Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-02276-391

Healthcare Inspection

Evaluation of a Patient's Care and Disclosure of Protected Information Atlanta VA Medical Center Decatur, Georgia

June 23, 2015

Washington, DC 20420

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Executive Summary

At the request of the Chairman and Ranking Member, Senate Committee on Veterans' Affairs and the Chairman and Ranking Member, House Committee on Veterans' Affairs, the VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review of the care a patient received at the Atlanta VA Medical Center (facility), Decatur, GA, prior to her death and evaluated an improper disclosure of protected information outside VA.

In general, we determined that facility staff provided, or attempted to provide, appropriate mental health (MH) treatment and psychosocial support services to the patient. The patient initially presented with housing-related concerns, which were promptly addressed. The patient received regular case management services and was hopeful and future-oriented. She was subsequently diagnosed with a chronic medical condition but was reluctant to fully engage in psychotherapy. She missed two MH appointments in winter 2014 and, when contacted via telephone, exercised her right and declined further MH services. While we noted several procedural deficiencies related to appointment scheduling and follow-up, we believe staff made reasonable efforts to provide MH treatment.

We found that there was a 23-day delay in placing a high-risk for suicide flag in the patient's record. We also determined that efforts to contact the patient after the high-risk flag was placed did not strictly comply with protocol requirements. Despite this, we believe that clinical staff used reasoned judgments in their efforts to intervene and support the patient. The patient died more than 2 months after she was referred for placement on the high-risk protocol, more than a month after the missed MH appointments, and 1 week after a face-to-face contact with a clinician. The timing suggests that, while facility staff did not consistently comply with some requirements, it is unlikely that these deficiencies had a direct impact on the outcome in this case.

We confirmed that an individual with access to the patient's electronic health record (EHR) improperly disclosed protected health information outside VA. This patient's record was designated as "non-sensitive" at the time of the disclosure, and the Veterans Health Administration currently lacks the ability to audit access to non-sensitive records. As a result, managers do not have the necessary tools to identify wrongdoers and, consequently, cannot enforce some rules and statutes. To date, OIG investigators have been unable to determine who accessed the patient's EHR and, therefore, could have been responsible for the improper disclosure.

We recommended that the Interim Under Secretary for Health evaluate options that would allow managers to identify individuals who access non-sensitive patient EHRs. We also recommended that the facility Director ensure that staff comply with guidelines for appointment scheduling, notification, and follow-up; make appropriate patient contacts in accordance with treatment plans; and adhere to suicide prevention program requirements.

Comments

The Interim Under Secretary for Health and the Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A, B, and C, pages 15–21, for the Under Secretary for Health and Directors' comments.) We will follow up on the planned actions until they are complete.

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Purpose

At the request of the Chairman and Ranking Member, Senate Committee on Veterans' Affairs and the Chairman and Ranking Member, House Committee on Veterans' Affairs, the VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review of the care a patient received at the Atlanta VA Medical Center (facility), Decatur, GA, prior to her death and evaluated the improper disclosure of protected health information outside VA.

Background

The facility is a 405-bed teaching hospital that provides a broad range of emergency, medical, surgical, long-term care, and mental health (MH) services. The facility has 273 hospital beds, 120 community living center beds, and 40 inpatient MH beds. Care is also provided at seven community based outpatient clinics (CBOCs) in Smyrna, Lawrenceville, Oakwood, East Point, Stockbridge, Newnan, and Blairsville, GA, and at an outpatient clinic in Decatur and an outreach clinic in Rome, GA. The facility is part of Veterans Integrated Service Network (VISN) 7 and serves a veteran population of 87,416 unique patients.

Health Care for Homeless Veterans Program

The facility offers an extensive Health Care for Homeless Veterans (HCHV) program that provides a wide range of services to outreach and engage homeless veterans into VA health care. The goal of these services is to provide treatment components along a continuum of care to ensure full recovery from homelessness and to provide the support needed to maintain functioning at the highest level of independence. The Department of Housing and Urban Development-VA Supported Housing (HUD-VASH) Program is a Section 8 Housing Choice Voucher[1] program in which a veteran is issued a HUD-VASH voucher. The veteran must actively participate in case management services provided by the facility to maintain his or her eligibility for the voucher. Case management home visits are generally weekly in the early stages of housing placement, then become less frequent as the veteran stabilizes in his or her new housing arrangements.

Suicide and Suicide Prevention

According to estimates from the Centers for Disease Control and Prevention (CDC), veterans account for approximately 20 percent of the deaths from suicide in the United States. More recent estimates from VA increase the estimate to 22 percent. Applying these proportions to the 36,900 suicides that occurred in the US in 2009 and the 38,600 that occurred in 2010, leads to estimates that 18–22 veterans die from suicide each

[1] Housing choice vouchers are administered locally by public housing agencies. The participant is free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects.

day. Female veterans account for about 3 percent of all veteran suicides; however, suicide rates among females aged 30–39 are similar when comparing veterans to non-veterans.[2]

People attempt suicide for a variety of reasons. Common risk factors include mental disorders, stressful life events, financial problems, lack of social supports, and acute and chronic medical conditions. Often, there are warning signs that someone may be or will soon become suicidal, including increasing or excessive substance use, giving away property, expressions of hopelessness, and expressions of purposelessness (for example, having no reason to live). While risk factors and warning signs should be considered during any MH assessment, "predicting with certainty whether any given individual will actually attempt suicide is difficult, if not impossible."[3]

In an effort to address the epidemic of veteran suicides, the Veterans Health Administration (VHA) has outlined measures to be implemented at all VHA health care facilities and large outpatient clinics. Each facility is to have:

- A Suicide Prevention Coordinator (SPC) or team that is responsible for ensuring high-risk veterans receive the appropriate services.
- Screening and assessment processes to assist in the identification of veterans at risk for suicide.
- An electronic patient record flag (PRF) system to assure continuity of care and alert caregivers to a veteran's high-risk status.
- A system to ensure that veterans who have been identified as being at high risk receive an enhanced level of care, including missed appointment follow-ups, safety planning, weekly follow-up visits, and care plans that directly address their suicidality.

