the mental health unit at the Fayetteville VAMC was full. She also acknowledged that early in the visit, the patient's wife inquired about hospitalization and the APN told her the mental health beds at the Fayetteville VAMC were full and that if he required hospitalization, they would admit him to a local hospital or he could be transferred to the Little Rock VAMC, located 250 miles away. However, the APN told us that she also told the patient's wife that she had not yet evaluated the patient and it was not yet clear whether or not he would require hospitalization. The APN told us that she also told the patient's wife that they needed to talk more to see what treatment was needed. The APN further reported that the bed status at the Fayetteville VAMC was irrelevant regarding whether or not to admit the patient to an inpatient psychiatric facility and did not factor into her decision making.

The Chief of Mental Health Services at the Fayetteville VAMC reported that although the unit may have been full at the start of the day, at the time of the patient's visit, beds were available on the unit. The APN who assessed the patient had experience working in mental health settings and in screening emergency department patients to determine need for inpatient psychiatric hospitalization. The APN asserted that if admission was indicated after the patient had been evaluated, or if the patient or his wife had said "he needs to be admitted," the APN would have admitted him to a facility. Although the

patient was not hospitalized, we did not substantiate the allegation that bed availability was the driver for the provider's decision to not admit the patient to a mental health unit.

Issue 2: Quality of Care –Mental Health Assessment and Clinical Management

Assessment and Management of Clinical Symptoms

Medical record documentation from the last visit to the CBOC indicates the patient reported symptoms of depression including recent feelings of worthlessness, helplessness, hopelessness, and feeling sad more than happy. The patient had a history of having had some anxiety/panic symptoms. He did not feel his medication regimen was working. While the patient's history of medication adherence is unclear, notes from the medical record indicate that the patient reported that he began taking the citalopram in mid to late May. Although the patient may not have had a full trial of citalopram, in light of his concerns of worsening symptoms after approximately 4 weeks on the medication, it was not unreasonable for the APN to consider switching medications. She appropriately asked the patient about prior treatment response and tolerance of other antidepressant medications before initiating a cross taper of the citalopram and the venlafaxine. Because the patient reported relief of panic symptoms in the remote past with chlordiazepoxide, the APN prescribed temporary use of clonazepam to address these symptoms and discontinued the buspirone. Clonazepam is in the same family of medications (benzodiazepines) as chlordiazepoxide. Benzodiazepines may be used to provide rapid but temporary symptomatic relief of anxiety while waiting for an antidepressant medication to begin providing more sustained benefit. Benzodiazepines are used in some patients for short term symptom management, but continued, regular usage can result in physiologic dependence. We determined the APN's pharmacologic treatment plan reasonably addressed the patient's depressive and anxiety symptoms.

The APN told the patient to call back if there were any problems. The APN was aware that the patient had an appointment with a psychologist at the CBOC's mental health clinic scheduled for early the following week. Other staff reported hearing the APN explain to the patient that if felt he needed to be admitted the following morning he should call and admission would be arranged. Since clonazepan is a medication on which a patient could overdose, the APN asked the patient's wife to secure the medication. We found a reasonable follow-up plan appears to have been initiated to address pharmacologic and psychologic aftercare.

Suicide Assessment

The patient endorsed having had recent suicidal ideation. He was described as hesitant to disclose too much regarding this and it was unclear to the provider how often he was having suicidal thoughts. We could not find evidence in the medical record documentation that the APN further explored relevant aspects of his occasional suicidal thoughts (onset, chronicity, frequency, nature, intensity, and circumstance or precipitants). In addition, the APN did not further elucidate whether the suicidal ideation was passive or active in nature or whether such ideation was accompanied by thoughts regarding a means and/or method.

Access to the Patient's Gun

The triage nurse indicated the patient's wife told her she had removed the weapon. Having reviewed this information from the triage nurse, the APN did not further inquire about the current location of the gun with either the patient or his wife during this encounter. We view this as a missed opportunity.

