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Healthcare Inspection Quality and Coordination of Care Concerns at Three Veterans Integrated Service Network 11 Facilities

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Executive Summary

At the request of Congresswoman Jackie Walorski, the Office of Inspector General Office of Healthcare Inspections conducted an evaluation in response to allegations brought forth by a patient's wife relating to access and quality issues at the Northern Indiana Health Care System, Fort Wayne, IN, affecting a patient who ultimately died by suicide after a self-inflicted gunshot wound.

The patient received care at multiple VA medical facilities and some non-VA facilities. We determined that, although the outcome may have been the same for this patient, there were several missed opportunities where the patient's care and the effectiveness of VA's system processes could have been improved. We found quality and coordination of care issues among three Veterans Integrated Service Network 11 facilities—VA Northern Indiana Health Care System, Fort Wayne, IN; VA Ann Arbor Healthcare System, Ann Arbor, MI; and Richard L. Roudebush VA Medical Center, Indianapolis, IN.

Communication breakdowns and providers' failures to review information available in the patient's electronic health record during care transitions compromised the patient's mental health and primary care and diminished the benefits associated with VA's electronic health record system. The advantages of comprehensive access to health records and exchange of health information, key features of the system, were not consistently and effectively utilized.

We found an absence of oversight in facilitating the continuum of this patient's care, which was especially challenging as it touched several VA medical centers, a community based outpatient clinic, and multiple non-VA care sites. We found no indication that VA providers analyzed the patient's multiple suicide risk factors including high-risk age group, history of trauma (Post Traumatic Stress Syndrome), chronic pain, a diagnosed mental illness, a history of aggressiveness, a previous suicide attempt, loss of a family relationship, and easy access to firearms. Further, although the Veterans Health Administration has extensive policy specifications to help ensure a patient's mental health course is comprehensively and continuously monitored, in the totality of this case, the policy was more abstract than applied. We made 14 recommendations.

Comments

The Veterans Integrated Service Network 11 Director and the Directors of VA Northern Indiana Health Care System, VA Ann Arbor Healthcare System, and Richard L. Roudebush VA Medical Center concurred with the report. (See Appendixes B–E, pages 26–36, for the Directors' comments.)



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Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Congresswoman Jackie Walorski to assess care provided to a patient who died by suicide after a self-inflicted gunshot wound in 2013.

Background

VA Northern Indiana Health Care System (VANIHCS) consists of two campuses, one located in Fort Wayne and the other in Marion, IN. It is part of Veterans Integrated Service Network (VISN) 11.

Fort Wayne offers primary and secondary medical care services. During the period relevant to this review, Fort Wayne operated a 24-hour/7-day per week emergency department (ED) and a 16-bed inpatient medical unit with telemetry monitoring for all beds. Marion provides outpatient primary care and mental health (MH) services, inpatient chronic and acute psychiatric care, and a community living center and rehabilitation services. The Peru Community Based Outpatient Clinic (CBOC) is a rural, mid-size clinic¹ and is one of four CBOCs under VANIHCS' oversight.

VANIHCS providers make specialty care referrals to VA Ann Arbor Healthcare System (HCS), Ann Arbor, MI, and Richard L. Roudebush VA Medical Center (Indianapolis VAMC), Indianapolis, IN. Both are also a part of VISN 11.

Since 2007, several external system reviews have identified quality of care issues that led to select services being paused at Fort Wayne. In 2007, surgery services were paused, and in 2009, reusable medical equipment services were paused. On October 11, 2012, admissions to the intensive care unit and telemetry beds were paused, but patients were still admitted to the acute medical unit. On October 22, all admissions to the acute medical unit were paused. The system's outpatient services at both campuses were unaffected by the pause. OIG conducted reviews of the circumstances leading to the pause in 2012² and of service phase-in processes in 2014.³

As a part of resuming limited inpatient services in December 2012, VANIHCS leadership reviewed and revised Fort Wayne medical unit admission criteria. At the time of events giving rise to this complaint (late fall and winter of 2013), admission criteria were strictly defined; patients with back pain could not be admitted if they exhibited associated neurologic symptoms.

¹ Based on the number of unique patients seen as defined by VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, the size of a CBOC facility is categorized as very large (> 10,000), large (5,000-10,000), mid-size (1,500-5,000), or small (< 1,500).

² *Review of Circumstances Leading to a Pause in Providing Inpatient Care, VA Northern Indiana Health Care System, Fort Wayne, Indiana*, Report No. 13-00670-265, August 2, 2013.

³ *Follow Up of the Pause in Providing Inpatient Care, VA Northern Indiana Healthcare System, Fort Wayne, Indiana*, Report No. 13-00670-262, August 28, 2014.

In 2013, a patient who had recently received MH and primary care services at VANIHCS died by suicide after a self-inflicted gunshot wound. In early 2014, Congresswoman Jackie Walorski contacted OIG and requested that we review the patient's care.

Scope and Methodology

We conducted a site visit at Fort Wayne on January 28–31, 2014. We interviewed the patient's wife, the VANIHCS Director, Chief of Staff, Associate Director, Public Relations Officer, and the current and prior Chiefs of Mental Health Services. We also interviewed VANIHCS quality management staff, a telephone triage (TT) nurse, a Non-VA Care⁴ transfer coordinator, a community liaison nurse, and Suicide Prevention Program staff. We interviewed by telephone the VISN 11 Director, the patient's Ann Arbor HCS and VANIHCS primary care providers (PCP), the Ann Arbor HCS Chief of Staff and Associate Chief of Psychiatry, Indianapolis VAMC Information Technology staff, and non-VA social services staff.

We reviewed the patient's VA electronic health record (EHR) and pertinent non-VA medical records, relevant policies and procedures, Fort Wayne and Marion inpatient census data, Fort Wayne and Marion staff training records, and Indianapolis VAMC consult policies.

Review of the quality of non-VA care that the patient received is outside the scope of our review.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

⁴ Non-VA Care is medical care provided to eligible veterans outside of VA when VA facilities are not available.

Introduction

Suicide. Suicide is a serious public health problem. In 2010, suicide was the tenth leading cause of death in the U.S., accounting for 38,364 deaths. During 2009, Centers for Disease Control and Prevention data revealed suicide related deaths outnumbered motor vehicle crash deaths in the U.S.⁵ Males committed suicide four times more often than females (79 percent) and most commonly used a firearm (56 percent). A MH problem was associated with 44.9 percent of all suicide completions, and 34.2 percent of males who completed suicide in 2009 had a history of a prior suicide attempt.⁶ Adults aged 65 and older are more likely to commit suicide than younger age groups.⁷ Veterans Health Administration (VHA) data, displayed below, indicates more than half of suicides in veterans who are receiving VHA health care are committed by those over age 60.

Table 1. Veteran Suicides by Age Group – Veterans Receiving VHA Health Care							
Age Range	<=29	30–39	40–49	50–59	60–69	70–79	>=80
Percent	3.0	5.2	14.0	23.4	19.6	20.0	14.8

Source: Veterans Health Administration, Suicide Data Report, 2012.⁸

There is no absolute means for preventing suicide. Even inpatient care is not absolutely preventive because suicide can occur in hospitals (5 percent of suicides were reported to be inpatients in 2004).⁹ In addition, identifiable risk factors and protective factors are not predictive of suicide.¹⁰ However, assessing risk factors helps identify individuals who may be more likely to consider suicide and are most at risk and in need of suicide prevention intervention.

Suicide risk factors pertinent to this review include history of trauma, major physical health problem, mental disorder, easy access to firearms, aggressiveness, previous suicide attempt, loss of a relationship, and lack of social support. Protective factors associated with lower rates of suicide include effective clinical care for mental and physical illness, ongoing MH support, easy access to a variety of clinical interventions,

⁵ Rockett IR, Regier MD, Kapusta ND, et al. *Leading Causes of Unintentional and Intentional Injury Mortality: United States, 2000–2009*. Am J Public Health 2012;102:e84–92.

⁶ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. www.cdc.gov/injury/wisqars/index.html. March 31, 2014.

⁷ Ibid.

⁸ Suicide Data Report, 2012. Department of Veterans Affairs, Mental Health Services, Suicide Prevention Program, Jan Kemp, RN, PhD, and Robert Bossarte, PhD.

⁹ Kanapaux, William, *Guideline to Aid Treatment of Suicidal Behavior*, Psychiatric Times, Volume 21. No.4, July 1, 2004.

¹⁰ Ibid.

support for help-seeking behavior, restricted access to firearms, and strong connections to family.¹¹

Important analytic components to be considered during suicide risk assessment and clinical decision making include appreciation of the multiple factors that may contribute to an individual's suicidal behaviors, a thorough MH evaluation, a specific suicide inquiry, determination of level of risk, determination of a treatment plan, and reviewing relevant documentation.¹²

“Direct questions about suicide are an essential tool in suicide assessment...Simply asking the patient about suicidal ideation and accepting a negative response may not be enough to determine actual suicide risk. 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.”¹³

VHA Suicide Prevention. VHA requires that every VA medical facility have a suicide prevention program and appoint a full-time Suicide Prevention Coordinator (SPC). SPCs, among other duties, must respond to referrals and establish and maintain a list of patients assessed to be at high-risk for suicide.¹⁴ At the time pertinent to this review, VANIHCS employed one SPC and one Suicide Prevention Specialist (SPS).