Treatment Options for Veterans/Patients at High Risk for Suicide

Outpatient Therapy and Support – When patients have suicidal ideation, but no plan or intent, they may be treated as outpatients if they have good social support systems in place.[4] The goal of treatment is to help patients recognize their triggers and develop personalized safety plans and strategies to calm themselves and keep themselves safe. Medication management and treatment of co-morbid conditions (such as depression or substance use disorder) may be components of outpatient treatment.

Voluntary Hospitalization – Voluntary hospitalization is the preferred treatment method for acutely suicidal patients who have the capacity to give informed consent for treatment. When patients agree to hospital admission, they have tacitly acknowledged

[2] *VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide*, June 2013.
[3] *VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide*, June 2013.
[4] http://www.aafp.org/afp/2012/0315/p602.html, retrieved February 23, 2015.

that they do not want to die (at least at that moment) and that they need a safe environment, support, and treatment to get better.

Emergency Detention – In Georgia, certain clinicians can initiate a Form 1013,[5] which allows the involuntary transport and admission of a mentally ill person to a designated facility for a MH evaluation. For a 1013 hold to be appropriate, the patient must require involuntary evaluation, must be mentally ill (defined under Georgia law as having a disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality or ability to cope with the ordinary demands of life[6]), AND

- Present a substantial risk of imminent harm[7] to self or others as manifested by recent overt acts or expressed threats of violence presenting a probability of physical injury, OR
- Be so unable to care for her/his own physical health and safety as to create an imminently life endangering crisis.[8]

Scope and Methodology

We visited the facility February 11–12, 2015, and interviewed the facility Director, the MH Assessment Team (MHAT) psychiatrist, the SPC and a Suicide Prevention case manager (SPCM), two HUD-VASH social workers, a medical social worker, a social work supervisor, and two psychologists involved in the patient's care.

We reviewed the patient's electronic health record (EHR) for the period covering the year prior to her death; relevant VHA and facility policies on suicide prevention, MH assessment and treatment, and patient rights; and, internal and external reviews of the case.

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.

[5] GA Department of Behavioral Health and Developmental Disabilities, Form 1013 – Certificate Authorizing Transport to Emergency Receiving Facility & Report of Transportation – Mental Health.
[6] Official Code of Georgia, § 37-1-1(12) (2014).
[7] Imminent Risk may be determined if an individual states both a desire and intent to die and has the capability of carrying through his/her intent. https://www.suicidepreventionlifeline.org, retrieved February 25, 2015.
[8] GA Department of Behavioral Health and Developmental Disabilities, Criteria for Mental Health Admissions of Adults to DBHDD Hospitals, 03-502, https://gadbhdd.policystat.com/policy/176096/latest/; Form 1013 and Form 2013 – Certificate Authorizing Transport to Emergency Receiving Facility and Report of Transportation, 01-110, https://gadbhdd.policystat.com/policy/1136700/latest/.

Case Summary

The patient was a female veteran in her 30s who initially presented to the facility's HCHV program in fall 2013 seeking housing until she could find a job. The patient had no documented history of mental illness or substance abuse. Within days, the patient was assessed and placed into a group home through the Homeless Grant and Per Diem program. A routine suicide risk assessment at the time of HCHV program intake was negative for suicidal ideation, a history of suicide attempts, or a family history of suicide. The patient reported looking forward to the future and was assessed to be at low imminent risk for suicide.

The patient moved into her own apartment through the HUD-VASH program in winter 2013. The HUD-VASH social worker maintained regular, ongoing weekly contact and provided supportive case management to the patient. The social worker documented that the patient appeared stably housed and "well-adjusted." A suicide risk assessment completed in early 2014 reflected that the patient was "emotionally stable and future oriented" and was at low risk for suicide.

The EHR reflects that by late spring 2014, the patient was working towards her goals and reported acclimating well. The frequency of HUD-VASH visits was reduced to twice per month, and the patient was encouraged to schedule ongoing primary care through the facility. Suicide risk assessments completed in spring and summer again showed the patient to be a low risk for suicide.

In summer 2014, the patient presented to a private-sector Emergency Department complaining of headache and hives all over her body. The following day, she called her HUD-VASH social worker who in turn called a nurse practitioner for the Homeless-Patient-Aligned Care Team (H-PACT), the facility's patient aligned primary care team specializing in the care of homeless veterans. The HUD-VASH social worker transported the patient to a walk-in visit with an H-PACT nurse practitioner later that day.

The nurse practitioner completed a history and physical examination and ordered a panel of routine laboratory blood tests. Additional blood work was sent for specialized testing. The patient denied feeling hopeless, having thoughts of taking her life, or having any history of suicide attempts. A depression screen was negative, and the patient did not appear to have a MH condition requiring further intervention.

