Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-02627-386

Healthcare Inspection

Alleged Poor Mental Health Care Resulting in a Patient Death at VA Central Iowa Health Care System Des Moines, Iowa

June 10, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
Web site: www.va.gov/oig

Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Senator Joni Ernst to assess the merit of allegations regarding poor mental health care resulting in a patient's death at the VA Central Iowa Health Care System (VACIHCS), Des Moines, IA.

We did not substantiate the allegation that the patient had been denied long term mental health services at the time of a winter 2015 Emergency Department visit. We found no documentation that the patient had requested these services or that his clinical condition would have warranted admission at the time of his presentation. We also did not substantiate that the patient received poor quality of care through the Emergency Department but concluded that VACIHCS did not comply with Veterans Health Administration (VHA) policy regarding case management services. We reviewed mental health programs at VACIHCS from the perspective of how they interfaced to provide care for this patient. The facility appeared to be substantially in compliance with its policy regarding time frames for consult completion. The patient did not experience a delay in obtaining mental health services, as he had not requested these services in the 2 years prior to his winter 2015 Emergency Department visit. We did not identify any barriers to the patient accessing other services available at VACIHCS, such as the post-traumatic stress disorder (PTSD) clinic.

We also examined whether or not this patient should have been contacted by the local recovery coordinator when he failed to follow up at VACIHCS for more than 2 years. We determined that the patient was not contacted by the local recovery coordinator because his name did not appear on the list of seriously mentally ill patients. This is because, for purposes of recovery coordinator activities, seriously mentally ill patients are considered to be those patients with a diagnosis of schizophrenia, bipolar disorder, or psychoses. A VHA Office of Medical Inspector report demonstrated reduced mortality among patients with diagnoses of schizophrenia or bipolar disorder who were contacted by VHA and returned for follow-up care after protracted absences. This patient had anxiety, depression, and PTSD but had never been diagnosed with schizophrenia, bipolar disorder, or a psychoses that would have triggered contact from the local recovery coordinator.

We recommended that: (1) the Interim Under Secretary for Health determine the feasibility and advisability of expanding recovery coordination activities to patients with PTSD and (2) the Veterans Integrated Service Network Director ensure that the VACIHCS Director provides all levels of case management services in accordance with VHA policy.

Comments

The Interim Under Secretary for Health, the Acting Veterans Integrated Service Network and Acting Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A, B, and C, pages 12–16 for the Interim Under Secretary and Acting Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Senator Joni Ernst to assess the merit of allegations regarding poor mental health care resulting in a patient's death at the VA Central Iowa Health Care System (VACIHCS), Des Moines, IA. Our inspection centered on the Des Moines VA Medical Center where the patient received his health care.

Background

VACIHCS provides inpatient and outpatient services to patients from more than 40 counties in central Iowa and northern Missouri. It is part of Veterans Integrated Service Network (VISN) 23, a regional network of VA hospitals and clinics. Health care services provided include inpatient units in Des Moines and community based outpatient clinics (CBOCs) in Knoxville, Marshalltown, Mason City, Fort Dodge, and Carroll, Iowa. From October 1, 2013 through November 30, 2014, VACIHCS serviced 18,773 unique veterans making a total of 61,184 outpatient visits. This same patient population received 2,837 hospital bed days of care.

VACHIS provides medical, surgical, psychiatric and substance abuse care, rehabilitative services, and long term care. It also operates an Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) transition clinic, which screened 306 new patients for primary care and mental health needs from October 2013 through November 2014. Between 2011 and 2014, the number of OEF/OIF veterans receiving services through VACIHCS increased from 1,040 to 1,334 veterans. VACIHCS employs a full-time OEF/OIF program manager who is responsible for coordinating outreach efforts. Currently, OEF/OIF veterans constitute 20 percent of all patients receiving mental health services through VACIHCS.

