DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Alleged Deficiencies in Oncology Psychosocial Distress Screening and Root Cause Analysis Processes at a facility in Veterans Integrated Service Network 15

HEALTHCARE INSPECTION | REPORT #19-06562-30 | DECEMBER 11, 2019

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at a Veterans Integrated Service Network (VISN) 15 medical facility (facility) in response to concerns identified by a prior OIG health care inspection.[1] This inspection evaluated (1) the oncology service staff's adherence to the facility's psychosocial distress screening standard operating procedure (SOP) in the care of two patients who died by suicide, and (2) facility leaders' response to the root cause analyses following the two patients' deaths.[2]

To achieve and maintain Commission on Cancer accreditation, oncology programs must demonstrate compliance with the Commission on Cancer eligibility requirements and standards, which include establishing a psychosocial distress screening process.[3] Screening of distress aims to identify psychological, social, financial, and behavioral issues that may interfere with a patient's treatment and negatively affect treatment outcomes, as well as provide patients resources and referrals for psychosocial needs.[4] The facility implemented the National Comprehensive Cancer Network Distress Thermometer (Distress Thermometer) and Problem List as the psychosocial distress screening tool.[5] Facility oncology service staff demonstrated compliance with psychosocial distress screening SOPs applicable at the time of both patients' visits. However, the OIG was unable to determine if a mental health evaluation completed prior to one of the patients leaving the clinic would have changed the patient's outcome. Completion of a mental health evaluation may have identified additional risk factors and provided opportunity for suicide prevention interventions prior to the patient leaving the clinic.

[1] The name of the facility is not being disclosed to protect the privacy rights of the subjects of the report pursuant to 38 U.S.C. §7332, Confidentiality of Certain Medical Records, January 3, 2012. VA Office of Inspector General, *Delay in Diagnosis and Subsequent Suicide at a Veterans Integrated Service Network 15 Medical Facility*, Report No. 19-00022-153, June 26, 2019.

[2] Facility SOP, Standard 3.2: Psychosocial Distress Screening, November 18, 2016. Facility SOP, Psychosocial Services: Oncology, September 20, 2017.

[3] Commission on Cancer of the American College of Surgeons, *Cancer Program Standards,* 2016 edition.

[4] Cancer Program Standards: Ensuring Patient-Centered Care, 2016 Edition, https://www.facs.org/quality-programs/cancer/coc. (The website was accessed on April 10, 2019.)

[5] The National Comprehensive Cancer Network Distress Thermometer and Problem List are self-report screening tools. On the Distress Thermometer, a patient assigns a number from 0 to 10 (with 10 the worst distress) that describes how much distress the patient experienced over the past week. The Problem List accompanies the Distress Thermometer and specifically inquires about 39 potential problems causing distress in the following areas: practical (such as child care, housing, treatment decisions), family (such as dealing with children or partner), emotional (such as depression, fears, worry), spiritual/religious, and physical (such as fatigue, pain, tingling in hands/feet).

The National Comprehensive Cancer Network standards of care state a patient should be screened at the initial visit and ideally at every visit.[6] Facility oncology service nursing staff were unclear about when to administer the psychosocial Distress Thermometer, a self-report tool that evaluates a patient's distress level, and therefore, administered the tool at every visit. Thus, nursing practice in the facility oncology service exceeded the facility SOP requirements and essentially provided the National Comprehensive Cancer Network ideal standard of care. The alignment of the SOP with the ideal standard and current practice is critical to ensure clear guidance to staff regarding the completion of the psychosocial Distress Thermometer.

The facility's Patient Safety Manager did not monitor progress toward root cause analysis action item completion. The OIG team learned from current and former facility patient safety staff that they did not have a process to track progress toward action item completion, as required by Veterans Health Administration.[7] Following the OIG team's expressed concern about this deficiency, the Patient Safety Manager implemented a tracking tool that same month.

After a patient's death by suicide in 2017, the Acting Suicide Prevention Coordinator did not complete a Suicide Behavior Report or Behavioral Health Autopsy, as required by Veterans Health Administration.[8] Without the facility submission of these required documents, Veterans Health Administration is unable to accurately track suicide-related events or evaluate the incident for quality improvement purposes.