VHA Electronic Health Record. VA medical facilities and outpatient clinics share a nationally connected EHR system known as Veterans Health Information Systems and Technology Architecture (VistA). VA providers use a VistA software application, Computerized Patient Record System (CPRS), to document care and services that patients receive. CPRS gives VA providers across the nation fast, convenient access to patients’ VHA health information regardless of where the care was received.

Viewing patient EHRs from other VA medical facilities is readily done. A provider’s view upon opening a patient’s EHR is documentation generated at the VA medical facility where the provider is located. When a patient has received care at other VA medical facilities, providers can view selections from a list of documents up to 4 years old.

Secure Messaging. VA offers patients the option of electronically communicating with their providers using a secure message feature, which is similar to e-mail and accessed through VA’s website www.myhealthvet.va.gov. The purpose of secure messaging is to allow patients and providers a communication tool for non-emergent questions or concerns.

¹¹ U.S. Library of Congress, CRS, *Suicide Prevention Efforts of the Veterans Health Administration*, by Erin Bagalman, CRS Report R42340 (Washington, DC: Office of Congressional Information and Publishing, January 10, 2013).

¹² Jacobs, Douglas MD, Brewer, Margaret, RN MBA, *APA Practice guideline provides recommendations for assessing and treating patients with suicidal behaviors*, *Psychiatric Annals*, 34:5, May 2004, p.373–380.

¹³ *Ibid.*

¹⁴ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

Case Summary

The patient was a male in his mid-sixties. He had a 100 percent service-connected disability rating for post-traumatic stress disorder¹⁵ (PTSD) related to military service in Vietnam. In 2013, a few days after being discharged from a non-VA hospital, the patient died by suicide after a self-inflicted gunshot wound.

Social History. At the time of his death, the patient lived at home with his wife. His wife's mother, who required assistance with daily living activities, also lived in the home. His parents were deceased, and he was not close to his siblings or their families. In 2012, a daughter and her family who had lived nearby for many years, moved 800 miles away but reportedly remained in contact. Prior to their move, the patient and his wife spent a great deal of time with the daughter's family. In the spring of 2013, he told a Marion Licensed Clinical Social Worker (LCSW) that he and his wife were grieving the absence of his daughter and grandchildren. In the fall of 2013, the patient's wife reportedly experienced a major medical event, which required a non-VA hospital stay that lasted several weeks.

The patient periodically experienced personal relationship conflicts. His reported coping mechanisms for dealing with stress were working on his home and land, mowing grass, cutting wood to heat the house, raising horses, taking care of his pond, hunting, and spending time with his wife and grandchildren. In the spring of 2013, he told the Marion LCSW that his physical activity had become limited due to back pain and neck surgery in 2012.

Medical History. The patient's pertinent medical diagnoses included chronic bilateral shoulder, neck, and back pain; lumbar spondylosis;¹⁶ osteoarthritis; osteopenia;¹⁷ cervical radiculopathy;¹⁸ cervical myelopathy;¹⁹ and spinal stenosis.²⁰ In fall 2012, the patient underwent cervical spine surgery at Ann Arbor HCS.

Prior to October 2011, the patient was regularly followed at the Marion primary care clinic (PCC). In October 2011, VANIHCS reassigned him to the PCC located at the Peru CBOC, and to PCP "A," because it was nearer his home. In late fall 2012, the patient requested that his primary care be transferred to the Ann Arbor HCS, and PCP

¹⁵ People who experience terrifying ordeals involving the threat of, or actual, physical harm may develop PTSD, a feeling of stress or fear when the person is no longer in danger. National Institute of Mental Health, Post-Traumatic Stress Disorder (PTSD), http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml?utm_campaign=Social+%2BMedia&utm_source=Twitter&utm_medium=Main%2BTwitter%2BF accessed March 31, 2014.

¹⁶ Lumbar spondylosis is a degenerative condition of the lower back affecting discs and the bony structure of the lumbar spine.

¹⁷ Osteopenia is lower than normal bone density.

¹⁸ Cervical radiculopathy denotes symptoms resulting from pressure on nerve roots in the neck region, manifesting in pain, weakness, numbness, or a combination of these.

¹⁹ Cervical myelopathy is an interruption, partial or complete, of spinal cord function of nerves originating in the neck area.

²⁰ Spinal stenosis denotes a narrowing of the anatomic spaces of the spine resulting in pressure on the cord and/or nerve roots emanating from it.

“B” became his provider for about six months. In the spring of 2013, the patient requested that his primary care be transferred back to the Marion PCC.

Two days after the request for transfer back to Marion, the patient was advised that the first appointment available to him at that PCC was 76 days after the appointment was requested.²¹ He voiced dissatisfaction at the wait time, and the appointment was subsequently moved up about 30 days. PCP “C” was his Marion PCC provider until his death.

VA PCPs prescribed physical therapy and narcotic and non-narcotic pain relievers to treat the patient’s back pain. Before and after the patient’s 2012 cervical spine surgery, providers periodically treated his complaints of neck, back, and shoulder pain with low dose, short-term courses of prednisone. Providers noted the patient and/or his wife associated pain relief with prednisone and specifically requested it on occasion during primary care, urgent care, and ED visits. For the 32 days before his death, the patient was maintained on a regimen of high dose prednisone, 20 mg, 3 times per day, without a stated indication for its use or plan for reducing or discontinuing the drug by the managing physician(s).

Mental Health History. The patient’s pertinent MH diagnoses, in addition to PTSD, included depression, anxiety, intermittent explosive disorder, bipolar depression, steroid-induced mood disorder, r/o [rule out] bipolar, alcohol abuse, and suicide attempt (1989). The patient was generally compliant and motivated for MH treatment and medication management; he rarely cancelled an appointment.

Prior to October 2011, the patient was followed regularly at the Marion MH clinic. In October 2011, he was reassigned to MH provider (MHP) “A” at the Peru CBOC. Between the winter of 2011 and spring of 2013, the patient had five face-to-face encounters with MHP A, three at the Peru CBOC and two at the Marion MH clinic. The patient also had two encounters with an LCSW at the Marion MH clinic.

Because the patient’s medical and MH history is complex, additional history is presented in table format in Appendix A for reference. (See Appendix A, Tables 2 and 3.)

²¹ The VHA target for new patient appointments was 14 days during the period in question. Although no EHR documentation indicates when the change occurred, the patient’s appointment was moved.

Inspection Results

The patient received care at multiple VA facilities and some non-VA facilities. We found quality and coordination of care issues among three VISN 11 facilities and between VA and non-VA care when reviewing this patient's case.

Issue 1: VA Health Care Services

In winter 2013, the patient's wife contacted Congresswoman Walorski's office because she was concerned the patient had been admitted for Non-VA Care at a local community hospital (Hospital A) and not VANIHCS or Indianapolis VAMC. Nine days later, the patient's wife contacted Congresswoman Walorski's office because she was concerned the patient was being discharged home. The patient was discharged to home with his wife the next day.

Non-VA Hospital Admission. A few weeks before the inpatient stay at Hospital A noted above, the patient had received non-VA care for back pain at a local ED. The non-VA ED provider called a Fort Wayne ED provider, who advised the non-VA caller to contact Indianapolis VAMC for possible transfer. An Indianapolis VAMC provider denied the transfer request because the patient's symptoms did not suggest an emergent neurological concern. The provider suggested the patient receive pain medication and a follow-up with Fort Wayne orthopedics and the patient's PCP or that he be admitted to the Fort Wayne acute medical inpatient unit if his pain could not be controlled. The patient was discharged home.

Later that day, the patient arrived at the Fort Wayne ED. The ED provider documented the patient as having back pain, leg hyperreflexia, weakness, and difficulty ambulating. The provider placed a request to transfer the patient to Indianapolis VAMC for a neurology consult, a service not available at Fort Wayne. Indianapolis VAMC providers again denied the transfer request, noting the patient was not exhibiting emergent neurological symptoms to warrant the transfer and suggested the patient receive magnetic resonance imaging (MRI) and evaluation locally. The ED provider then requested that the patient be transferred to receive Non-VA Care at Hospital A for an MRI and further evaluation. Hospital A accepted the patient, and he was transferred the next morning.

Although the patient was denied VA services at VANIHCS due to Fort Wayne's admission criteria, which excluded patients with back pain and neurological symptoms, we determined he was not denied care because he received Non-VA Care paid for by the VA at Hospital A for a little more than 3 weeks.²² We also determined that Indianapolis VAMC neurosurgery and medical services were not required to accept a transfer because services were available locally, and the patient's symptoms did not indicate an emergent concern.

²² See Appendix A, Table 3.

Rehabilitation Services. After the first week of his inpatient stay, Hospital A providers wished to transfer the patient to the Marion Extended Care and Rehabilitation Program. A VANIHCS physical therapist reviewed the patient's Hospital A physical therapy notes and determined he was not a candidate for rehabilitation because he did not regularly participate in his physical therapy due to his reported pain. The therapist noted a rehabilitation program might be indicated after pain management had been achieved. We determined Hospital A medical record documentation supported the VANIHCS physical therapist's opinion.