Inpatient Mental Health Services

VACIHCS maintains 10 beds for acute psychiatric care and also provides a behavioral recovery unit for patients with skilled nursing care needs whose disruptive behaviors make them inappropriate for the community living center (nursing home). In addition, VACIHCS operates a 60-bed mental health residential rehabilitation treatment program (MHRRTP) that provides residential treatment for patients with post-traumatic stress disorder (PTSD), substance abuse issues, homelessness, and other mental health conditions. Lengths of stay in this unit usually range from 56 days to 120 days, with longer stays being associated with housing and employment needs.

Outpatient Mental Health Treatment Programs

VACIHCS also operates several outpatient mental health treatment programs including Mental Health Intensive Case Management (MHICM), Psychosocial Residential Rehabilitation Treatment Program, Therapeutic and Supported Employment Services (TSES), Outreach, Employment and Supportive Services to Homeless Veterans, and other ancillary services for patients with mental health conditions. The CBOCs also

provide outpatient mental health services in rural areas, to include medication management, group and individual therapy, and telemental health services. In fiscal year (FY) 2014, CBOCs provided 105,839 outpatient visits for mental health services.

Suicide Prevention Program

VACIHCS also maintains a suicide prevention program. From October 1, 2014 through December 31, 2014, VACIHCS identified 26 patients as being at high risk for suicide and reported 12 suicide attempts during this time frame.

Allegation and Congressional Request. Senator Joni Ernst wrote a letter to the OIG regarding the care a patient received prior to his death. Specifically, the Senator requested a review of:

- An allegation that a patient received poor care at VACIHCS because he had requested long term mental health treatment services while in the Emergency Department (ED) and was instead provided with medication and discharged.
- The quality of the treatment provided to the patient at VACIHCS.
- Mental health treatment programs available at VACIHCS.

We limited our review of VACIHCS mental health treatment and case management programs to wait times and selected programs providing services relevant to this patient's medical history.

Scope and Methodology

We conducted an on-site review in early 2015. We interviewed the acting VACIHCS Director, the Chief of Staff, the patient's health care providers, the OEF/OIF coordinator, the mental health program manager, patient advocates, a patient safety official, and individuals involved in the process of scheduling mental health consults. We also contacted a friend of the patient to obtain more information regarding his state of mind immediately prior to his death.

We reviewed relevant national and VACIHCS policies and procedures, reports regarding the timeliness of mental health consult completion, data from the Care Management Tracking and Reporting Application (CMTRA),[1] personnel data, recovery care coordinator patient lists, and the patient's electronic health record (EHR).

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.

[1]An electronic database that provides the OEF/OIF Care Management team with a means to identify and track OEF/OIF service members and Veterans.

Case Summary

The patient was a veteran who received comprehensive and regular mental health services from VACIHCS for various conditions including depression, anxiety, and PTSD between 2009 and 2011. His medical history included previous suicide attempts and admissions to mental health facilities.

During the 2009–2011 time frame, the patient also received case management services at VACIHCS for mental health conditions. In 2010, the patient met with his case manager, who helped him schedule mental health appointments. Following this meeting, the patient received regular psychotherapy over the next 2 years. In spring 2011, the patient told his OEF/OIF case manager that he was attending mental health appointments and doing well. Following several missed appointments where the patient cancelled or did not call (no show) in summer and fall of 2011, the patient's EHR documents that the OEF/OIF coordinator attempted to call the patient in spring 2012 and then mailed the patient a letter. While previous letters had asked the patient to call the OEF/OIF case manager, this letter stated: "If I do not hear from you, I will assume that you are doing well and no longer need care management services from the OEF/OIF/OND Team." The patient did not contact VACIHCS staff again until summer 2014 and did not speak with an OEF/OIF case manager before his death.

In summer 2014, he presented to VACIHCS ED with complaints of cold and flu-like symptoms. ED staff screened the patient for depression and did not identify signs or symptoms of depression at that time. He was discharged with a prescription for antibiotics and throat lozenges.