The OIG made four recommendations related to Radiation Oncology Clinic mental health evaluation coverage, alignment of standard operating procedures for psychosocial distress screening with the National Comprehensive Cancer Network's ideal standards, tracking of action items to completion, and the completion of Suicide Behavior and Overdose Reports and Behavioral Health Autopsies.

[6] National Comprehensive Cancer Network, *NCCN Clinical Practice Guidelines in Oncology: Distress Management,* Version 2.2018, February 23, 2018. The NCCN Clinical Practice Guidelines Version 3.2019 were updated in May 6, 2019. The 2019 guidelines contain the same or similar language.

[7] VHA's patient safety program was initiated in 1999 with a goal of improving patient safety and preventing harm to patients. VHA Handbook 1050.01. VHA Directive 1026.

[8] In April 2019, VHA revised the Suicide Behavior Report to a new template and renamed it Suicide Behavior and Overdose Report. Deputy Under Secretary for Health for Operations and Management, *Suicide Behavior and Overdose Report Computerized Patient Record System (CPRS) Note Template Implementation*, April 8, 2019.

Comments

The VISN and Facility Directors concurred with the recommendations and provided acceptable action plans (see appendixes A and B, pages 10–14). The OIG will follow up on the planned actions until they are completed.

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

Contents

Abbreviations

CT	computerized tomography
OIG	Office of Inspector General
SOP	standard operating procedure
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at a Veterans Integrated Service Network (VISN) 15 medical facility (facility) to review (1) the oncology service staff's adherence to the facility's psychosocial distress screening standard operating procedure (SOP) in the care of two patients who died by suicide, and (2) facility leaders' response to the root cause analyses following the two patients' deaths.[9]

Prior OIG Report and Concerns

In the June 26, 2019, report, *Delay in Diagnosis and Subsequent Suicide at a Veterans Integrated Service Network 15 Medical Facility*, the OIG found deficiencies in the coordination of care that contributed to a delay in a cancer diagnosis of a patient (Patient 2) who later died by suicide.[10] Additionally, the OIG found deficiencies in quality management activities and recommended the VISN 15 Medical Facility Director review quality management practices and ensure compliance with Veterans Health Administration (VHA) guidance related to root cause analyses.[11]

During the course of that healthcare inspection, the OIG team identified concerns with the facility's oncology service psychosocial distress screening process and root cause analyses associated with Patient 2 and another patient (Patient 1) who died by suicide prior to the death of Patient 2. The OIG determined to conduct a further healthcare inspection on these issues. The inspection team reviewed staff's compliance with the facility's oncology psychosocial distress screening SOPs and facility leaders' response to root cause analysis action items. During the course of this healthcare inspection, the OIG team also identified a concern about the completion of Suicide Behavior Reports and Behavioral Health Autopsies, as required by VHA.[12]

Scope and Methodology

The OIG initiated the inspection on January 11, 2019, and conducted a site visit from March 11 through March 14, 2019.

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[9] The name of the facility is not being disclosed to protect the privacy rights of the subjects of the report pursuant to 38 U.S.C. §7332, *Confidentiality of Certain Medical Records*, January 3, 2012. Facility SOP, *Standard 3.2: Psychosocial Distress Screening,* November 18, 2016. Facility SOP, *Psychosocial Services: Oncology*, September 20, 2017.

[10] VA Office of Inspector General, *Delay in Diagnosis and Subsequent Suicide at a Veterans Integrated Service Network 15 Medical Facility*, Report No. 19-00022-153, June 26, 2019.

[11] VA Office of Inspector General, *Delay in Diagnosis and Subsequent Suicide at a Veterans Integrated Service Network 15 Medical Facility*, Report No. 19-00022-153, June 26, 2019.

[12] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide,* July 18, 2008. This directive expired July 31, 2013, and has not been renewed. VA Deputy Under Secretary for Health for Operations and Management, Memorandum—*Behavioral Autopsy Program Implementation*, December 11, 2012.