Long Term Care. Because the patient had a 100 percent service connected disability, he was eligible to receive VA contracted long term care (nursing facility). EHR documentation indicates that, after learning he was not a candidate for inpatient rehabilitation, the patient and his wife desired that he be placed in a nursing facility close to their home, and providers at VANIHCS and Hospital A agreed. A VANIHCS Community Nursing Home Coordinator gave the Hospital A case manager a list of contract nursing facilities close to the patient's home for the patient's wife to review. The patient's wife selected a nursing facility and Hospital A staff initiated the admission process, which included a federally required State Pre-Admission Screening and Resident Review (PASRR) assessment.²³

Because of the patient's MH diagnoses, an Indiana State reviewer completed a Level II PASRR assessment.²⁴ The reviewer determined the patient did not require nursing facility care because he was able to walk unassisted for over 200 feet and perform his own activities of daily living (shower, toilet, bathe) without assistance. Consequently, the contract nursing facility was unable to accept the patient.

Discharge Home. Hospital A care providers discharged the patient home with his wife on day 23 post admission. Because it is outside the scope of our authority, this report does not review care the patient received at Hospital A. However, in Issue 3, Continuity and Coordination of Care, we discuss our concerns related to VANIHCS Non-VA Care coordination during the patient's Hospital A inpatient stay and subsequent discharge.

Issue 2: Medication Management and Clinical Judgment

We determined two of the patient's providers (PCP C and MHP A²⁵) did not consistently use sound clinical judgment in managing the patient's clinical conditions.

Prednisone. Prednisone is an anti-inflammatory corticosteroid medication with potentially serious side effects. Risks associated with corticosteroids pertinent to this case include psychiatric symptoms, which can range from minor mood changes to

²³ Department of Health and Human Services, Medicaid Program Information, www.medicaid.gov, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Preadmission-Screening-and-Resident-Review-PASRR.html> accessed April 19, 2014.

²⁴ To ensure only individuals with a mental illness who are in demonstrable need of nursing facility care are admitted to reside in a nursing facility, each state is required to establish a PASRR, a two-step (Level I and Level II) assessment. Individuals diagnosed with a mental illness must receive a Level II PASRR assessment.

²⁵ MHP A was no longer employed at VANIHCS or any other VA facility at the time of our review.

mania and delirium.²⁶ Generally, the deleterious effects of corticosteroids are less problematic with lower dosage levels and limited duration of use.

The patient was managed on varying low doses of prednisone for limited durations over a span of several years, but for the 32 days prior to his death, he was maintained on a sustained regimen of high dose prednisone for an unclear indication and without a stated plan by managing physician(s) for dose reduction and/or eventual discontinuation of the drug.

Steroid Induced Mood Disorder. A diagnosis of steroid-induced mood disorder is a clinical diagnosis in that it relies on observing behavioral changes temporally associated with corticosteroid use.

The patient exhibited mood changes during his rehabilitation at the Ann Arbor HCS after the 2012 cervical spine surgery, and psychiatry staff were consulted. The psychiatry consultants noted the patient was receiving prednisone and felt his condition to be “most consistent with a steroid induced mood disorder” and recommended tapering the prednisone and monitoring the patient for this complication when he received steroids. However, the patient’s Ann Arbor HCS discharge summary did not include the psychiatric consultants’ clinical impression of steroid induced mood disorder, the problem list was not updated to include the diagnosis, and there were no EHR flags or pharmacy alerts to notify providers of the patient’s history of suspected steroid induced mood disorder.

Polymyalgia Rheumatica. Polymyalgia rheumatica (PMR) is an inflammatory disorder that causes muscle aching and stiffness most often affecting the shoulders, upper arms, neck, and hips. Low dose prednisone use during exacerbations is a known therapeutic treatment.²⁷

An Ann Arbor HCS rheumatologist who evaluated the patient in spring 2013 excluded PMR as a possible cause of the patient’s pain. The rheumatologist noted the patient did not require steroid therapy.

Primary Care Provider C

Summary of Events Pertinent to Primary Care Provider C

A few weeks after the patient’s spring 2013 Ann Arbor rheumatology appointment, he was in Oklahoma and walked into a Jack C. Montgomery VAMC CBOC without an appointment. He was treated for back pain and released. The next day, the patient was treated for back pain at the Jack C. Montgomery VAMC’s ED. The ED provider acknowledged the Ann Arbor HCS rheumatologist’s documentation that the patient did

²⁶ Brown SE, Khan DA, Nejtck VA. *The Psychiatric Side Effects of Corticosteroids.* Ann Allergy Asthma Immunol. 1999;83:495–504.

²⁷ Weyand CM, Fulbright JW, Evans JM, et al: Corticosteroid requirements in polymyalgia rheumatica. Arch Intern Med 1999; 159:577.

not have PMR and did not require steroids. The ED provider noted, "*Discussed with him [patient] that we would not go against their decision.*"

In the summer of 2013, PCP C examined the patient at the Marion PCC for the first time. The patient complained of neck and back pain. The PCP prescribed a muscle relaxant, increased the patient's pain medication dosage, and advised follow-up with him in a year, sooner if necessary.

About 1 week later, the patient complained of severe back pain and was evaluated at the Marion Urgent Care Center. The patient told the urgent care provider that he was "pain free" while on steroids but that the steroid medication had been discontinued and he was again in pain. The patient said he was not taking his prescribed muscle relaxant, specifically requested prednisone, and was prescribed a 1-week course. After completing the prednisone course and being off the drug for several days, the patient called PCP B (Ann Arbor HCS) and requested the prednisone be restarted. PCP B advised that since the patient had established his care at the Marion PCC, he now needed to make requests through PCP C.

The patient saw PCP C 2½ weeks later and complained of back pain. He reported that prednisone "helped him quite a bit" and that the muscle relaxant medication "bothered" him. PCP C prescribed prednisone 5 mg daily. The patient was advised to return in 6 months, or as needed.

Shortly before the patient's Non-VA hospital stay, in the winter of 2013, the patient received Non-VA Care at a local ED for back pain and was discharged home. The day after the ED visit, the patient's wife called the Marion telephone triage (TT), spoke with the TT nurse, and described the patient to be in "*excruciating pain*" and "*ready to blow his brains out*" to get relief from his agony. The TT nurse advised the patient to seek care at the Fort Wayne ED and included PCP C on the documentation as an additional signer.²⁸ Later that day, the patient was evaluated for severe back pain at the Fort Wayne ED. The ED provider noted the patient had been to a non-VA ED the prior day for back pain and was "weepy" when talking about his pain.

The patient had an appointment with PCP C 3 days after the spouse called the TT nurse to report the excruciating pain. At the time of the PCC visit, a PCC nurse documented the patient had rated his pain a "10" claiming he "*cannot take this pain much longer.*" PCP C examined the patient and noted, "*He is crying today. He has a lot of history of post-traumatic stress disorder and depression and generally not doing well.*" Among the patient's previously prescribed medications was prednisone 5 mg daily, which PCP C had prescribed in the summer noting at that time "*he was told he has polymyalgia rheumatica.*" For the current visit, PCP C documented patient complaints of low back pain, (intervertebral) disc problems, and a history of PMR and

²⁸ "Additional signer" is a communication tool used to alert a clinician about information pertaining to the patient. This functionality is designed to allow clinicians to call attention to specific documents and for the recipient to acknowledge receipt of the information. VHA Handbook 1907.01, *Health Information Management and Health Records*, September 9, 2012.

increased the dosage of prednisone to 20 mg, 3 times daily.²⁹ PCP C noted that an electronic pain consult (E-Consult) had recently been placed, in response to the TT nurse's note, and listed a MH consult as part of the patient's plan of care. However, there is no evidence a MH consult was placed that day.

Clinical Judgment

We found no evidence that PCP C reviewed the patient's Ann Arbor HCS documentation, which offered a subspecialist's opinion that the patient did not have PMR. In addition, although PCP C acknowledged receiving the TT note that documented the patient was "*ready to blow his brains out*" to get relief from his agony and a PCC nurse had recorded that the patient said he "*cannot take this pain much longer,*" we also found no evidence PCP C assessed the patient's suicide risk or contacted the patient's MH provider (who was co-located with PCP C)³⁰ or Suicide Prevention Program staff after documenting that the patient was crying and "generally not doing well." Although we noted PCP C documented a plan to place a MH consult, the consult was not placed.

Medication Management

The patient's behavior from spring through the fall and winter of 2013 is consistent with "doctor shopping"³¹ with the objective of obtaining prednisone despite being informed by providers on two different visits in the spring that he did not require it. We acknowledge the challenges facing PCPs when patients, or their family members, demand specific medications that are not clinically indicated; nonetheless, we found no rationale to support PCP C's decision to prescribe prednisone 20 mg, 3 times daily. The dosage and duration was not reasonable, even without knowledge of the patient's prior steroid induced mood disorder diagnosis and a rheumatologist's exclusion of PMR as a cause of the patient's pain. We could not identify a medically logical basis to support prescribing high doses of prednisone with no reduction plan or stop date specified.

²⁹ The patient was transferred from the Fort Wayne ED to Hospital A with a list of his prescribed medications, which included prednisone 20 mg, 3 times daily. Hospital A administered the prednisone as prescribed throughout the inpatient stay and the patient was discharged home with the same regimen.

³⁰ VA medical centers are required to offer on-site integrated MH care services. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, June 11, 2008.