He saw a primary care physician (PCP) for follow-up shortly after his ED visit. The physician did not record a depression screening at that visit but reported that the patient's mood and affect were normal. The PCP ordered antibiotics to treat the patient.

In mid-winter 2015, approximately 6 months after the follow-up visit to his PCP, VACIHCS staff received a call from the patient's place of employment. VACIHCS staff documented in the EHR that the patient's employer had not heard from the patient for 2 days and that none of the patient's emergency contacts could locate him. The patient's employer stated he/she would be filing a missing person's report. Nine days later, the patient's employer called VACIHCS to report that the patient had been located.

A friend of the patient told us that he began staying at her home about the time the employer had located him. VACIHCS staff called the patient and left a message asking him to call to schedule an appointment. Three days later, the patient walked into the ED, reporting increased anxiety due to a number of stressful situations in his personal life. According to the patient's friend, he gave her his house and work keys in anticipation of a long stay when he left to go to the VACIHCS ED. However, the EHR documents stated that the patient only asked to be re-started on his anti-anxiety and anti-depressant medication. The ED physician re-started the medications. The patient denied suicidal ideation or intent. The ED physician requested a mental health

consultation, informed the patient that someone from the mental health service would probably contact him the next day, and discharged him home. The patient picked up the prescribed medications from the pharmacy on the same day.

The friend of the patient told us that he returned home and took the medications that evening. The friend also reported that the patient slept well and seemed to be doing well the next day. Two days after the ED visit, the patient left his friend's home. She did not have further contact with him. The patient was found dead 3 days after leaving the friend's home.

The EHR showed no evidence that staff took action on the mental health consult request that the ED physician ordered prior to the patient's death. We could not find in the EHR documented attempts by VACIHCS staff to contact the patient between the day of the ED visit and the day VACIHCS staff documented that the patient had died.

Inspection Results

Issue 1: Alleged Poor Access to Mental Health Services After a VACIHCS ED Visit

We did not substantiate that the patient requested long term mental health care and was instead discharged from VACIHCS ED with medication. The EHR documents that the patient came to the ED in winter 2015 requesting medications, not that he requested long term mental health care. ED staff stated in interviews that the patient had requested only medication. The staff documented in the EHR that the patient denied suicidal thoughts. While the patient's friend told us the patient was anticipating a long stay when he left her house to go to the VACIHCS ED, the friend admitted that the patient may have told the ED staff something different than he told her. The ED physician provided the requested medications and placed a request for a routine mental health consult (psychotherapy) in the EHR.

VACIHCS' 2011 consult policy requires direct contact between the ordering provider and the consulting service for inpatient consults or when the consult is classified as requiring more urgent action than routine. Otherwise, the service consulted is responsible for ensuring timely follow-up on a consult.[2] The policy states:

> *The receiving service will act on the consult within seven (7) work days. Each consult service will set up internal processes to triage incoming consults, schedule the patient to be seen, and send notice (acknowledgement and the date patient scheduled) to the originator according to time frames specified in this policy.*

[2] VACIHCS Policy, Patient Care Programs – 31. *Consultations*, April 2011.

The local policy (which is consistent with VHA's consult policy[3]) also contains a statement that the timeline for a response to a routine outpatient consult request is preferably within 7 days, but no later than 30 days from the date of the request.

No VACIHCS policy or written document describes how the outpatient mental health clinic processes consult requests. However, mental health clinic staff told us that consult requests appear on a list that is printed off daily by medical scheduling assistants (MSAs). For routine requests, mental health clinic staff said the MSAs contact the patient and offer them the next available appointment with a social worker who evaluates the patient and determines in collaboration with the patient what services are needed. If the consult requests that the patient be seen sooner than a provider has an appointment available, scheduling staff told us that they contact a nurse who asks providers to accommodate the patient with an overbooking or outside their usual clinic hours.