The OIG inspection team reviewed VHA directives, handbooks, and memoranda, and a facility policy and SOPs in effect June 2017 through July 2018 related to training, root cause analysis, oncology services, and suicide prevention.

The OIG team reviewed electronic health record documentation related to the care provided immediately before two patients' deaths that occurred on July 6, 2017, and June 13, 2018, respectively.

The OIG team interviewed a National Center for Patient Safety Analysis Officer, facility leaders and managers, facility staff including nurses and physicians, social workers, the suicide prevention coordinator, and former and current patient safety staff. During the site visit, the OIG team conducted a walk-through of the radiation oncology and hematology oncology clinics.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

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

Patient Case Summaries

Patient 1

The patient was in their 70s with a history of leukemia at the time of death. The patient presented to the facility outpatient oncology clinic for follow-up in summer 2017. A physician documented the patient's National Comprehensive Cancer Network Distress Thermometer (Distress Thermometer) score of five and that the patient attributed this level of distress to a family member's health problems.[13] The patient declined an oncology social work consult. Sixteen days later, the patient died by suicide.

Patient 2

The patient was in their 60s with a history of oropharyngeal cancer at time of death. After a summer 2018 radiation oncology clinic appointment at the facility, the patient died by suicide in the parking lot of another VISN 15 Medical Facility.

That day, the patient checked in early for a 1:00 p.m. radiation oncology appointment at the facility. A registered nurse completed an initial assessment and documented the patient scored a 10 on the Distress Thermometer. The patient denied suicidal ideation and reported "worry" related to cancer and physical problems of "breathing[,] eating[,] pain" and "tingling in hands/feet" on the National Comprehensive Cancer Network Problem List (Problem List). The registered nurse entered a social work consult at 12:55 p.m.

During this appointment, the radiation oncology physician documented that the patient reportedly first noticed a neck mass and difficulty swallowing in 2016. The physician noted the patient's initial 2016 computerized tomography (CT) scan of the neck that showed extensive lymphadenopathy and the patient's 2018 diagnosis of oropharyngeal cancer.[14] The physician documented that the patient denied suicidal ideation. The patient checked out of the clinic at 3:02 p.m.

At 3:24 p.m., a social worker documented an attempt to telephone contact the patient and left a message requesting the patient call back. Within one hour of the social worker's documented

[13] The OIG uses the singular form of they (their/them) to protect the patients' privacy. The National Comprehensive Cancer Network Distress Thermometer and Problem List are self-report screening tools. On the Distress Thermometer, a patient assigns a number from 0 to 10 (with 10 the worst distress) that describes how much distress the patient experienced over the past week. The Problem List accompanies the Distress Thermometer and specifically inquires about 39 potential problems causing distress in practical (such as child care, housing, treatment decisions), family (such as dealing with children or partner), emotional (such as depression, fears, worry), spiritual/religious, and physical (such as fatigue, pain, tingling in hands/feet) problems.

[14] The VA Office of Inspector General reviewed the alleged delay in diagnosis in a separate report. VA Office of Inspector General, *Delay in Diagnosis and Subsequent Suicide at a Veterans Integrated Service Network 15 Medical Facility*, Report No. 19-00022-153, June 26, 2019.

call, an employee at another VISN 15 Medical Facility reported that the patient appeared unresponsive in a vehicle parked in the Emergency Department parking lot. At 4:01 p.m., staff initiated a rapid response, and providers found the patient with a self-inflicted gunshot wound to the head. Providers called a code blue at 4:03 p.m. and attempted to resuscitate the patient. A physician pronounced the patient dead at 4:24 p.m.