Issue 3: Quality of Care – Monitoring and Referral in Primary Care

During the course of this investigation, we determined the Mt. Vernon CBOC primary care service did not provide the patient with a mental health consultation within the required timeframe and did not adequately monitor his mental health needs.

Timeliness of Mental Health Consultation

The patient received a comprehensive, new patient evaluation at the Mt. Vernon CBOC in early April. During this evaluation, a newly hired physician documented the patient's positive depression and PTSD screen, diagnosed him with depression, and prescribed antidepressant medication. The physician also noted the patient should receive a mental health consult within 14 days. However, 9 weeks passed before he received a mental health consultation. The consult delay occurred because the physician did not properly place an order for the mental health consult.

Although the physician received a week of orientation prior to starting work at the CBOC, which included 2 full days of CPRS training, at the time she evaluated the patient she did not fully understand the CPRS consult ordering process. Within CPRS, physicians use check lists to allow for more efficient documentation and the physician believed CPRS would automatically generate a consult when she checked a box indicating a consult was required. However, CPRS does not automatically generate consults in that manner and physicians are required to use the ordering system to properly generate a mental health consult. Consequently, although the physician believed she had ordered a mental health consult, one was not properly ordered until after the patient called the CBOC 9 weeks later and specifically requested to be seen by the BHS.
We found newly hired providers are not assigned mentors to perform initial chart audits to assure new staff are sufficiently adept with use of CPRS. At the inspection team's

request, CBOC staff reviewed the patient records of all patients who were assessed by the practitioner to require a mental health consult. This review revealed the physician made the same inadvertent error for two other patients. We reviewed both records, the CBOC contacted both affected patients to arrange mental health consults, and there appeared to be no resulting negative outcome in either case.

Prior to our onsite visit, CBOC leadership examined the circumstances surrounding the physician's failed attempt to properly order a mental health consult and had already instituted a process change. Corrective action included enhancing the CPRS system. Now, if a practitioner documents that a mental health consult is required, a consult order window automatically appears on the computer screen and the physician cannot go forward without properly ordering a consult.

Monitoring of Patient's Mental Health Status at Unscheduled Primary Care Visits

The patient transferred his care to the Mt. Vernon CBOC in early April. The CBOC was aware this OEF/OIF Veteran had a history of depression, had recently screened positive for depression and PTSD, and was prescribed antidepressant medications. The patient's clinical record indicates he interacted in person or by telephone at least five times between his initial evaluation and mental health consult, performed 9 weeks later.

Three exchanges were telephone contacts initiated by the CBOC. These telephone calls were made to address non-mental health medical needs. In early April 2009, he presented to the CBOC for unscheduled care, requesting an EKG. During that encounter, he advised CBOC staff that he was not taking his prescribed antidepressants and that he had recently required ambulance transport to a local, private hospital emergency department and received care for an "anxiety attack." A few weeks later, he again presented for unscheduled care and advised CBOC staff his current antidepressant was not effective and that he had increased the dosage without medical advice. During these two unscheduled, in-person exchanges to urgent care/primary care where mental health issues were central to the visits, staff did not make an appointment with his primary care physician or query his primary care physician as to whether a mental health consult should be initiated. There is no indication primary care staff reviewed the totality of his recent medical history during these exchanges or fully discussed with him the status of his mental health.

We found that after the initial primary care evaluation in April, CBOC primary care staff missed opportunities to proactively facilitate further assessment of the patient's ongoing mental health care needs. In early June, the patient himself called the BHS and requested a mental health consult.

Conclusions

We did not substantiate the allegation that the patient was denied hospitalization due to a lack of available beds at the Fayetteville VAMC. Although the patient was not hospitalized, we determined bed availability was not the driver for the provider's decision to not admit the patient to a mental health unit. However, we could not find evidence in the medical record documentation that the APN sufficiently explored relevant aspects of his recent suicidal thoughts or further inquired about the location of the patient's gun. Finally, the CBOC primary care service did not provide the patient with a mental health consult within the required timeframe and did not facilitate further assessment of the patient's mental health when he presented to the CBOC for unscheduled visits with mental health issues. Although we identified these patient care issues, given all the facts in this case, including those relating to the care provided to this patient both at VA and at non-VA facilities, we cannot conclude that these deficiencies impacted the patient's outcome.