In this instance, a mental health consult was placed on the day of the ED visit, and the patient died 5 days later, before the 7 workday time period for acting on the consult specified under VACIHCS' consult policy had expired. The ED physician designated the consult as routine, and the EHR does not contain evidence that the patient's clinical condition warranted a more urgent consult. In an email to his supervisor, an MSA documented that he accessed the patient's record to address the pending consult a few days after the patient died and discovered a note that recorded the death of the patient. He closed the record without further action.

Because there is no documentation in the EHR that the patient requested mental health services from the ED staff other than medications and because the EHR does not contain evidence that the consult request should have been designated as urgent or emergent considering the patient's mental state at the time, we did not substantiate that the patient received poor access to care through the ED 5 days before he died.

Issue 2: Alleged Poor Quality of Mental Health Care

We did not substantiate that the patient received poor quality of care from ED staff who provided care to the patient in winter 2015, 5 days before the patient's death. However, we determined that case management services offered through VACIHCS did not comply with VHA policy.

When the ED physician saw the patient in winter 2015, progress notes in the EHR, as well as statements from interviews, indicated that the patient was neat, clean, and in no immediate distress. Progress notes also specifically stated that the patient asked to be restarted on his medication. He denied thoughts of suicide. The ED physician started him back on his anti-anxiety and anti-depressant medications and placed a consult request specifically for psychotherapy, rather than for general mental health services. The ED physician requested a routine consult because the patient's need for mental

[3] VHA Directive, 2008-56. *VHA Consult Policy*. October, 2008. This policy was due for renewal in 2013 but has not yet been updated.

health services did not appear to be urgent at that time. The consult request was placed through the EHR and appeared on a list of pending consults in the mental health clinic and was processed in accordance with VACIHCS policy, as described above.

However, we identified opportunities for improvement in the case management services available through the OEF/OIF program at VACIHCS.

VHA Handbook 1010.01 describes the levels of case management services available to OEF/OIF patients, depending on their needs.[4] The VACIHCS OEF/OIF program manager first ensures that all patients are screened to determine the need for case management services. Following this screening, patients are assigned to an OEF/OIF case manager. Depending on the individual patient's needs, he/she may receive either intensive, progressive, supportive, or lifetime case management services. These levels of case management dictate how often a case manager is expected to contact the patient. Intensive case management requires at least weekly contacts, progressive requires monthly contacts, supportive mandates quarterly contacts, and lifetime case management requires at least one annual contact.

Even at the lowest intensity—lifetime case management—case managers are responsible for assessing long-term patient care needs and referring to other health care personnel as appropriate to meet identified patient needs. Case managers are also responsible for ensuring that an annual psychosocial assessment is completed, to include engagement of appropriate staff in addressing the patient's and family's psychosocial needs.[5]

In particular, case managers are expected to assist patients through difficult transitions, to include a "change in [a] patient's psychosocial status (e.g. care-giver stress, marital status change, decline in support system, death of a family member, loss of job, new employment, substance abuse, etc.)."[6]

The OEF/OIF program manager informed us that the patient we reviewed had been discontinued from case management services. She stated that, due to an influx of returning OEF/OIF veterans in 2011, VISN 23 changed its policy on case management. She clarified that her understanding of the VISN change in policy was based on a conference call, not on a written document. Beginning in 2012, the OEF/OIF program manager told us that case managers contacted all patients who were receiving contacts less often than quarterly (lifetime case management services) and discontinued case management services if they reported doing well or moved them to quarterly contacts (supportive case management) if they were not doing well. They also discontinued services if they were unable to reach the patient. The patient's OEF/OIF case manager made a single phone call and sent one letter in an attempt to reach the patient in 2012.

[4] VHA Handbook 1010.01, *Case Management of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*, October 9, 2009. This Handbook was scheduled for recertification by October 2014 but has not yet been updated.
[5] VHA Handbook 1010.01.
[6] VHA Handbook 1010.01.

Following this unsuccessful attempt, the EHR does not contain documentation that the patient received further case management services.