Inspection Results

1. Psychosocial Distress Screening Procedures

The facility oncology service, which includes the hematology oncology clinic at the main facility and an off-site radiation oncology clinic, voluntarily sought Commission on Cancer accreditation.[15] To achieve and maintain Commission on Cancer accreditation, oncology programs must demonstrate compliance with the Commission on Cancer eligibility requirements and standards, which include establishing a psychosocial distress screening process.[16] Screening of distress aims to identify psychological, social, financial, and behavioral issues that may interfere with a patient's treatment and negatively affect treatment outcomes, as well as provide patients resources and referrals for psychosocial needs.[17]

In November 2016, the facility's cancer committee established an SOP related to psychosocial distress screening and completed a revised version in September 2017. Both SOPs required use of the Distress Thermometer and Problem List, a psychosocial screening assessment tool. The November 2016 SOP advised that staff should offer a social work consult for patients who score four or greater on the Distress Thermometer.[18] Following a review of Patient 1's death, facility leaders implemented the September 2017 SOP that required staff to enter a social work consult (not only offer the consult) for patients with Distress Thermometer scores of four or greater and also complete a suicide risk assessment for scores of eight or greater.[19]

The OIG team found that oncology service staff complied with the SOPs in effect at the time of both patients' clinic visits. Patient 1 scored five on the Distress Thermometer, and the physician discussed the reasons for the patient's distress. Consistent with the SOP in effect at the time of

[15] The Commission on Cancer is a group of organizations that works to improve all aspects of cancer care "through standard-setting, which promotes cancer prevention, research, education, and monitoring of comprehensive quality care." Commission on Cancer, *Cancer Program Standards: Ensuring Patient-Centered Care, 2016 Ed.* (American College of Surgeons, 2015).

[16] Commission on Cancer of the American College of Surgeons, *Cancer Program Standards,* 2016 edition.

[17] Cancer Program Standards: Ensuring Patient-Centered Care, 2016 Edition, https://www.facs.org/quality-programs/cancer/coc. (The website was accessed on April 10, 2019.)

[18] Facility SOP, Standard 3.2: Psychosocial Distress Screening, November 18, 2016.

[19] Facility SOP, *Psychosocial Services: Oncology*, September 20, 2017.

the visit, the physician offered a social work consult, which the patient declined. Patient 2 scored 10 on the Distress Thermometer, and as required by the applicable September 2017 SOP, the registered nurse entered a social work consult. The patient denied suicidal ideation to the nurse and then to the physician. In an interview with the OIG team, the physician recalled checking on how the patient was doing before the patient left the clinic.

The National Comprehensive Cancer Network Standards of Care for Distress Management include that licensed mental health professionals "be readily available as staff members or by referral."[20] A social worker documented a telephone call to Patient 2 less than 2.5 hours after the nurse submitted the consult and less than 30 minutes after the patient checked out of the radiation oncology appointment. Consistent with this standard, the Chief of Radiation Oncology told the OIG team that if a patient is highly distressed and the provider thinks the patient should be evaluated by a mental health provider, a social worker will be available by phone while the patient is at the clinic. A nurse told the OIG that a social worker had always been available for consultation with patients.

Based on the OIG team's review of the patient's electronic health record and interviews with the physician and nurse, the OIG team did not identify clear indicators that staff should have pursued an immediate mental health intervention at the time of the patient's appointment. The OIG was unable to determine if the completion of a mental health evaluation in person or by phone prior to leaving the clinic would have changed the outcome for this patient. However, given a mental health provider's training and expertise, a mental health evaluation prior to the patient's leaving the clinic may have identified additional risk factors and provided opportunity for suicide prevention interventions.

National Comprehensive Cancer Network Standards of Care for Distress Management state that "[a]t a minimum, patients should be screened…at [the] initial visit, at appropriate intervals, and as clinically indicated [particularly] with changes in disease status." The standards also note that "[i]deally, patients should be screened for distress at every medical visit as a hallmark of patient-centered care."[21] The SOP in effect at the time of the OIG team's March 2019 site visit required staff to complete a psychosocial distress screening at the time of a patient's first visit and any additional visits the provider designated the patient at risk of greater distress, called a pivotal visit.

The OIG found that facility oncology service nursing staff were unclear about the definition of a pivotal visit nor did they have sufficient information at the beginning of a patient's visit to

[20] National Comprehensive Cancer Network, *NCCN Clinical Practice Guidelines in Oncology: Distress Management,* Version 2.2018, February 23, 2018. The NCCN Clinical Practice Guidelines Version 3.2019 were updated in May 6, 2019. The 2019 guidelines contain the same or similar language.