Recommendations

Recommendation 1. We recommended that the VISN Director ensures that the Medical Center Director requires documented discussion in the patient's medical record regarding access to lethal weapons for patient's determined by the evaluating clinician to be at heightened risk for suicide.

Recommendation 2. We recommended that the VISN Director ensures that the Medical Center Director requires newly hired providers are initially monitored through chart review to assure new staff are sufficiently adept with use of CPRS.

Recommendation 3. We recommended that the VISN Director ensures that the Medical Center Director assures patients seen in the primary care clinic and who have mental health needs receive timely referral.

Recommendation 4. We recommended that the VISN Director ensures that the Medical Center Director assures that clinical staff facilitate further assessment of patient's mental health care needs for patients who present to primary care for unscheduled visits where mental health issues are central to the visit.

Comments

The VISN Director and the Medical Center Director agreed with the findings and conclusions. (See Appendixes A and B for the Directors' comments.) Management submitted appropriate implementation plans; we will follow up until all actions are complete.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 18, 2009

From: Director, South Central VA Health Care Network (10N16)

Subject: **Healthcare Inspection – Alleged Denial of Care and Quality of Care Issues, Veterans Health Care System of the Ozarks, Fayetteville, Arkansas**

To: Director, Chicago and Kansas City Offices of Healthcare Inspections (54CH/KC)

1. Enclosed is the response to the subject report. I concur with the recommendations.

2. If you have any questions regarding the report, please contact Kathy Fogarty, Medical Center Director, Veterans Health Care System of the Ozarks, at 479-444-5000 or Mary Jones at the Network Office, 601-364-7871.

(original signed by:)

George H. Gray, Jr.

Network Director

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 16, 2009

From: Director, Veterans Health Care System of the Ozarks (564/00)

Subject: **Healthcare Inspection – Alleged Denial of Care and Quality of Care Issues, Veterans Health Care System of the Ozarks, Fayetteville, Arkansas**

To: Director, South Central VA Health Care Network (10N16)

Fayetteville concurs with the four recommendations made by the inspector general and is in the process of implementing the recommendations.

(original signed by:)
Kathleen R. Fogarty,
Medical Center Director

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensures that the Medical Center Director requires documented discussion in the patient's medical record regarding access to lethal weapons for patient's determined by the evaluating clinician to be at heightened risk for suicide.

Concur Target Completion Date: 3/1/2010

Recommendation 2. We recommended that the VISN Director ensures that the Medical Center Director requires that newly hired providers are initially monitored through chart review to assure new staff is sufficiently adept with the use of CPRS.

Concur Target Completion Date: Completed

Recommendation 3. We recommended that the VISN Director ensures that the Medical Center Director assures patients seen in the primary care clinic and who have mental health needs receive timely referral.

Concur Target Completion Date: Completed 12/10/09

Recommendation 4. We recommended that the VISN Director ensures that the Medical Center Director assures that clinical staff facilitate further assessment of patient's mental health care needs for patients who present to primary care for unscheduled visits where mental health issues are central to the visit.

Concur Target Completion Date: Completed 12/10/09

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Michael Shepherd, MD Senior Physician (434) 220-8062
Acknowledgments	Stephanie Hensel, RN, JD Dorothy Duncan, RN, MHA, CPHQ

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, South Central VA Health Care Network (10N16)
Director, Veterans Health Care System of the Ozarks (564/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Christopher S. Bond, Blanche L. Lincoln, Claire McCaskill, Mark L. Pryor
U.S. House of Representatives: Marion Berry, Roy Blunt, John Boozman, Mike Ross, Vic Snyder; Jo Ann Emerson

This report is available at http://www.va.gov/oig/publications/reports-list.asp.