Administrative Closure
Alleged Violation of Patient Rights
Sheridan VA Health Care System
Sheridan, Wyoming
2013-00244-HI-0312

On September 24, 2012, Senator Bill Nelson requested the VA Office of Inspector General (OIG) to review allegations made by a complainant concerning the treatment he received at two VA health care facilities in Wyoming. The complainant alleged that he sought care at a community based outpatient clinic for [redacted] but did not receive the medications or services he requested; his civil rights were violated (during and subsequent to a [redacted] appointment) by various VA and non-VA clinicians in Powell, Cody, and Sheridan, WY; and that he suffered financial, psychosocial, and psychological consequences as a result of clinical staff members' improper actions.

We did not substantiate that the patient did not receive [redacted] and counseling services that he requested from his primary care provider (PCP). The patient had two clinic appointments and one telephone contact with his PCP before the [redacted] appointment. The patient's medical record documentation related to these contacts reflects that the patient initially declined prescription medications and repeatedly declined [redacted] and that the PCP appropriately addressed the patient's presenting problems during these three contacts.

We determined that the patient's PCP, a non-VA provider, appropriately initiated the emergency detention during the [redacted] appointment, but because the patient left the clinic, the PCP was unable to inform him of his rights as required. We found that VA providers involved in the Title 25 procedures were not sufficiently familiar with some administrative and clinical requirements of the emergency civil commitment process, and coordination of patient care across county jurisdictional boundaries was disjointed. In reviewing the patient's electronic health record, it was often difficult to tell whether the patient was thought to be voluntarily submitting to treatment or whether he was an involuntary patient under the Title 25 Hold. Nonetheless, VA providers did not violate any laws with regards to this veteran.

State law in this case allows providers without mental health training or expertise to serve as examiners in relation to the Title 25 process, and several of the involved VA providers who made decisions related to continuing the emergency civil commitment of this patient did not possess specific mental health expertise. This practice complied with state law. The question about the appropriateness of the applicable state law is beyond the scope of our inspection.

We recommended the System Director ensure that: (1) staff members who are, or potentially will be, involved in the Title 25 process be specifically trained on its administrative and clinical requirements or have ready access to qualified professionals to provide prompt mental health evaluations or consultations; and, (2) local policy and practice promotes a high level of communication and collaboration between mental

health and primary care/urgent care practitioners with the goal of safeguarding patients' rights at all stages of the emergency detention and involuntary hospitalization process.

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan.

Because the OIG has no authority to review or comment on state laws, I am administratively closing this case.

3/25/15

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Healthcare Inspections