Five days later, the HUD-VASH social worker transported the patient to a follow-up visit with the H-PACT nurse practitioner in order to review a positive laboratory test result. The patient was reportedly "shocked" at the new diagnosis. The clinical staff explained that she had a manageable chronic illness and that a high quality of life could be maintained with adherence to a treatment regimen. At the time, the patient denied suicidal ideation but was assessed to be at moderate risk for suicide. The HUD-VASH social worker noted that "linkage" to specialty medical care and additional services were initiated immediately to "reduce potential harm to self and provide immediate emotional and medical support."

The same day that the patient was told of her newly diagnosed condition, she met with the specialty clinic staff who would be treating her condition. They answered the patient's questions and made a referral to a primary care MH (PCMH) psychologist for time-limited therapy aimed at helping the patient adjust to her newly diagnosed illness. On the way home, the patient told her HUD-VASH social worker that she "did not feel alone" and knew that "it was going to be alright." The HUD-VASH social worker continued to maintain ongoing contact and provide supportive case management.

Within 2 weeks, the patient was evaluated by a physician assistant at the specialty medical clinic and begun on a treatment regimen. The patient denied thoughts of wishing she were dead or hurting herself.

The patient completed an initial visit with a PCMH psychologist (therapist A) in late summer. The patient reported feeling angry but noted that she had "accepted that this is what is meant to be." She also stated that she would not be upset if "God called her home" but denied trying to hasten her death and denied a thought, plan, or intent to harm herself or anyone else.

In early fall 2014, the patient told her HUD-VASH social worker that things were going well, that she was coping well, but still had some "tough days." About this time, she was seen by a second PCMH psychologist (therapist B) at a CBOC closer to her home and expressed having mixed emotions and ambivalence regarding whether to stay here or to "go home" to heaven. The patient reported that she would "definitely wait at least a year to figure out what I am going to do" and desired to do things for her and her family before making any "drastic decisions." While the patient initially expressed an interest in brief supportive therapy with therapist B, she later requested a different therapist.[9]

Approximately 4 weeks later, the patient contacted therapist B and inquired about the referral to another therapist and about the possibility of trying medication. She was offered an appointment with therapist B until an appointment could be scheduled with a new therapist, but the patient declined. Therapist B informed her that her primary care provider would likely be prescribing her medication.

In mid-fall, the patient followed up in the specialty medical clinic and reported that her energy level was improved. The next day, the HUD-VASH social worker documented that the patient was excited about a job fair and her job prospects, that she had a better energy level, and that she denied suicidal or homicidal ideation.

Approximately 2 weeks after the specialty medical clinic visit when she reported improved energy levels, the patient saw therapist C for the first time. During this visit, the patient endorsed feelings of loneliness and isolation and acknowledged having considered suicide but stated she was willing to give living with her medical condition a year before acting on those thoughts. Therapist C discussed support groups, but the patient stated that she would be unable to attend due to her child care responsibilities during the day.

[9] The EHR and witness testimony conflict as to the reason for the requested change in therapists.

During a follow-up visit with therapist C in early winter, the patient reported that she viewed suicide "as retiring from the world and being at peace instead of working daily" and that she did not want to learn to cope with her medical condition. She did, however, assure therapist C that she did not have a current plan or intent to act on her thoughts of suicide. Therapist C completed a suicide safety plan with the patient during this visit (suicide safety plan [SSP] day 0) and added the SPC as an additional signer to her progress note, documenting that "it is this writer's belief that the veteran should be added to the high risk protocol." Therapist C also sent a consult request for the patient to be seen by an MHAT[10] psychiatrist. The initial MHAT appointment was scheduled for approximately 2 weeks later on SSP day 19. In the interim, the HUD-VASH social worker attempted to visit the patient at the patient's apartment but was unable to contact her.

The patient missed the SSP day 19 MHAT appointment. On SSP day 22, the patient attended the year's last session of a twice monthly group for HUD-VASH participants. On SSP day 23, a precautionary category 1 high risk for suicide PRF was activated in the patient's EHR. On SSP day 24, the patient attended a holiday dinner for veterans sponsored by a local church.

The patient's missed MHAT appointment had been rescheduled to SSP day 26, which the patient also missed. The MHAT psychiatrist attempted to call the patient the day she missed the rescheduled appointment without success, but therapist C was able to reach the patient later that day. Therapist C documented that the patient reported doing well and that she declined to schedule another appointment (with therapist C), stating "I got what I needed. I just needed someone to listen to me. I've made my decision and I'm comfortable with it." The patient denied a plan to commit suicide at that time. Therapist C added the suicide prevention team to the note for further guidance. The MHAT psychiatrist documented that the patient declined MH services. The consult was cancelled per facility policy.

On SSP day 33, an SPCM attempted to contact the veteran per the high risk protocol; however, the patient did not answer the phone, so the case manager left a message requesting a return call. On SSP day 41, the same SPCM phoned the patient again but received an outgoing message that the "person you are trying to reach is not accepting calls at this time." On SSP day 50, the SPCM again attempted to contact the patient but got the same message that the patient's cell phone was not accepting calls. The SPCM then attempted to contact the patient's mother, listed as the legal next-of-kin in VA records, without success. On SSP day 58, the patient's HUD-VASH social worker attempted to reach the veteran to confirm their appointment for the upcoming week, but the patient's phone was disconnected.