In eliminating annual or semi-annual case management services, it appears VACIHCS staff affirmatively decided to no longer offer lifetime case management services as described in VHA Handbook 1010.01. While case management services can be discontinued on an individual basis if patients no longer require them,[7] this patient's case management services stopped after a single attempt to contact him by phone and a letter that instructed him to call or the case manager would assume that the patient no longer required case management services. This does not reflect a determination as to whether or not this individual patient needed additional services. Such a determination should have been made, considering the patient's history of suicide attempts and mental health hospitalizations.

Rather, it is consistent with the OEF/OIF program manager's statements that discontinuing all patients receiving services less often than quarterly, including those that could not be reached by the case manager, or moving them to a quarterly schedule of contacts, was a systematic decision to eliminate lifetime case management services. VISN staff denied that any written policy existed which would have altered the frequency of case management services as dictated by VHA policy, and could not confirm any phone calls that suggested this change.

Issue 3: Review of Mental Health Programs Available at VACIHCS

A review of all aspects of the mental health programs available at VACIHCS is beyond the scope of this report. Instead, we examined general wait times for mental health services, as discussed above, as well as the way in which available mental health and case management programs interfaced to provide care to the patient who is the subject of this hotline complaint. Because the patient had not received outreach from the local recovery coordinator or treatment through the PTSD clinic despite his history of previous suicide attempts and inpatient hospitalizations, we then examined what barriers existed, if any, to his ability to access these programs.

VACIHCS Mental Health Consult Delays and Wait Times

To determine if VACIHCS had systemic barriers to accessing mental health services, we looked at mental health consult delays. In FY 2014, the facility informed us that 61.27 percent of mental health consults were completed within 45 days; in FY 2015, 64.84 percent of consults were completed within 45 days. VACIHS policy requires that consults be completed within 30 days of the date the consult was created in the EHR.

The facility subsequently informed us that they had supplied us with incorrect data. The initial percentage completion rates included consults that had been canceled, rather than measuring the time frames for completed consults. Excluding canceled consults, the facility completed 87.5 percent of FY 2014 consults within 45 days and 97.1 percent

[7] VHA Handbook 1010.01.

of FY 2015 consults. The facility canceled 29.9 percent of all mental health consults in FY 2014 and 23.6 percent of mental health consults in FY 2015.

To exclude the possibility that these consults were being canceled and then rescheduled for purposes of ensuring timely consult completion, we requested data from the facility identifying the reason for these cancellations. The facility reviewed 524 consult cancellations for FY 2014 and 169 for FY 2015. The reasons for cancellation were grouped into five categories: patient cancelled; unable to contact the patient; cancelled by clinic; patient 'no show'; and, other (such as duplicate consult, scheduling error, discontinued by the provider on the same day, and transition from inpatient to outpatient status). In FY 2014, 17.37 percent and in FY 2015 11.83 percent of consults were canceled and then resubmitted to the same service. The majority of consult cancellations, however, resulted from patient cancellations.

Therefore, we determined that the facility was substantially in compliance with VACIHS policy regarding completion of consults. While the facility had a high rate of consult cancellations, the most common reason documented for those cancellations was cancellation by patient.

We also determined that the patient reviewed in this report did not experience a prolonged wait time for a mental health appointment. VHA policy requires that all new patients requesting or referred to mental health services receive an evaluation within 24 hours and a more comprehensive diagnostic and treatment planning evaluation within 14 days.[8] The initial 24-hour evaluation does not have to be conducted by a mental health professional; any licensed independent practitioner can perform this evaluation. For established patients, waiting times must be less than 30 days from the desired date of the appointment.

We found no evidence that the patient we reviewed in this report experienced wait times in excess of those permitted under VHA policy. The EHR does not document that the patient requested an appointment with mental health other than at the ED visit in winter 2015. The ED physician performed the initial evaluation as described under VHA policy. Even if the patient had been considered a new patient for purposes of this policy because of his protracted absence, VACIHCS had 14 days to schedule a follow-up evaluation for this patient. That time period had not lapsed before the patient's death.