³¹ Doctor shopping is defined as seeing multiple treatment providers to procure prescription medications. Doctor shopping may be driven by a patient's misunderstanding or nonacceptance of treatment. Patients who engage in doctor shopping are a challenge to manage in the clinical setting. Sansone RA, Sansone LA, *Doctor Shopping: A Phenomenon of Many Themes*, *Innov Clin Neurosci*. 2012 Nov;9 (11-12):42-6.

Mental Health Provider A

Summary of Events Pertinent to Mental Health Provider A

During the patient's rehabilitation at Ann Arbor HCS following his 2012 cervical spine surgery, he exhibited mood changes and received an inpatient psychiatric evaluation. As a part of the patient's discharge planning, a psychiatrist entered a consult request to VANIHCS for MH follow up closer to the patient's home. The request included the following:

"noted to have manic symptoms thought to be due to steroid mood disorder but unable to r/o [rule out] bipolar disorder...Psychotropic meds were adjusted (bupropion, effextor,[sic] d/c'd [discontinued], initiated on Seroquel [quetiapine] with improved symptoms. Will need ongoing MH follow-up closer to home, requested further treatment in Marion, IN."

The patient's assigned PCP at that time, PCP A of Peru CBOC, acknowledged receipt of the consult request, noted the patient was established with MH at the Peru CBOC, had a MH appointment scheduled with MHP A about 5 weeks later, and that MHP A would be notified to review the patient's Ann Arbor EHR. The patient was a "no show" for the scheduled MH appointment with MHP A.³²

PCP B (Ann Arbor HCS) provided the patient's primary care for several months after the cervical spine surgery. During that time, PCP B prescribed pain medications and refilled the patient's antianxiety and antipsychotic prescriptions. PCP B placed a MH consult request to VANIHCS (Marion) in the spring of 2013, and noted, "... he would benefit from MH care dealing w/ [with] chronic pain as well."

About a month later, a Marion MH clinic LCSW conducted a psychosocial assessment of the patient documenting that the plan was to have individual psychotherapy once every 2 weeks to focus on management of psychiatric symptoms and pain management.

Two weeks after the psychosocial assessment, MHP A had a scheduled encounter with the patient and noted:

"He said that he just came back to talk with me a little bit as we had gotten along well in the past... [He] said that he takes an anti-psychotic medication for his bipolar disorder and is on quetiapine, I think, and he said that he is doing very well with it. They also give him pain medicines for that he said for his neck pain[sic]. He will call me if he has any problems, otherwise I will see him back in three to four months here..."

On a Thursday afternoon in the summer of 2013, the patient secure messaged the MH clinic:

³² Because the patient's, 2012 Ann Arbor HCS discharge instructions did not list the MH appointment with MHP A among other appointments listed, it is unclear whether the patient was aware of the appointment.

“(MHP A), I need to talk to you about my meds. I’m on quetiapine, 3/day for bi-polar disorder. I can’t take them no more because they make my muscles hurt so bad. [PCP B] put me on 5 mg prednisone for pain in my back from the spine operation. I’m having troubles here at home. Wife says I’m so aggressive. I need some help. Can you call me or something.”

- Five days later, a MH administrative clerk responded to the message: *“[MHP A] is only in the office on Tuesdays and Wednesdays. I have given him this message and he will call you when he has a chance between his patients. Thank you!”*

On a Sunday evening in the summer of 2013, the patient secure messaged the MH clinic:

“Can you please answer my last e-mail and let (MHP A) look at it. I don’t have his e-mail or phone number. He said before I could call him any time. I need to talk to him. I have an appt. [appointment] with him [next month]I just need to talk to him.”

- Two days later, a MH administrative clerk responded to the message: *“I gave (MHP A) the message.”*

About three weeks after the messages noted above, MHP A had a scheduled encounter with the patient and noted:

“He takes his medications from Ann Arbor but says he quit taking most of them because they cause him muscle cramps and he says he is doing well without them so he is going to stay without out [sic] out them and see if he is okay. I told him all he has to do is call and we will put him back on the medications we had him on. They took him off all our medications and put him on Depakote³³ and some others, he said, but it bothered him tremendously and he could not take them. I told him to go back and check with them and he was hesitant, but he may. I do not know whether he will or not. In the meantime, I say we are available to him in any way we can. All he has to do is call us or come in if he is having problems. He said he would. He is going to check with primary care or something. I have forgotten what that was now, but he is going to check with them about something and other than that, he is doing well....I told him we will follow through any time he wants...He had a history of bipolar, I believe, but I did not make that diagnosis. He is getting service-connected for posttraumatic stress disorder.”

³³ EHR review indicates the patient had not been prescribed Depakote since 2006.

Clinical Judgment and Medication Management

MHP A did not note that he reviewed the patient's Ann Arbor HCS EHR as advised to do by PCP A of Peru CBOC. MHP A did not document attempting to contact the patient after he missed his post-2012 hospital stay scheduled MH appointment. Finally, although we presume that the patient's appointment with MHP A was moved in fall 2013 based on his secure messages, there is no indication MHP A addressed the patient's secure messaging concerns.

Issue 3: Continuity and Coordination of Care

VA medical facilities must coordinate the care and services patients receive to ensure continuity, prevent duplication, and assist providers to better meet patients' health care needs. Care coordination facilitates communication between patients and providers to ensure patients receive "the right health care services, in the right order, at the right time, and in the right setting."³⁴

We determined the patient's care was not consistently coordinated. We found the patient's 2012 Ann Arbor HCS discharge summary and discharge instructions did not include all required elements, his EHR problem list was not updated, and his Non-VA Care coordination was not performed as required at the time of his inpatient stay at Hospital A in the winter of 2013. Further, as discussed in Issue 2, there is no indication the patient's primary care and MH providers communicated with each other to ensure his care was coordinated.

Discharge Summary and Discharge Instructions. VHA requires that medical staff with primary care responsibility for a hospitalized patient prepare the discharge summary and discharge instructions. The summary must list the principle diagnosis and all other diagnoses for which the patient received treatment and include drug reactions. VHA also requires that discharge instructions include all diagnoses, recommendations for follow up, and patient education.³⁵

During the patient's 2012, Ann Arbor HCS hospitalization,³⁶ Psychiatry Service was consulted and documented the patient's Axis V, Global Assessment Functioning scale.³⁷ Axis I diagnoses (that is, clinical syndromes) were steroid induced mood disorder, PTSD, and bipolar disorder. Previously prescribed antidepressants were discontinued, quetiapine was added, and psychiatry consultants recommended that the patient's prednisone dosage be reduced and that he be monitored for future mood swings if on steroids again. The consultants also recommended that he receive outpatient follow-up care at the geriatric psychiatry clinic for continued medication

³⁴ Institute of Medicine (U.S.). Division of Health Care Services. Committee on the Future of Primary Care., *Primary care: America's Health in a New Era*. Washington, D.C.: National Academy Press; 1996.

³⁵ VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.

³⁶ See Appendix A, Table 2.

³⁷ Axis V, Global Assessment Functioning scale is a five axis model that provides a comprehensive psychological, social, and occupational functioning diagnosis to assess a patient's mental health. PsyWeb, *Axis V – Global Assessment Functioning Scale*, http://www.psyweb.com/DSM_IV/jsp/Axis_V.jsp, Accessed April 5, 2014.

management and that his MH care be followed up closer to his home. A MH appointment with the patient's assigned Peru CBOC MH provider (MHP A) was scheduled.

We found that the patient's Ann Arbor HCS discharge summary and discharge instructions did not list steroid induced mood disorder as a diagnosis, did not include patient education regarding steroid induced mood disorder symptoms, did not include psychiatry's recommendation for follow-up at the geriatric psychiatry clinic, and did not include mention of the MH appointment that had been scheduled with MHP A. Additionally, a part of the discharge summary titled, "Information For Your Physician," did not discuss steroid related mood disorder, advise monitoring for mood swings, advise follow-up MH care, and did not effectively address the patient's discharge MH status. Finally, the "Information for your Physician" section stated that the patient was evaluated by psychiatry for anxiety with adjustment of his home medications noting, *"psych has signed off and the patient is tolerating his prednisone without mood symptoms."* However, the assessment was not reflective of the patient's actual condition as cited in one of the Ann Arbor psychiatrist's note, *"appears to have stabilized, though still [mood] somewhat elevated, this may be due to his remaining on steroid."*

We interviewed the Ann Arbor HCS Chief of Staff and Associate Chief of Psychiatry. Both stated that the patient's Ann Arbor HCS discharge summary and instructions should have included more information related to his psychiatric condition, treatment, and recommendations, including suspected steroid related mood effects.

Problem List. The CPRS patient problem list is an important health provider communication tool to assist with continuity and coordination of patient care through transitions of providers and settings. VHA requires that by a patient's third outpatient or ambulatory care visit the health care provider initiate and maintain a summary, or problem list, that includes: (1) known significant diagnoses, (2) conditions, (3) pertinent past procedures, (4) allergies to foods or drugs, (5) current medications, and (6) significant procedures performed outside VHA.³⁸

We found that the patient's outpatient providers did not ensure his problem list was updated to include all relevant diagnoses by the third outpatient visit.