On SSP day 63, the HUD-VASH social worker visited the patient and two[11] of her children at the patient's apartment and noted the patient was engaged (participatory;

[10] The MHAT consists of a group of mental health care providers, including psychiatrists, tasked with the initial evaluation of patients referred to the Mental Health Service Line.
[11] The oldest child was in school during the visit.

involved) with one of her children, and she reported that her phone would be back on "soon." During the visit, the HUD-VASH social worker asked the patient about MH follow-up, to which the patient replied that the initial meeting with therapist C was "sufficient" and that it had helped her get things off her chest and put them in perspective. The patient stated, "I don't want to harm myself or anyone else…I just needed to talk and I made that clear. I will follow-up in the future should I feel the need." When asked about her coping, the patient reported having good and bad days. The HUD-VASH social worker assessed the patient to be at chronic risk[12] for suicide but identified her children and employment as mitigating factors.[13] Again, the patient denied any plan or intent to harm herself. The HUD-VASH social worker and the patient planned to meet in the next 1–2 weeks for ongoing supportive case management.

On SSP day 68, the HUD-VASH social worker attempted to call the patient to confirm their appointment for the next day, but the patient's phone was still disconnected. The following day, the HUD-VASH social worker and one of her colleagues arrived at the patient's apartment complex for a visit where they learned that the patient was deceased.

[12] Patients at chronic risk for suicide is are not at immediate risk; rather, they have a long-term vulnerability to being suicidal. http://www.dcoe.mil/event_docs/suicide_prevention_conf/12_JAN_09_BERMAN_1405-1445_LONESTAR_D_Assessing_and_Formulating_Acute_Risk_for_Suicide.pdf, retrieved June 4, 2015.

[13] Mitigating (or protective) factors are capacities, qualities, and environmental and personal resources that mitigate a person's drive to commit suicide. Examples of protective factors include religious beliefs, children in the home, or a future event that the person wishes to observe (such as a relative's marriage or graduation).

Inspection Results

Autonomy is a basic principle of health care ethics and essentially requires health care providers to honor a competent patient's right to make his or her own decisions. Legal standards for determining competence and decision-making capacity for consent to treatment generally include the ability to communicate a choice, to understand the relevant information, to appreciate the medical consequences of the situation, and to reason about treatment choices.[14] The facility's Bill of Patient's Rights, which is to be provided to all patients, states, "You can agree to or refuse any treatment."

The patient's right to refuse treatment is central to this case.

Issue 1: MH Treatment

Facility staff provided, or attempted to provide, appropriate MH treatment and psychosocial support services. The patient initially presented to the facility with housing-related concerns. She was promptly assessed and placed in a supported housing program with regular case management visits. Progress notes reflect that the patient was engaged with, and appreciative of, HUD-VASH services and that she was hopeful and future-oriented.

In summer 2014, the patient was diagnosed with a chronic medical condition. Facility staff provided appropriate counseling and support services and referred her for additional therapy through the PCMH program. The EHR reflects that the patient was struggling with this new diagnosis but was reluctant to fully engage in psychotherapy. Recognizing the seriousness of the patient's mental state, therapist C consulted the MHAT in early winter.

While we found the patient's care to this point to be proactive and well-documented, we found the following deficiencies:

- **Therapist C stated in her early winter note that the patient was to return to clinic in 2 weeks.** This appointment was never scheduled.

- **MHAT appointments must be scheduled within 2 weeks of the consult request** (as required by the facility's MHAT standard operating procedure [SOP])**.** The MHAT appointment was scheduled 19 days after the consult request.

- **Per SOP, patients scheduled for initial MHAT evaluation will receive notification of their appointment by phone and in writing, and those actions will be documented in the EHR.** We found no documentation in the EHR stating that the patient was notified verbally or in writing of the first scheduled MHAT appointment.

[14] http://www.nejm.org/doi/full/10.1056/NEJMcp074045, retrieved February 20, 2015.

- **Per SOP, patients who do not present for their appointments will be contacted by the assigned provider and offered another appointment with MHAT.** We found no documentation that the assigned provider attempted to contact the patient after she missed the first scheduled MHAT appointment.

- **Per SOP, if the patient is not reachable after two attempts, a letter will be sent offering them a tentative second appointment.** We found no documentation that the provider attempted to contact the patient by phone after she missed her first scheduled MHAT appointment; however, a letter rescheduling the appointment to December 15 was sent.

The patient exercised her right to decline further MH services. Of note, the HUD-VASH social worker, who had maintained regular (about twice monthly) visits and/or phone calls in accordance with the patient's treatment plan, did not have any documented contacts (actual or attempted) with her between SSP day 24 and SSP day 58.

The patient died by suicide more than a month after the missed MHAT appointments and a week after a face-to-face contact with a HUD-VASH clinician. The timing suggests that while facility staff did not consistently follow some required processes, it is unlikely that these deficiencies had a direct impact on the outcome in this case.

Issue 2: Suicide Prevention Activities

Overall, facility staff complied with suicide prevention guidelines for managing this high-risk patient. While we identified some process-related deficiencies, we believe that clinical staff used reasoned judgment in their efforts to provide care.