Local Recovery Coordination

Between 2009 and 2011, this patient received comprehensive and regular mental health services from VACIHCS. However, from 2012 to the patient's return to the VACIHCS ED in summer 2014, the patient did not receive services, nor did VACIHCS staff contact the patient. We therefore examined what VHA policy requires facilities to do when a patient who has a significant mental health history is lost to follow-up.

[8] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008. This Handbook was scheduled for recertification by 2013 but has not yet been updated.

VHA Directive 2012-002 states:

> *It is VHA policy that Veterans with SMI [serious mental illness] who have been lost to follow-up care must be identified on an ongoing basis; that the local treating facility must assess these Veterans' need for continued treatment; and the local treating facility must re-engage the Veterans in treatment as warranted.*[9]

Patients with SMI are defined as those with schizophrenia, bipolar disorder, or other psychoses. To facilitate contacting these patients, the VA Serious Mental Illness Treatment Resource & Evaluation Center within the Office of Mental Health Operations in VA Central Office generates a quarterly list of patients and distributes them to local recovery coordinators. Local recovery coordinators call and/or mail a letter to each patient offering to help the patient obtain care through his/her local VA facility.

As noted in the policy, this initiative resulted from a 2010 VHA Office of Medical Inspector (OMI) report.[10] OMI found that significant numbers of patients with schizophrenic or bipolar disorder who had been lost to follow-up for a period of 1 year would return for care if facility staff contacted patients and offered to schedule an appointment. This report further found that patients who returned to VA for care had a significantly lower death rate than those who did not return for care.

The patient who is the subject of this report did not have diagnoses of schizophrenia, bipolar disorder, or a psychosis. He did have PTSD but primarily complained of anxiety during his winter 2015 visit to the VACIHCS ED and had not complained about PTSD symptoms in the past 2 years. While VHA Directive 2012-002 indicates that patients with severe PTSD may be classified as having SMI for purposes of local recovery coordinator activities, we were told the initiative had not yet been expanded to patients with PTSD who do not have another qualifying SMI. This was because while data existed on the effectiveness of this approach for patients with schizophrenia, bipolar disorder, and psychoses, adequate studies had not been done on whether this approach would work with PTSD patients.

PTSD Treatment Program

Between 2009 and 2011, the patient identified in this report primarily received individual outpatient psychotherapy treatment. This was through the general outpatient mental health clinic rather than through the PTSD clinic. We did not identify barriers to the patient receiving specialized care in the PTSD clinic, if his providers or the patient had requested additional care for his PTSD. Patients seeking psychotherapy at VACIHCS for PTSD are not required to have a substantiated or validated diagnosis of PTSD, nor does the PTSD have to be military or service-related. New patients may access these services either by calling the mental health outpatient clinic directly or by consults from

[9] VHA Directive 2012-002, *Re-Engaging Veterans With Serious Mental Illness in Treatment* January 10, 2012.
[10] Quality Improvement Assessment: *Outreach Services to Schizophrenic and Bipolar Patients Lost to Follow-up care (2010-D-252*), December 7, 2010.

their providers. An intake interview is scheduled, and the patient is referred to appropriate providers based on the patient's needs and preferences. If a patient has already established care at VACIHCS, an intake interview is not required.

The primary treatment modality offered by the VACIHCS PTSD Clinical Team is trauma-focused psychotherapy (Cognitive Processing Therapy and Prolonged Exposure). To date in FY 2015, VACIHCS averaged 7.6 referrals per week for PTSD psychotherapy.

In this instance, we found no evidence that the patient requested psychotherapy services between 2011 and his winter 2015 visit to the ED. We did not identify barriers to the patient either contacting the clinic directly for an appointment or requesting the service during his summer 2014 ED visit. Further, although he had a history of PTSD, the EHR documents the patient primarily complained of anxiety during his February visit to the ED.