The following MH related problems were listed in the patient's EHR problem list: PTSD and "stopped lithium based on labs." However, a review of MH related problems listed in consults and other EHR documentation starting in spring 2011 through the winter of 2013 included depression, anxiety, intermittent explosive disorder, bipolar depression, steroid-induced mood disorder, r/o [rule out] bipolar, alcohol abuse, and suicide attempt.

Non-VA Care Coordination. We determined VANIHCS Non-VA Care Coordination staff missed opportunities in the coordination of the patient's care during his Hospital A inpatient stay. We found that the staff did not case manage this complex patient's

³⁸ VHA Handbook 1907.01.

Non-VA Care, did not document critical Non-VA Care provider communications, and did not notify VANIHCMS MH services after becoming aware the patient was receiving MH services at Hospital A because he had stated that he wanted to jump out a window due to back pain.³⁹

VANIHCMS Non-VA Care Coordination consists of Inter-Facility Transfer Coordinators (IFTC) and Community Hospital Liaisons (CHL). At the time pertinent to this review, VANIHCMS employed one IFTC and one CHL; at the time of the patient's winter 2013 Hospital A stay, the average daily VANIHCMS Non-VA Care census was 18.8.

A Hospital A psychiatrist had noted the patient endorsed suicidal and homicidal ideation. The psychiatrist diagnosed severe major depressive disorder without psychotic features and severe adjustment disorder with mixed disturbances of emotions and conduct. The psychiatrist prescribed an antidepressant and planned to refer the patient to a non-VA behavioral health hospital after he was medically stable.

The day after the patient's suicidal and homicidal ideation was noted in the record, a psychiatrist met with the patient and his wife and documented that they declined non-VA inpatient psychiatric care and preferred the Marion VA hospital to avoid co-payment costs.

In a routine daily communication,⁴⁰ Hospital A staff faxed the psychiatrist note to VA with the information that the patient preferred Marion hospitalization over a non-VA psychiatric hospitalization.

Four days later, a Hospital A psychiatrist documented that the patient stated that he did not mean he wanted to jump out a window but that he made the comments out of frustration and that his statement was not a suicidal statement. The psychiatrist noted the patient denied suicidal or homicidal ideas.

Shortly thereafter, a Hospital A Social Work staff documented the following telephone communication: "Call also placed to [IFTC] at the VA to question if pt [patient] might be able to go to the VA for a psych stay...The VA did not feel he would be able to go to one of their units as he is needing some assistance..."

Case Management and MH Care Coordination: We determined this patient's Non-VA Care was not case managed. Case management provides a formal process for planning, managing, and communicating a patient's health care needs in an interdisciplinary setting. Although both the IFTC and the CHL told us they did not believe their job responsibilities included case management of patients receiving Non-VA Care, their job function statements included the following: "case managing and

³⁹ During the course of his 2013 Hospital A stay, the patient received three psychiatric evaluations after verbalizing this intent to harm himself.

⁴⁰ Non-VA hospitals provide Non-VA Care staff with daily clinical status updates.

expediting transfer/discharge of Veterans from Non-VA Care hospitals and the timely transfer of Veterans to and from other VA hospitals.”⁴¹

We determined that, had the patient’s care been case managed, his medical and psychiatric needs may have been recognized and communicated to a VANIHCMS MH provider prior to his Hospital A discharge. Additionally, had a case manager been assigned, a social worker or suicide prevention professional may have been alerted to the patient’s psychiatric state during his hospitalization and at discharge. Finally, we determined that had a case manager with a MH background been assigned, the case manager may have better appreciated the significance of the patient’s chronic pain, mental health diagnosis, and psychosocial stressors.

EHR Documentation: We determined the IFTC nurse did not document critical telephone and fax communications with Hospital A. Health record documentation is required to record pertinent facts and findings to facilitate communication and continuity of care.⁴² We determined the IFTC did not document the discussion with the Hospital A Social Work staff regarding the patient’s MH needs or the basis for his ineligibility for an inpatient admission at the Marion psychiatric unit. We also found that other Hospital A contact with VANIHCMS staff was not consistently reflected in the patient’s VANIHCMS EHR.

Although an expectation of Non-VA Care Coordinator staff is that personnel include in the medical record the updates that outside facilities provide, we determined Non-VA Care Coordinators did not scan or otherwise document Hospital A’s faxed daily updates.

Issue 4: Mental Health Services

We found MHP A did not receive periodic professional performance monitoring, and quarterly EHR quality reviews did not occur within VANIHCMS MH services. We determined MH clinic staff did not follow up after the patient was a “no show” for a MH appointment. We found MH clinic staff did not adequately respond to the patient’s secure messages requesting MH behavioral and medication management assistance. We determined the patient was not assigned a Mental Health Treatment Coordinator (MHTC) per VHA policy and that the MH service did not have a system in place to ensure patients were assigned another MHTC if the assigned MHTC was no longer available. We also determined a LCSW did not conduct MH treatment as planned and did not follow up with the patient or adjust the treatment plan as the patient’s non-participation in treatment warranted.

Mental Health Provider Evaluation and Electronic Quarterly Quality Review. VHA requires evaluation of privileged practitioners.⁴³ We found a 10-month time frame during which MHP A did not receive ongoing professional practice evaluation monitoring. VHA also specifies that outpatient programs complete quarterly EHR

⁴¹ VA Northern Indiana Health Care System, Functional Statement, Non-VA Care Nurse/Non-VA Care Community Admission Liaison: Nurse II.

⁴² VHA Handbook 1907.01.

⁴³ VHA Directive 1100.19, *Credentialing and Privileging*, October 15, 2012.

quality reviews.⁴⁴ We found quarterly EHR quality reviews did not occur within MH services.

We also noted through records of OIG's Combined Assessment Program Reviews (February 2011 and March 2014) that VANIHCS was generally not meeting the requirement that the quality of EHR documentation be reviewed.⁴⁵

Follow-Up After a “No Show” Appointment. When a patient does not report (“no-show”) for a scheduled appointment, VHA requires that the responsible provider, surrogate, or designated team representative review the patient's EHR and determine and initiate appropriate follow-up action.⁴⁶ We did not find evidence MHP A or other MH clinic staff reviewed the patient's EHR or initiated a follow-up action after he did not report for the MH appointment that had been scheduled at the Peru CBOC after discharge from the Ann Arbor facility in 2012.

Secure Message Response. The EHR included secure messages the patient sent to the MH clinic in the summer (discussed in Issue 2) and fall of 2013.⁴⁷ We determined MH clinic staff did not respond appropriately to the patient's secure messages. For example:

On a Thursday evening in the fall of 2013, the patient secure messaged the MH clinic:

“Could you please tell [MHP A] that I'm going to be running low on diazepam, for panic attacks. PCP B said that it should be handled from Mental Health. I've been taking 5 mg 3 per day or as needed. I need that prescription refilled. Previously, Ann Arbor Mich. Had been handling that before I started seeing [MHP A] in Marion. He has previously handled that for me. My next appointment isn't [for three months]. Thank you very much.”

The next day, a MH administrative clerk responded:

“[MHP A] is only here on Tuesday and Wednesday. I will give him this message and call you next week and let you know what the Dr. wants to do. He may want you to come in. Thanks, have a great weekend.”

EHR documentation does not indicate MHP A or the clerk contacted the patient.

About a week after the Thursday evening message noted above, the patient secure messaged the MH clinic:

⁴⁴ VHA Handbook 1907.01.

⁴⁵ *Combined Assessment Program Review of the VA Northern Indiana Health Care System, Marion, Indiana*, Report No. 14-00684-132, April 28, 2014.

⁴⁶ VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.

⁴⁷ We do not know how many secure messages the patient actually sent the MH clinic because staff have the option to either delete a secure message or include it in a patient's health record.

“could you please have [MHP A] call me as soon as possible about ordering my diazepam 5 mg for panic attacks. 3 per day or as needed. I need to know I’m running low.” [sic]

On the same day, a MH administrative clerk messaged the patient:

“I will give the message for (MHP A) to call you.”

No further secure messages are in the patient’s EHR, and we found no evidence that MHP A or other MH clinic staff attempted to contact the patient.

We determined MHP A and/or clinic staff did not adequately respond to the patient’s repeated secure messages requesting assistance. We learned there were no guidelines for MH staff related to documenting and responding to secured messages.

Mental Health Treatment Coordinator. On March 26, 2012, VHA issued a memorandum directing that all patients receiving MH services be assigned a MHTC⁴⁸ by their third MH visit to ensure patients “maintain an enduring relationship with a MH provider who can serve as a point of contact, especially during times of care transitions.”⁴⁹

The memorandum tasks MHTCs to ensure regular contact is maintained with the patient and that the patient’s MH treatment plan involves all clinicians (interdisciplinary) providing care to the patient. The MHTC is also tasked to ensure the MH treatment plan is monitored and revised as necessary. The memorandum requires that a specific MHTC note be entered into the EHR to identify the assigned MHTC and, if a change in MHTC occurs, it should be planned in collaboration, and with input from, the patient. The facility created a local policy, dated August 12, 2012,⁵⁰ that reflects the VHA memorandum.

We were advised that the patient’s assigned MHTC was a Marion LCSW who saw the patient twice, in the spring of 2013. However, there was no EHR note that identified the LCSW as the patient’s MHTC, and the LCSW made no EHR entries of attempts to maintain regular contact with the patient.