Complexities of Managing the Potentially Suicidal Patient

When patients communicate thoughts and feeling of suicide, clinicians must determine the most appropriate means to address the patient's suicidality and safety concerns while also assuring that the patient's rights are being respected. Sometimes, just talking to someone who cares and who does not judge them is enough to reduce the risk of suicide. Some patients may agree to hospitalization and treatment to reduce or eliminate the suicidality, and others, who meet the clinical criteria and definition of "mentally ill," can be involuntarily committed for treatment. However, for those patients who have expressed suicidal ideation, but have declined voluntary hospitalization and do not meet criteria for commitment, the course of care is less certain. In these cases, clinicians must use their professional judgment as to the most appropriate course of action given their knowledge of the patient and circumstances of the case *at the time*. The clinicians we interviewed described this scenario as a "balancing act" where staff must continue efforts to engage the patient in treatment but not be so aggressive as to alienate him or her.

One of the single most important components in successful psychotherapy is the therapeutic relationship, including comfort and trust, between the patient and the clinician. In this case, the patient saw therapist A for an initial evaluation, was

transferred to and later expressed dissatisfaction with therapist B, and was ultimately reassigned to therapist C.

Therapist C saw the patient for therapy twice in early winter 2014. Therapist C described the patient as depressed, initially hesitant to "share" [her thoughts and feelings], and "skittish" about treatment. During the second early winter session, the patient verbalized her feelings about suicide and how it would bring her peace to go to heaven, and she did not view suicide as a sin. Therapist C documented, "Provider gently challenged her beliefs in an attempt not to totally alienate her." While therapist C did send a consult request to the MHAT after this visit, she (therapist C) told us that the patient was non-committal about the referral. Therapist C also told us that she discussed the possibility of hospitalization with the patient; however, the patient declined because she needed to take care of her children.

On SSP day 26, therapist C made phone contact with the patient to inquire about the missed MHAT appointments. Therapist C documented that the patient said, "I don't need to come back to see you—you've helped me." While the patient was still making disturbing statements, she again denied having a plan or intent. Therapist C did not think that an involuntary commitment could be sustained.

Clinicians we interviewed expressed concerns about the patient's psychological state and mindset and admitted that they thought about "initiating a 1013"; however, they were reluctant to do this for several reasons. Specifically, the patient repeatedly denied having a current plan or intent, thus bypassing the "imminent risk" criteria that would have supported a 1013 emergency detention. From these clinicians' points of view, having the patient detained against her will for evaluation (that would probably not result in hospitalization) would only serve to alienate her from treatment. Further, the Division of Family and Children Services would remove her children from the home, as there would be no adult caregiver during the time that she was hospitalized. Clinical staff were concerned that, with this act, they would cause more stress to the patient, she would no longer trust them, and she would isolate further from any efforts to engage her in therapeutic services.

When the patient declined another session with therapist C during the HUD-VASH home visit on SSP day 63, she provided a reasonable explanation for the declination—that it [the previous session] "helped me get things off my chest and put them in perspective. I don't want to harm myself or anyone else." Taken at face-value, this statement reflects a mental awareness and understanding of her situation, which is an encouraging sign and indicative of assimilation and healing.

The clinical staff were faced with a difficult ethical dilemma,[15] and despite their conscientious and repeated efforts to engage and support the patient, the patient chose not to participate in MH treatment or seek an alternate resolution to her suicidality. Although the patient declined formal MH services, she was still engaged with the

[15] The ethical dilemma involved the principles of autonomy (the patient's right to refuse treatment) and paternalism/beneficence (the clinician's duty to look out for the patient's best interests).

HUD-VASH program and would continue to receive case management and support services through the HUD-VASH social worker for the foreseeable future.

Deficiencies in Complying with the High-Risk Protocol

During the second early winter visit, therapist C assessed the patient to be at chronic risk for suicide and documented, "Veteran recently diagnosed with [potentially life-altering diagnosis] and cannot identify any mitigating factors against suicide including her children. She does not currently have a plan or intent but does have chronic thoughts of suicide with feeling of peace regarding that decision…I recommend that this veteran be considered for the high risk protocol." Therapist C signed the progress note, copied the note to the SPC and completed a SSP with the patient at the time of this visit.

Therapist C's progress note should have prompted initiation of the high risk protocol. We found several deficiencies with this process, as follows:

- **The SPC should review the case and activate a PRF within 3 days of becoming aware of an event.** The SPC did not acknowledge the note or activate the PRF until SSP day 23.

- **After activation of a PRF, an initial visit is required within 7 days with subsequent weekly contacts (which may be via telephone based on the clinical judgment of the provider) for the first 30 days.** The facility met the intent of the initial visit within 7 days, as the patient was scheduled for an MHAT appointment within the time frame; however, she did not attend this appointment and when contacted later that day, declined future MH services.

  The SPCM attempted to contact the patient via phone on SSP day 33, 41, and 50. Staff told us that they did not increase the frequency of calls or request a "welfare check" because they wanted to be a supportive presence, not overbearing (which they thought would alienate the patient). There was no apparent effort by the SPCM to contact the patient the week of SSP days 53–59. We also found no evidence that a HUD-VASH visit or contact was requested or attempted between SSP days 25–58, even though the HUD-VASH social worker had established a rapport with the patient in the preceding year.

- **The PRF should be reviewed in 30 days.** There is no documented evidence that the PRF was re-evaluated on or around the 30 day timeframe as required. At that time, the patient had not had contact with any clinical staff person for 4 weeks.