We found VACIHCS to be substantially in compliance with VHA's policies regarding mental health consultation and wait times. We further noted that the patient did not receive recovery coordinator services, but this was because the scope of the program is limited primarily to patients with schizophrenia, psychoses, and bipolar disorders. The patient had not been diagnosed with these conditions. Finally, while the patient did not receive services through the PTSD clinic at VACIHCS, we did not find documentation that either the patient or his providers had requested care through the PTSD clinic.

Conclusions

We did not substantiate the allegation that the patient had been denied long term mental health services at the time of his winter 2015 visit to the ED. We found no documentation that the patient had requested these services or that his clinical condition would have warranted admission at the time of his presentation. We did not substantiate that the patient received poor quality of care through the ED but concluded that VACIHCS did not comply with VHA policy regarding case management services. Data obtained from the facility demonstrated that most consults were completed within the time frames permitted under local policy. We did not identify barriers to the patient accessing other services available at VACIHCS, such as the PTSD clinic.

We determined the patient did not appear on lists generated for purposes of local recovery coordination because he did not have a diagnosis of bipolar disorder, schizophrenia, or psychoses. While it is not known whether or not a contact by VACIHCS staff during the patient's protracted absence from VA care would have altered the outcome in this case, we do note that he responded favorably and began to receive care regularly following a contact made by an OEF/OIF coordinator in 2011.

Local recovery coordination activities are currently limited to patients with the most severe mental illness. While the results of a previous OMI study concluded that mortality rates were reduced among bipolar and schizophrenic patients if they were contacted by facilities and returned to VA care, it is not known whether these results

would apply to patients with PTSD or whether it would be feasible to expand the program to patients with PTSD.

Recommendations

1. We recommended that the Interim Under Secretary for Health determine the feasibility and advisability of expanding recovery coordination activities to patients with post-traumatic stress disorder.

2. We recommended that the Veterans Integrated Service Network Director ensure that the VA Central Iowa Health Care System Director provides all levels of Operation Enduring Freedom/Operation Iraqi Freedom case management services in accordance with Veterans Health Administration policy.

Appendix A

Interim Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: May 8, 2015

From: Interim Under Secretary for Health (10N)

Subj: Healthcare Inspection—Alleged Poor Mental Health Care Resulting in a Patient's Death, VACIHCS, Des Moines, Iowa

To: Assistant Inspector General for Healthcare Inspections

1. Thank you for the opportunity to review the OIG draft report of the Healthcare Inspection Alleged Poor Mental Health Care Resulting in a Patient Death at the VA Central Iowa Health Care System in Des Moines, Iowa.

2. I concur with the findings and recommendations in the draft report and provide comments in response to recommendation 1. Comments in response to recommendation 2 will be provided to OIG by the Veterans Integrated Service Network Director.

3. Please direct questions or concerns regarding the content of this memorandum to Karen Rasmussen, MD, Director, Management Review Service (10AR) at VHA10ARMRS2@va.gov.

(original signed by:)

Carolyn M. Clancy, MD

Comments to OIG's Report

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

OIG Recommendation

Recommendation 1. We recommended that the Interim Under Secretary for Health determine the feasibility and advisability of expanding recovery coordination activities to patients with post-traumatic stress disorder.

Concur

Target date for completion: October 2015

Interim Under Secretary response:

Veterans' mental health is a high priority and this report provides us with an opportunity to consider expanding recovery coordination activities in our current PTSD programs. We need to do everything we can to ensure Veterans are getting the care they need.

There are some intensive recovery coordination activities in the Serious Mental Illness (SMI) Re-Engage Program that may help strengthen our PTSD programs. VHA's office of Patient Care Services will review PTSD and Transition and Care Management programs to determine if any of the recovery and coordination activities associated with the SMI-Reengage program may also benefit Veterans with PTSD who need help engaging in the appropriate level of care. This review will also determine feasibility and advisability of potential programmatic changes.