Based on the patient’s attempts to contact MH clinic staff via secure messaging, it did not appear the patient was aware he had an assigned MHTC. We also learned the LCSW retired in mid-summer 2013 and that there was no system in place to ensure the LCSW’s cases were reassigned.

Peru CBOC MH Services. VHA requires that mid-size CBOCs provide general MH services as warranted by their patient cohorts, using telemental health as needed.⁵¹ In

⁴⁸ Formerly known as the Principal Mental Health Provider (PMHP).

⁴⁹ Deputy Under Secretary for Health for Operations Management, “Assignment of the Mental Health Treatment Coordinator,” March 26, 2012.

⁵⁰ *SOP Mental Health Treatment Coordinator*, SOP Policy NO. 116A-47-12, August 12, 2012.

⁵¹ VHA Handbook 1160.01

mid-winter, 2013, Ann Arbor PCP B submitted a routine MH consult request to VANIHCS.⁵² About one month later, a Peru CBOC staff discontinued the consult and noted, “Currently, no MH provider is available at Peru and it is unclear when a doctor will be assigned.”⁵³

We determined the CBOC did not offer required MH services for a period of 11 months.

Mental Health Treatment Plan. In the spring of 2013, a Marion MH clinic LCSW conducted a psychosocial assessment of the patient. After assessing the patient, the LCSW documented a treatment plan that included individual psychotherapy once every 2 weeks to focus on management of psychiatric symptoms and pain. Two weeks later, the patient had his only session with the LCSW. The patient advised the LCSW he would schedule another MH appointment with his next primary care appointment to help reduce his trips to Marion. Although the patient had a primary care appointment at Marion the next month, he did not schedule a MH appointment with the LCSW.

We determined the LCSW did not attempt to re-engage the patient or adjust the treatment plan. The LCSW retired in mid-summer 2013, and no MH provider was assigned to follow up with the patient.

Issue 5: Suicide Prevention

We identified opportunities for improvement related to Suicide Prevention Coordination staff and other staff notification when patients make a suicidal statement to TT staff.

On the day that the patient’s wife called the Marion TT in late fall 2013, a TT nurse documented that the patient’s wife said he was in “*excruciating pain*” and that he expressed being “*ready to blow his brains out*” to get relief from his agony. The TT nurse documented hearing the patient yelling in the background. The TT nurse noted the wife stated the patient had access to guns and documented advising the patient’s wife to remove the guns. The TT nurse also documented advising the wife to take the patient to the Fort Wayne ED. The TT nurse included a Suicide Prevention program staff and PCP C as additional signers on the EHR note. As advised, the patient’s wife brought him to the Fort Wayne ED. His reported pain was a 10 (1–10 scale). The ED provider noted the patient had been to a non-VA ED the day before for back pain and was “weepy” when talking about his pain.

We identified three missed opportunities related to the call to the TT nurse: (1) Suicide Prevention Coordination staff acknowledged receipt of the TT nurse’s note but did not call the TT nurse, the patient’s PCP or MHP, or the patient to discuss the TT nurse’s concerns related to the patient’s suicidal statements; (2) the TT nurse did not call the Fort Wayne ED to alert them of the patient’s suicidal statements; and (3) the Fort

⁵² It is unclear why this consult was placed because the patient’s assigned MH clinic location was at the Peru CBOC as of October 2011.

⁵³ There is no documentation in the electronic medical record to explain why a month elapsed between the time the consult was entered to the time VANIHCS staff cancelled the consult.

Wayne ED provider did not involve a psychiatrist or social worker although he/she noted that the patient was “weepy.”

During our review, we learned TT staff did not have a standard operating procedure for psychiatric emergencies.

Issue 6: Chronic Pain and Mental Health Management

We determined PCP C did not adequately consider the patient’s psychosocial factors when assessing his chronic low back pain in the late fall of 2013.

VHA requires that providers implement stepped consultative care and integrate behavioral health with the primary care of chronic pain. The complexity of pain management is often outside the expertise of primary care practitioners, especially for those patients whose pain is complicated by other conditions and psychosocial issues.⁵⁴

We determined the patient’s primary and acute care providers generally adhered to VHA pain management policy before late fall 2013. They documented pain scores, evaluated diagnostic imaging and laboratory tests, adjusted pain medications, and arranged for non-VA physical therapy. However, the patient’s pain and MH response to the pain changed in late fall 2013 and PCP C missed opportunities by failing to integrate behavioral health with the patient’s primary care in response to the patient’s increasingly complex clinical circumstances.

We determined PCP C missed an opportunity to walk the patient to a co-located primary care MH integration program staff when the patient exhibited psychiatric symptoms which were apparently related to his pain.

Issue 7: Interfacility Pain Consultation

We determined Indianapolis VAMC Clinical Application Coordinators did not ensure that all VISN 11 clinical staff were aware the Indianapolis VAMC no longer offered electronic pain consults (E-Consult) to referring facilities or that “E-Consults for pain templates” were removed from the VANIHCS ordering system.

In the fall of 2013, the VANIHCS Pain Management Committee sent a document to VANIHCS medical staff titled, “Pain Management Resources for Providers.” Indianapolis VAMC was one of three facilities listed that provided an “E-Consult for Pain.” Two months later, PCP C placed an E-Consult for pain to Indianapolis VAMC. Indianapolis VAMC staff did not act on the consult until early 2014, when an Indianapolis VAMC staff member cancelled the consult.

We learned Indianapolis VAMC stopped offering E-Consults for pain in the summer of 2013; the change was documented in VISN 11 Pain Committee meeting minutes. However, VANIHCS and some other medical centers did not receive the notice. In addition, Indianapolis VAMC staff did not ensure Clinical Application Coordinators at

⁵⁴ VHA Directive 2009-053, *Pain Management*, October 28, 2009.

other VISN 11 facilities were advised to remove the E-Consult for pain request template. Because the template was available, PCP C could reasonably expect that Indianapolis VAMC still offered the requested service.

VHA requires that facilities establish procedures to track and process consults that are without action within 7 days of the consult request.⁵⁵ We determined that although the pain clinic had a process in place that addressed and completed IFCs within 7 days, this patient's consult was not addressed within the required time frame.

During this review, we learned that 23 E-Consults for pain for other patients were submitted from October 2013 through March 2014; however, those consults were all addressed within 4 days. During the week of March 17, 2014, Indianapolis Clinical Application Coordinators contacted the appropriate staff at each facility to ensure providers no longer had access to the E-Consult for pain template.

Conclusions

In summary, this was a difficult and complicated case. Although the outcome may have been the same for this patient, there were several missed opportunities where the patient's care and system processes could have been improved.

Communication breakdowns and providers' failures to review information available in the patient's EHR during care transitions compromised the patient's MH and primary care. The exchange of health care information was particularly important for this high-risk MH patient with a complex psychosocial background and chronic pain history who was treated by multiple clinicians. There was an absence of oversight in facilitating the continuum of care, which was especially challenging in this case as it touched several VAMCs, a CBOC, and multiple non-VA care sites. The benefits associated with VA's EHR system, including ready access to health records and the exchange of health information, were not consistently and effectively utilized.

We found no indication in the EHR that VA providers analyzed the patient's multiple suicide risk factors: high-risk age group, history of trauma (PTSD), chronic pain, a diagnosed mental illness, a history of aggressiveness, a previous suicide attempt, loss of a family relationship, and easy access to firearms. As cited in this report, VHA has extensive policy specifications to help ensure a patient's MH course is comprehensively and continuously monitored but, in the totality of this case, the policy was more abstract than applied.

The VANIHCS leadership reviewed this case and has taken corrective action with some of the providers involved in the patient's care.

⁵⁵ VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.

Recommendations

Recommendation 1. We recommended that the Network Director evaluate the care of the patient discussed in this report with Regional Counsel for possible institutional disclosure.

Recommendation 2. We recommended that the Network Director initiate a root cause analysis to evaluate system issues outlined in this report.

Recommendation 3. We recommended the Network Director conduct a thorough review of the Northern Indiana Health Care System Mental Health Service's processes and leadership.

Recommendation 4. We recommended that the Network Director ensure providers' electronic health record documentation is consistent with VHA Handbook 1907.01, *Health Information Management and Health Records*, especially in regards to discharge instructions and summaries, patient problem lists, and critical telephone and fax communications, as discussed in this report.

Recommendation 5. We recommended that the Network Director ensure that Northern Indiana Health Care System Non-VA Care Coordination staff case manage patients consistent with their current functional statements or that the role of Non-VA Care Coordination staff be reassessed and functional statements changed to reflect tasks actually performed by the Non-VA Care Coordination staff.

Recommendation 6. We recommended that the Network Director ensure that all Northern Indiana Health Care System providers receive ongoing professional practice evaluations consistent with VHA Directive 1100.19, *Credentialing and Privileging*.

Recommendation 7. We recommended that the Network Director ensure that responsible clinical staff review the patient's electronic health record and initiate appropriate follow-up action consistent with VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, when a patient is a "no show."

Recommendation 8. We recommended that the Network Director ensure that the Northern Indiana Health Care System Director develop guidelines for documenting and responding to secure messages.

Recommendation 9. We recommended that the Network Director ensure that Northern Indiana Health Care System mental health patients be assigned a Mental Health Treatment Coordinator and that a process is in place to reassign coordinators in the event of staff departure consistent with the Deputy Undersecretary for Health for Operations and Management's *"Assignment of the Mental Health Treatment Coordinator"* and local policy requirements.