The patient died more than 2 months after she was referred for placement on the high risk protocol and 1 week after a face-to-face contact with a clinician. The timing suggests that, while facility staff did not comply with guidelines for PRF placement or conduct all of the follow-up contacts, these deficiencies likely did not have a direct impact on the outcome in this case.

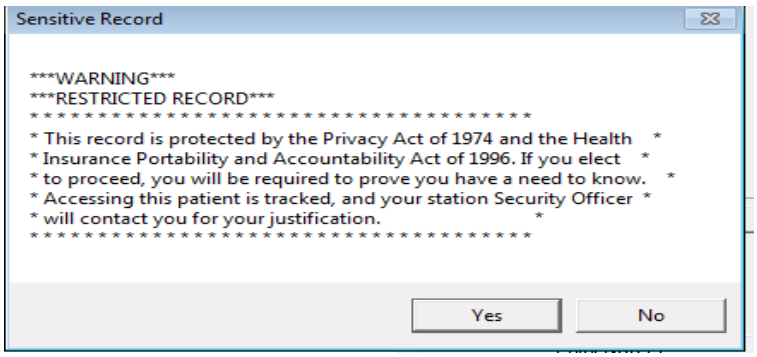
Issue 3: Improper Disclosure of Confidential Patient Information

The Health Insurance Portability and Accountability Act (HIPAA) defines protected health information as information gathered by providers or health care entities to treat a patient or pay for care that includes a subset of data that could be used to identify the individual (also known as individually identifiable information).[16] The HIPPA Privacy Rule protects all individually identifiable health information held or transmitted by a covered entity in any form or media from disclosure absent an exemption. Individually identifiable health information includes patients' medical or MH condition(s), as well as many common identifiers such as name, address, birth date, and Social Security Number (SSN).

Every VA employee with access to patient health records in any medium is responsible for the proper use, disclosure, and handling of the patient health records. VA employees are also accountable for safeguarding patient confidentiality and privacy, and failure to do so will result in administrative action, up to and including, termination or other legal adverse action.[17]

We confirmed that an individual with access to the patient's EHR improperly and illegally disclosed protected health information outside VA. It appears that this person used a cellphone camera to take "screenshots" that included the patient's name, SSN, progress note titles, and other medical information. However, OIG investigators were unable to determine who accessed the patient's EHR during the 3-day interval between the time the facility became aware of the death and the time the patient's private health information was displayed via local media.

Some specific health record types are deemed sensitive and may be flagged in facility computerized record repositories. Sensitive records may include those of veteran-employees, veteran-volunteers, or patients involved in tort claims.[18] When a record is flagged as "sensitive," the following screen appears when someone attempts to access the EHR.



[16] 45 CFR §160.103.

[17] VHA Directive 1605, *VHA Privacy Program,* April 11, 2012; VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[18] We have also seen VHA medical facilities place sensitive record flags on EHRs when the case is high-profile or there are other clinical or administrative concerns.

An internal audit mechanism permits supervisors to identify who accessed sensitive records and whether those individuals had a legitimate need to do so. In this case, however, the patient's EHR was not flagged as sensitive for approximately 3 days. Therefore, with the current lack of tracking functionality for non-sensitive records, we were unable to ascertain the wrongdoer. This lack of audit functionality places patients' EHRs at risk for improper use and disclosure because managers do not have the necessary tools to identify wrongdoers and, consequently, cannot enforce the rules and statutes.

Conclusions

In general, we determined that facility staff provided, or attempted to provide, appropriate MH treatment and psychosocial support services for this patient. The patient initially presented to the facility with housing-related concerns which were promptly addressed. The patient was engaged in HUD-VASH services and was hopeful and future-oriented. In summer 2014, the patient was diagnosed with a chronic medical condition. Facility staff provided appropriate counseling and support services and referred her for additional therapy, and although the patient was struggling with this new diagnosis, she was reluctant to fully engage in therapy. Recognizing the seriousness of the patient's mental state, a therapist consulted the MHAT; however, the patient missed two appointments and, when contacted via telephone after the second missed appointment, exercised her right to refuse treatment and declined further MH services. While we noted several procedural deficiencies related to appointment scheduling and follow-up, we believe staff made reasonable efforts to provide MH treatment and follow-up.

We found that there was a substantial delay in flagging the patient's record. Twenty-three days elapsed between the clinician's recommendation for a flag and actual activation in the patient's record. We also determined that efforts to contact the patient after the high risk flag was placed did not strictly comply with protocol requirements. Despite this, we believe that clinical staff used reasoned judgment in their efforts to provide care. The clinical staff were faced with a difficult ethical dilemma, and despite their conscientious and repeated efforts to engage and support the patient, the patient chose not to participate in MH treatment or seek an alternate resolution to her suicidality.

The patient died more than 2 months after she was referred for placement on the high risk protocol, more than a month after the missed MHAT appointments, and a week after a face-to-face contact with a clinician. The timing suggests that, while facility staff did not consistently comply with some requirements, it is unlikely that these deficiencies had a direct impact on the outcome in this case.

We confirmed that an individual with access to the patient's EHR improperly and illegally disclosed protected health information. This patient's record was designated as "non-sensitive" at the time of the disclosure, and VHA currently lacks the ability to audit access to these records. This lack of audit functionality places patients' EHRs at risk for

improper use and disclosure because managers do not have the necessary tools to identify wrongdoers and, consequently, cannot enforce the rules and statutes.