To complete this action plan, VHA will provide the following documentation:

1. Results and recommendations from the review; and

2. Action plans addressing the recommendations, if any.

Status: In progress

Appendix B

Acting VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: April 23, 2015

From: Acting Director, VA Midwest Health Care Network (10N23)

Subj: Healthcare Inspection—Alleged Poor Mental Health Care Resulting in a Patient's Death, VACIHCS, Des Moines, Iowa

To: Director, Clinical Review Management, Office of Healthcare Inspections (54D)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I have reviewed and concur with the response to Recommendation 2 to ensure that VA Central Iowa Health Care System provides all levels of Operation Enduring Freedom/Operation Iraqi Freedom case management services in accordance with Veterans Health Administration policy.

2. If you have any questions, you may contact Diane M. Peterson, VISN 23 OEF/OIF Coordinator at Diane.Peterson3@va.gov .

(original signed by:)
Steven C. Julius, M.D.

Acting Network Director, VISN 23

Comments to OIG's Report

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

OIG Recommendation

Recommendation 2. We recommended that the Veterans Integrated Service Network Director ensure that the VA Central Iowa Health Care System Director provides all levels of Operation Enduring Freedom/Operation Iraqi Freedom case management services in accordance with Veterans Health Administration policy.

Concur

Target date for completion: multiple dates below, final target completion date September 30, 2015.

VISN response: To ensure that the VA Central Iowa Health Care System provides all levels of Operation Enduring Freedom/Operation Iraqi Freedom case management services in accordance with Veterans health Administration policy, the following actions will be completed:

1. Re-educate all OEF/OIF staff at Central Iowa HCS regarding case management levels, documentation, and policies regarding inactivation of case management. Implement a process for at least annual education thereafter.
   Completion date: June 30, 2015
   Review and, if indicated, revise, all forms sent by OEF/OIF staff from Central Iowa to Veterans when closing cases/inactivating to ensure compliance with VHA policy.
   Completion date for review: June 30, 2015
   Completion date for implementation of revised form letters: August 31, 2015
2. With the support of VISN, Iowa VA HCS Program Manager will implement a process to send an outreach letter or post card to all inactivated Veterans yearly.
   The post cards/letters will contain contact information for appointments, the crisis hot line and the OEF/OIF Program and invite them to make appointments if needed or to call with questions/concerns.
   Completion date: September 30, 2015
3. VISN 23 OEF/OIF Coordinator will, in collaboration with Central Iowa VA HCS OEF/OIF coordinator, evaluate inactivation rates for Central Iowa OEF/OIF Program to determine if further actions are indicated for those Veterans who have been "inactivated" from the program.
   Completion date: July 30, 2015
4. VISN 23 OEF/OIF Coordinator will conduct a site visit to review practices and confirm compliance of the Central Iowa VA HCS OEF/OIF programs with VHA policy.
   Completion date: September 30, 2015

Appendix C

Acting System Director Comments

Department of Veterans Affairs

Memorandum

Date: April 22, 2015

From: Acting Director, VA Central Iowa Health Care System (584/00)

Subj: Healthcare Inspection—Alleged Poor Mental Health Care Resulting in a Patient's Death, Des Moines, IA

To: Director, VA Midwest Health Care Network (10N23)

I concur with the Revised Draft Report Healthcare Inspection – Alleged Poor Mental Health Care Resulting in a Patient Death at VA Central Iowa HCS, Des Moines, Iowa and VISN response to Recommendation 2, provide all levels of Operation Enduring Freedom/Operation Iraqi Freedom case management services in accordance with Veterans Health Administration Policy.

(original signed by:)
SARA ACKERT, MS
Acting Director

Appendix D

OIG Contact and Staff Acknowledgements

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Andrea Buck, MD, JD, Donald Braman, RN, BSN

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Midwest Health Care Network (10N23)
Director, VA Central Iowa Health Care System (584/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Joni Ernst, Charles E. Grassley
U.S. House of Representatives: Rod Blum, Steve King, David Loebsack, David Young

This report is available on our web site at **www.va.gov/oig**.