Recommendation 10. We recommended that the Network Director ensure that Northern Indiana Health Care System Community Based Outpatient Clinic mental

health services are provided consistent with VHA Directive 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*.

Recommendation 11. We recommended that the Network Director ensure processes are in place at the Northern Indiana Health Care System to ensure continuity of mental health care in the event of staff departure and/or reassignment.

Recommendation 12. We recommended that the Network Director ensure Northern Indiana Health Care System telephone triage, suicide prevention program, and emergency department staff receive training regarding expected psychiatric emergency response.

Recommendation 13. We recommended that the Network Director ensure Northern Indiana Health Care System providers implement stepped consultative care and integrate behavioral health with the primary care of chronic pain consistent with VHA Directive 2009-053, *Pain Management*.

Recommendation 14. We recommended that the Network Director ensure that Richard L. Roudebush VA Medical Center Clinical Application Coordinators remove Computerized Patient Record System consult order templates from facility ordering systems when a consult service is no longer offered.

Table 2. VA Outpatient Primary and MH Care 2000–2013

Mental Health Outpatient Care	Date	Facility	Service	Reason for Change	Provider
	2000–2005	Marion	PTSD Counseling	NA	varied
	2004–2006	Marion	Anger Management Counseling	NA	varied
	2000–2011	Marion	Mental Health Clinic	NA	varied
	2011–2013	Peru CBOC	Mental Health Clinic (3 visits)	VHA Reassigned	MHP A
	2013–Death	Marion	Mental Health Clinic (2 visits)	VHA Reassigned	MHP A
	Spring 2013	Marion	Mental Health Clinic (2 visits)	NA	LCSW
Primary Health Outpatient Care	Date	Facility	Service	Reason for Change	Provider
	2000–2011	Marion	Primary Care Clinic	NA	varied
	2011–2012	Peru CBOC	Primary Care Clinic	VHA Reassigned	PCP A
	2012–2013	Ann Arbor HCS	Primary Care Clinic	Patient Request	PCP B
	2013–Death	Marion	Primary Care Clinic	Patient Request	PCP C

Table 3. Pertinent VA and Non-VA Hospital Admissions 1985 through December, 2013

Psychiatric Admissions	Date	Facility	Diagnoses	Days Admitted
	1985	Edward Hines, Jr. VA Hospital	Affective Disorder	6
	1988	Marion	Alcohol Intoxication	5
	1989	Marion	PTSD	30
	1989	Marion	Acute Depression	135
1991	Marion	Chronic PTSD	24	
Medical Admissions	Date	Facility	Diagnoses	Days Admitted
	Fall 2012	Fort Wayne	Cervical Spinal Stenosis, Degenerative Arthritis, Gastrointestinal Reflux	2
	Fall 2012	Ann Arbor HCS	Cervical Myelopathy, Cervical Spine Surgery Steroid Induced Mood Disorder	56
Winter 2013	Non-VA Hospital (Hospital A)	Neck Pain, Back Pain, Lumbar spondylosis, Radiculopathy,	23	

Source: OIG Analysis of VA EHR

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 21, 2014

From: Director, Veterans Integrated Service Network (10N11)

Subj: Healthcare Inspection—Quality and Coordination of Care Concerns
at Three Veterans Integrated Service Network 11 Facilities

To: Director, Kansas City Region Office of Healthcare Inspections (54KC)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. Please find attached responses to the Draft Quality and Coordination of Care Concerns at Three Veterans Integrated Service Network 11 Facilities Report.
2. If you have any questions regarding our responses and actions to recommendations in the report, please contact me.

Sincerely,

for Tony Zapata
Paul Bockelman, FACHE

cc: Director, VA Northern Indiana Healthcare System (610/00)
Director, Ann Arbor VAMC (506/00)
Director, Richard L. Roudebush VAMC (583/00)

Attachment

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Network Director evaluate the care of the patient discussed in this report with Regional Counsel for possible institutional disclosure.

Concur

Target date for completion: October 7, 2014

Facility response: VANIHCS had a teleconference with VISN 11 Regional Counsel staff to discuss the case on October 6th and 7th. A review of the Veteran's chart with a timeline of care was discussed and the VHA Handbook 1004.08 (Disclosure of Adverse Events to Patients, dated October 12, 2012) was referenced. The care provided to the Veteran by VANIHCS, did not meet institutional disclosure criteria, as it did not lead to a sentinel event, a disability, or death. The chart review of the care the Veteran received at VANIHCS revealed areas for improvement; but, the care did not lead to a disability, the Veteran's death, or a sentinel event. VANIHCS arranged for Non-VA care inpatient admission to a local tertiary care hospital where the Veteran remained an inpatient for approximately 6 weeks. The Veteran did not commit suicide until several days after he was discharged from the local tertiary care hospital.

Recommendation 2. We recommended that the Network Director initiate a root cause analysis to evaluate system issues outlined in this report.

Concur

Target date for completion: July 14, 2015

Facility response: A technique similar to a root cause analysis process will be utilized in coordination with Ann Arbor HCS, Indianapolis VAMC, and Northern Indiana VA Health Care System to analyze, drill down, and evaluate the system issues outlined in this report.

Recommendation 3. We recommended the Network Director conduct a thorough review of the Northern Indiana Health Care System Mental Health Service's processes and leadership.

Concur

Target date for completion: February 1, 2015

Facility response: The VISN 11 Mental Health Director will task an interdisciplinary team to conduct a site visit to VANIHCS prior to February 1, 2015, to conduct a thorough review of processes and leadership. Previous longstanding leadership vacancies in Mental Health have been filled effective August 10, 2014.

Recommendation 4. We recommended that the Network Director ensure providers' electronic health record documentation is consistent with VHA Handbook 1907.01, *Health Information Management and Health Records*, especially in regards to discharge instructions and summaries, patient problem lists, and critical telephone and fax communications, as discussed in this report.

Concur

Target date for completion: April 15, 2015

Facility response: The Network Director will ensure that providers' electronic health record documentation is consistent with VHA Handbook 1907.01, *Health Information Management and Health Records*, especially in regards to discharge instructions and summaries, patient problem lists, and critical telephone and fax communications. We will use education, chart review, and ongoing monitoring to assure compliance with this Handbook. Reports will be compiled from these reviews, analyzed, and corrective action(s) taken, if applicable.

An original scanning note is started when the first record is obtained, and then addenda are created as each additional report for each Veteran is received. To ensure that care is coordinated, the Non-VA Care Coordination staff add the Inter-facility Transfer Nurse and the Non-VA Care Coordination Utilization Review Nurse as an additional signer of all notes entered. As part of our improvement efforts, we changed our process in April 2014 from a paper fax line to electronic Stream. This new process ensures all faxes are received at one Stream line in one location to be reviewed. This eliminates the chances of lost documents.

Ann Arbor VA will provide enhanced education on comprehensive discharge documentation for clinical providers involved in the discharge process through their Clinical Executive Board (CEB).

Recommendation 5. We recommended that the Network Director ensure that Northern Indiana Health Care System Non-VA Care Coordination staff case manage patients consistent with their current functional statements or that the role of Non-VA Care Coordination staff be reassessed and functional statements changed to reflect tasks actually performed by the Non-VA Care Coordination staff.

Concur

Target date for completion: November 1, 2014

Facility response: VANIHCS revised functional statements for Non-VA Care RN/Non-VA Care Community Admissions and the core functional statement competencies in March,

2014. The revised functional statements denoted the individuals are responsible for coordinated care. The previous functional statements listed these positions were responsible for the case management of Veterans that are Non-VA Care based in the community. The revisions made in March 2014 were communicated to two of the three staff members in March, 2014 and the remaining staff member's was communicated in June 2014 when he transitioned to this role full-time. Recently, additional changes were made to the functional statements to clarify roles for all Non-VA Care Coordination staff. These functional statements have been approved by the Chief Nurse Executive and are currently with our labor partners for their review. Copies of the recently revised functional statements have been provided to the Network Director for his review to ensure the role of VANIHCs Non-VA Care Coordination staff has been reassessed and functional statements changed to reflect tasks actually performed by the Non-VA Care Coordination staff.

Recommendation 6. We recommended that the Network Director ensure that all Northern Indiana Health Care System providers receive ongoing professional practice evaluations consistent with VHA Directive 1100.19, *Credentialing and Privileging*.

Concur

Target date for completion: October 31, 2014

Facility response: The Network Director will ensure all VA Northern Indiana Health Care System providers receive ongoing professional practice evaluations consistent with VHA Directive 1100.19, *Credentialing and Privileging*. An Ongoing Professional Performance Evaluation tracking spreadsheet is used to ensure no evaluations are missed or delinquent in the future.

Recommendation 7. We recommended that the Network Director ensure that responsible clinical staff reviews the patient's electronic health record and initiates appropriate follow-up action consistent with VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, when a patient is a "no show."

Concur

Target date for completion: April 15, 2015

Facility response: The Network Director will ensure responsible clinical staff review the patient's electronic health record and initiate appropriate follow-up action consistent with VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, when a patient is a "no show." VANIHCs's MH Service has established a No Show monitor for FY 2015, which includes a review of the "No-Show" contact template note. VANIHCs Suicide Prevention Coordinator educated MH staff during MH Staff's August, 2014 staff meeting regarding high risk "no show" MH patients. Chart audits and monitoring for compliance will be ongoing by VANIHCs.