OIG investigators have been unable to determine who accessed the patient's EHR and, therefore, could have been responsible for the improper disclosure.

Recommendations

1. We recommended that the Interim Under Secretary for Health evaluate options that would allow managers to identify individuals who access non-sensitive patient electronic health records.

2. We recommended that the Facility Director ensure that Mental Health Assessment Team appointments are scheduled within required timeframes, that patients are properly notified of those appointments, and that appropriate follow-up is documented when patients miss Mental Health Assessment Team appointments.

3. We recommended that the Facility Director ensure that Housing and Urban Development-VA Supportive Housing program contacts or home visits occur as outlined in the patient's treatment plan.

4. We recommended that the Facility Director ensure that patient record flags identifying patients at risk for suicide are placed promptly and that required high-risk protocols, including weekly contacts, are implemented and documented accordingly.

Appendix A

Interim Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: April 16, 2015

From: Interim Under Secretary for Health (10)

Subj: **Draft Report**—Healthcare Inspection – Evaluation of a Patient's Care and Disclosure of Protected Information, Atlanta VA Medical Center, Decatur, Georgia (VAIQ 7590326)

To: Assistant Inspector General for Healthcare Inspections

1. Thank you for the opportunity to review the OIG draft report of the Healthcare Inspection Evaluation of a Patient's Care and Disclosure of Protected Information at the Atlanta VA Medical Center in Decatur, Georgia.

2. I concur with the findings and recommendations in the draft report and provide comments in response to recommendation 1. Comments in response to recommendations 2, 3, and 4 will be provided to OIG by the facility Director.

3. Please direct questions or concerns regarding the content of this memorandum to Karen Rasmussen, MD, Director, Management Review Service (10AR) at VHA 10ARMRS2@va.gov.

Carolyn M. Clancy, MD

Attachment

cc Director, Atlanta Office of Healthcare Inspections (54AT)

Comments to OIG's Report

The following Interim Under Secretary for Health's comments are submitted in response to the recommendation in the OIG report:

OIG Recommendation

Recommendation 1. We recommended that the Interim Under Secretary for Health evaluate options that would allow managers to identify individuals who access non-sensitive patient electronic health records.

Concur **Target date for completion:** April 2015

The Veterans Health Administration (VHA) has and continues to elevate this issue. VHA Office of Informatics and Analytics (OIA) recently worked with the Office of Information Technology (OI&T) on the feasibility of the VistA system logging access to all patient records. Historically, VistA system risk analyses and assessments performed for the audit of VistA Record Access included the impact of audit data collection for patient record access to the VistA environment. One VA hospital could see approximately 125,000 unique patient visits per year. Each patient is touched by approximately eight different VistA users (clinical and administrative), on average 13 times per year. Per OI&T this would generate 3,000,000 log entries just for outpatient visits at one facility. The number of log entries for all VHA facilities could exceed 753,888,000 based just on outpatient and inpatient visits. This estimate does not include log entries from repeat visits, patient billing, or other reasons, that might also trigger an audit event.

This volume of audit activity spread across the system can impose an adverse impact on system resources, resulting in system degradation or outages due to the immense volume of data collected. Such high volume activity exploits system limitations with storage, system resources (central processing unit, memory, and user load), journaling, contingency system relying on real-time production feeds (VistA Read Only, Bar Code Medication Administration Backup). These factors all present a patient care/safety issue due to system performance degradation and extended periods of system unavailability.

Based on this risk analysis, VA audits those records designated as sensitive. These include, but are not limited to:

a. VA Veteran employee patient health records;
b. Regularly scheduled Veteran volunteers;
c. Individuals engaged in the presentation of claims before VA, including representatives of Veterans' organizations, or cooperating public or private agencies, or Administrative Tort Claims;
d. Records involved in Administrative Tort Claim activities; and
e. Other health records per management decision.

To mitigate the risk of inappropriate access to all records, VA has implemented the following compensating controls:

a. All users must complete Information Security and Privacy Awareness training;
b. All users must sign the VA Rules of Behavior;
c. All users complete VHA Privacy and HIPAA Focused training;
d. Access is controlled by VistA menu options and security keys;
e. All users are trained on the minimum necessary policy as well as knowing their functional category as outlined in VHA Handbook 1605.02; and
f. Supervisors utilize the employee's functional category for the assignment of VistA menu and security.

Beyond the creation of an access log for all non-sensitive records within VistA/Computerized Patient Record System (CPRS), which as discussed above is not feasible, there is only one option for identifying unauthorized access to electronic health records and it is employed within VHA today. The option is complaint based identification of unauthorized access. When a Veteran or employee complains about alleged unauthorized access, that complaint is reviewed and examined by the Privacy Officer and the alleged employee wrongdoer interviewed. If it cannot be determined that the access was appropriate, then per policy the unauthorized access occurred and appropriate administrative actions taken.

VHA has evaluated options that would allow managers to identify individuals who access non-sensitive electronic health records and believes a variety of safety provisions have been instituted to prevent and/or discourage inappropriate and unauthorized access to health records.

Status: Completed

Appendix B

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: April 13, 2015

From: Interim Director, VA Southeast Network (10N7)

Subj: **Draft Report**—Healthcare Inspection – Evaluation of a Patient's Care and Disclosure of Protected Information, Atlanta VA Medical Center, Decatur, GA

To: Atlanta Office of Healthcare Inspections (54AT)
Director, Management Review Service (VHA 10AT MRS OIG Hotline)

1. I have reviewed the Veterans Affairs (VA) Office of Inspector General Office of Healthcare Inspections draft report on the Evaluation of a Patient's Care and Disclosure of Protected Information at the Atlanta VA Medical Center, Decatur, GA.

2. I concur with the attached draft report and recommendations.

3. Should you have additional questions, please contact Heather Miller, Chief, Quality Management Officer, at (404)321-6111, ext. 2108, or by e-mail at heather.miller6@va.gov.

Thomas C. Smith III, FACHE

Appendix C

Facility Director Comments

Department of
Veterans Affairs

Memorandum

Date: April 13, 2015

From: Director, Atlanta VA Medical Center (508/00)

Subj: **Draft Report**—Healthcare Inspection – Evaluation of a Patient's Care and Disclosure of Protected Information, Atlanta VA Medical Center, Decatur, Georgia

To: Director, VA Southeast Network (10N7)

1. I have reviewed the Veterans Affairs (VA) Office of Inspector General Office of Healthcare Inspections draft report on the Evaluation of a Patient's Care and Disclosure of Protected Information at the Atlanta VA Medical Center, Decatur, GA.

2. I concur with the draft report and recommendations. Attached are corrective action plans.

3. Should you have additional questions, please contact Heather Miller, Chief, Quality Management, at (404) 321-6111 ext 2108, or by e-mail at heather.miller6@va.gov.

Leslie Wiggins

Comments to OIG's Report

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

OIG Recommendations

Recommendation 2. We recommended that the Facility Director ensure that Mental Health Assessment Team appointments are scheduled within required timeframes, that patients are properly notified of those appointments, and that appropriate follow-up is documented when patients miss Mental Health Assessment Team appointments.

Target date for completion: August 15, 2015

Facility response: Concur

the Veteran was scheduled in the Mental Health Assessment Team (MHAT) Special Group Access clinic. Per policy, No Shows to the Special Group Access Clinic were not outreached by phone for non-High Risk Veterans. After the Veteran was flagged as High Risk, outreach attempts for Veteran did occur.

Based on review of this case, the MHAT Special Group Access clinic will be discontinued on April 27, 2015. As a result, when the Veteran has not been reached after the required number of phone call attempts to schedule an assessment appointment, the Veteran will no longer be automatically scheduled in the Special Group Access Clinic and notified via letter. Instead, schedulers will send a letter to the Veteran requesting a call to schedule an appointment. If the Veteran is on the High Risk Protocol, a certified letter will be sent. All Veterans will be scheduled in a specific individual provider clinic in lieu of the Special Group Access Clinic and the individual appointment No Show Policy will be followed.

The MHAT Standard Operating Procedures (SOPs) are under revision to include current Atlanta VA practices for Sub-Specialty Consults regarding scheduling. The clinically indicated date and Veteran appointment date will be included to assure appointments are scheduled within requested timeframe. Completion of monthly compliance audits for MHAT scheduling will begin on May 1, 2015.

Recommendation 3. We recommended that the Facility Director ensure that Housing and Urban Development-VA Supportive Housing program contacts or home visits occur as outlined in the patient's treatment plan.

Target date for completion: July 15, 2015

Facility response: Concur

The Housing and Urban Development-VA Supportive Housing (HUD VASH) program completed a reorientation of all HUD VASH staff on January 30, 2015. All staff were re-educated on program Standard Operating Procedure(s) (SOP) and signed

acknowledging their receipt of the SOPs. On February 1, 2015, SOPs for HealthCare for Homeless Veterans (HCHV), including HUD VASH were revised. The HUD VASH staff work as members who are organized into five interdisciplinary housing first teams. Veteran participants are now followed by an entire team instead of one provider. This model allows other team members to make home visits and thus, provide gap coverage. Each team is assigned a Licensed Clinical Social Worker (LCSW) Supervisor who completes random chart audits. Chart audits include verification of treatment plans and ensuring visits coincide with schedule indicated on treatment plan. Visit schedules cannot be reduced without a completed chart review from a Supervisor. Review includes verification of treatment plan, documentation of scheduled visits, and suicide assessments as outlined in the SOP and/or High Risk Protocol.

Recommendation 4. We recommended that the Facility Director ensure that patient record flags identifying patients at risk for suicide are placed promptly, and that required high risk protocols, including weekly contacts, are implemented and documented accordingly.

Target date for completion: September 30, 2015

Facility response: Concur

The Veteran was referred to the Suicide Prevention (SP) team to review for placement on the High Risk (HR) protocol as a precautionary exception. When a Veteran meets criteria requiring they be followed on the HR protocol, there is a referral process within the electronic health record system to forward the note to the Suicide Prevention (SP) team for review. In November 2014, the Electronic Health Record (EHR) template for placement on High Risk protocol was not designed to include Veterans considered at increased risk in the absence of suicidal behavior, as was the circumstance with this Veteran, and therefore the automated process for referral did not occur. The Atlanta VA Medical Center (VAMC) revised the referral process to include all SP program referrals placed through the same EHR template, allowing standardization of how reviews, precautionary or otherwise, are completed. The Atlanta VAMC Mental Health Service Line will add chart audits for Veterans followed on the high risk protocol to the performance improvement plans of all Mental Health units.

Appendix D

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Appendix E

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