Recommendation 8. We recommended that the Network Director ensure that the Northern Indiana Health Care System Director develop guidelines for documenting and responding to secure messages.

Concur

Target date for completion: October 1, 2014

Facility response: The Network Director will ensure VA Northern Indiana Healthcare System Director develops guidelines for documenting and responding to secure messages. Compliance for responding to secure messaging will continue to be monitored on a monthly basis in FY15.

Recommendation 9. We recommended that the Network Director ensure that Northern Indiana Health Care System mental health patients be assigned a Mental Health Treatment Coordinator and that a process is in place to reassign coordinators in the event of staff departure consistent with the Deputy Undersecretary for Health for Operations and Management's *"Assignment of the Mental Health Treatment Coordinator"* and local policy requirements.

Concur

Target date for completion: December 31, 2014

Facility response: VANIHCS revised Mental Health Treatment Coordinator standard operating procedure (SOP) was published on May 23, 2014. This SOP addresses how Veterans are reassigned if the MH Treatment Coordinator changes. During June, 2014 MH Service cross checked Veterans whose Providers departed or changed positions to ensure they had a MH Treatment Coordinator assigned. Two-hundred and fifty-nine patients were re-assigned due to two provider's retirements. Letters notifying the affected Veterans were sent to them in June 2014. MH Service has a service level monitor in place for FY 2015 to ensure applicable MH Veterans have a MH Treatment Coordinator assigned.

Recommendation 10. We recommended that the Network Director ensure that Northern Indiana Health Care System Community Based Outpatient Clinic mental health services are provided consistent with VHA Directive 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*.

Concur

Target date for completion: March 31, 2014

Facility response: The Network Director will ensure all VA Northern Indiana Healthcare System Community Based Outpatient Clinical Mental Health Services are provided consistent with VHA Directive 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics. Currently, all VANIHCS CBOC's have on-site Mental Health staff and three of our four sites have on-site Mental Health prescribers. The fourth CBOC has consistent tele-mental health prescriber coverage.

Recommendation 11. We recommended that the Network Director ensure processes are in place at the Northern Indiana Health Care System to ensure continuity of mental health care in the event of staff departure and/or reassignment.

Concur

Target date for completion: June 30, 2014

Facility response: The Network Director will ensure processes are in place at the VANIHCS to ensure continuity of mental health care in the event of staff departure and/or reassignment. VANIHCS has a SOP published which addresses Mental Health Treatment Coordinator assignments. MH Service has a monitor in place for FY 2015 for assignment and reassignment of Mental Health Treatment Coordinator. During June, 2014 MH Service cross checked VANIHCS Veterans whose Provider had a change in position to ensure affected Veterans had a MH Treatment Coordinator. Any Veteran whose MH Treatment Coordinator retired, left the facility, or had a change in position was reassigned a new MH Treatment Coordinator and a letter was sent to the Veteran in June, 2014. Consistent monitoring will be performed to assure that all MH Veterans have a MH Treatment Coordinator.

Recommendation 12. We recommended that the Network Director ensure Northern Indiana Health Care System telephone triage, suicide prevention program, and emergency department staff receive training regarding expected psychiatric emergency response.

Concur

Target date for completion: October 17, 2014

Facility response: The Network Director will ensure VANIHCS telephone triage, suicide prevention program, and emergency department staff received training regarding expected psychiatric emergency response. The Fort Wayne Telephone Triage staff received training for VANIHCS Telephone Call Center policy 136-19-14 in May and June 2014. Marion Campus Telephone Triage staff received a copy of VANIHCS Management of Psychiatric Emergencies policy 116A-35-10 on October 3, 2014 as a refresher. An annual competency validated by direct observation of the call or a review of notes will be completed by all Telephone Triage staff by October 17, 2014. Training of the Suicide Prevention program staff will be completed by the targeted date of completion. Training for emergency department staff was provided on October 8, 2014. Follow-up training competency with emergency department staff will be validated by October 17, 2014.

Recommendation 13. We recommended that the Network Director ensure Northern Indiana Health Care System providers implement stepped consultative care and integrate behavioral health with the primary care of chronic pain consistent with VHA Directive 2009-053, *Pain Management*.

Concur

Target date for completion: December 15, 2014

Facility response: The Network Director will ensure VANIHCs providers implement stepped consultative care and integrate behavioral health with the primary care of chronic pain consistent with VHA Directive 2009-053, Pain Management. VANIHCs has hosted four educational opportunities during FY 2014 for clinical staff related to opioid management and integrated mental health, specifics are noted in the table below:

Title of Educational Opportunity	Date	Place	Number of Attendees
Chronic Pain in Patients with Mental Health and/or Substance Use Disorders	4/30/2014 (one hour)	VANIHCs	25 Staff (17 Providers, 6 Nurse Practitioners, the Chief of Staff, and 1 Administrative staff member)
Pain/Psychiatry Presentation	5/28/2014 (one hour)	VANIHCs	34 Staff (13 Providers, 8 Nurse Practitioners, 3 RN's, 3 Ph.D.'s, 3 Social Work staff, 2 Pharmacy Students, One Physician Assistant, the Chief of Staff)
Veteran's in Pain	8/21/2014	VANIHCs, Marion Campus	56 Participants (16 staff members and 40 other individuals attended). Veterans, their family members, and congressional staff were made aware of this workshop.
Veteran's in Pain	8/22/2014	VANIHCs, Fort Wayne Campus	82 participants (15 staff members and 67 other individuals attended). Veterans, their family members, and one congressional staff member attended this workshop.

In addition, VANIHCs is enhancing services by implementing the new opioid pain management safety guidelines under the direction of the VISN 11 pain management subject matter expert. VANIHCs is developing new protocols for Veteran receiving opioids and benzodiazepines to facilitate more direct involvement and referral with Mental Health services including Primary Care Mental Health Integration (PCMHI). These protocols will be completed by December 15, 2014. Ongoing chart audits and monitoring will occur to assure that VHA Directive 2009-053 standards are being followed.

Recommendation 14. We recommended that the Network Director ensure that Richard L. Roudebush VA Medical Center Clinical Application Coordinators remove

Computerized Patient Record System consult order templates from facility ordering systems when a consult service is no longer offered.

Concur

Target date for completion: October 15, 2014

Facility response: The Richard L. Roudebush Clinical Application Coordinator (CAC) reviewed the identified pain consult to ensure it was disabled which indicates it is not visible to local staff. An e-mail notification via Outlook on February 12, 2014 was sent to VISN 11 Clinical Informatics staff to inform of the change (Attachment B). VISN 11 Clinical Informatics staff was notified again of the discontinuation of use for this IFC via Outlook on March 13, 2014. The PMRS Pain Clinic inter-facility consultation was discontinued on March 31, 2014 (date all consultations were closed). A standard operating process for disabling inter-facility consultations (IFC) has been developed and include the process for notifying other VISN 11 facilities and documentation of requestor, date disabled, and facilities notified including date of notification.

VA Northern Indiana Health Care System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 14, 2014

From: Director, VA Northern Indiana Health Care System

Subj: Healthcare Inspection—Quality and Coordination of Care Concerns
at Three Veterans Integrated Service Network 11 Facilities

To: Director, Veterans Integrated Service Network (10N11)

I concur with VA Northern Indiana Health Care System's response and action plans as detailed within this report.

Thank you,



Denise M. Deitzen

VA Ann Arbor Healthcare System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 20, 2014

From: Director, VA Ann Arbor Healthcare System

Subj: Healthcare Inspection—Quality and Coordination of Care Concerns
at Three Veterans Integrated Service Network 11 Facilities

To: Director, Veterans Integrated Service Network (10N11)

1. Recommendation 2: Concur. Plan for action: The VA Ann Arbor Healthcare System will participate in the Root Cause Analysis (RCA) with the Veterans Integrated Service Network 11 Patient Safety Manager.
2. Recommendation 4: Concur. Plan for action: Through our Clinical Executive Board, the VA Ann Arbor Healthcare System will provide enhanced education on comprehensive discharge documentation for clinical providers.
3. I appreciate the opportunity to review our processes to improve the care that we provide to our Veterans.



ROBERT P. MCDIVITT, FACHE/VHA-CM

Richard L. Roudebush VA Medical Center Director Comments

Department of
Veterans Affairs

Memorandum

Date: October 8 2014

From: Director, Richard L. Roudebush VA Medical Center

Subj: Healthcare Inspection—Quality and Coordination of Care Concerns
at Three Veterans Integrated Service Network 11 Facilities

To: Director, Veterans Integrated Service Network (10N11)

This memorandum serves as our concurrence with recommendation #14: Ensure that Richard L. Roudebush VA Medical Center Clinical Application Coordinators remove Computerized Patient Record System consult order templates from facility ordering systems when a consult service is no longer offered.

I appreciate the opportunity to review our processes to improve the care to our Veterans and collaboration with other VA facilities within our VISN.

Thank you,



Thomas Mattice, FACHE
Richard L. Roudebush VA Medical Center Director

OIG Contact and Staff Acknowledgments

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