[21] National Comprehensive Cancer Network, *NCCN Clinical Practice Guidelines in Oncology: Distress Management,* Version 2.2018, February 23, 2018. The NCCN Clinical Practice Guidelines Version 3.2019 were updated in May 6, 2019. The 2019 guidelines contain the same or similar language.

determine if any given appointment was a pivotal visit. Oncology service nursing staff told the OIG that they performed psychosocial distress screenings at all clinic appointments because they were not aware if there was a change in condition or treatment that would meet criteria for a pivotal visit. Thus, nursing practice in the facility oncology service exceeded the facility SOP requirements. Facility nursing staff essentially provided the National Comprehensive Cancer Network ideal standard of care for distress management screening since the SOP was not clearly understood. To ensure staff's clarity regarding procedures, facility leaders should seek the alignment of the SOP with the ideal standard and current practice. This alignment will provide clear guidance to staff regarding the completion of the Distress Thermometer.

2. Root Cause Analyses

A root cause analysis is an internal review "process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."[22] A root cause analysis utilizes a multidisciplinary team approach to review systems and processes. A thorough root cause analysis must identify system vulnerabilities and their potential contribution to the adverse outcome, and determine whether or not potential process or system improvements would decrease the likelihood of future adverse events. A credible root cause analysis must identify at least one root cause with corresponding action, outcome measure, and a plan to evaluate the effectiveness of corrective actions. Facility leaders must communicate action outcomes to the VISN and National Center for Patient Safety through WebSpot, a software application used by VHA to report and track patient safety event investigations.[23]

A National Center for Patient Safety Program Analysis Officer (Program Analysis Officer) told the OIG team that the facility director must sign concurrence with a root cause analysis.[24] The Program Analysis Officer also stated that an action item not completed or amended following a facility director's concurrence must be documented in WebSpot. Consistent with the VHA requirement for meeting minutes to track issues to resolution, the Program Analysis Officer stated that facility leaders are responsible for tracking and documenting the expected implementation date, progress toward completion, closure, and effectiveness for each action.[25]

[22] "Adverse events that may be candidates for an RCA are untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical facility, outpatient clinic, or other VHA facility." VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This handbook was scheduled for recertification on or before the last working day of March 2016 and has not been recertified.

[23] VHA Handbook 1050.01.

[24] VHA Handbook 1050.01.

[25] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. This directive was scheduled for recertification on or before the last working date of August 2018 and has not been recertified.

Facility's Root Cause Analyses

The facility completed a root cause analysis following Patient 1's death in 2017. The root cause analysis team identified actions to prevent similar adverse events in the future, including changes to the oncology team's psychosocial distress screening process. Specifically, staff were expected to enter rather than only offer a social work consult for Distress Thermometer scores of four or greater. Facility leaders reported that the identified actions were completed.

The facility completed a root cause analysis after Patient 2's death in 2018. The Patient Safety Manager told the OIG team that changes were made to action items after the Facility Director signed the concurrence document. The Patient Safety Manager documented changes made to action items in WebSpot. However, the OIG team learned from current and former facility patient safety staff that they did not have a process to track progress toward action item completion, as required by VHA.[26] Following the OIG team's expressed concern about this deficiency, the Patient Safety Manager implemented a tracking tool that same month.

3. Additional Concern

In November 2012, VHA implemented the Behavioral Health Autopsy Program for quality improvement purposes. Suicide prevention coordinators must complete an electronic health record review and analysis within 30 days of their awareness of a veteran's death by suicide. Suicide prevention coordinators conduct the analysis using an electronic health record template that includes relevant historical events and medical history and then submit the collected information to VHA's Office of Mental Health and Suicide Prevention.[27]

In 2008, VHA required clinical staff to complete the Suicide Behavior Report when they became aware of any suicidal self-directed violence.[28]

Staff at another VISN 15 facility completed a Suicide Behavior Report and Behavioral Health Autopsy following Patient 2's death.[29] Following Patient 1's death, the Acting Suicide Prevention Coordinator did not complete a Suicide Behavior Report or Behavioral Health Autopsy, as required by VHA. Without the facility submission of these required documents,

[26] VHA's patient safety program was initiated in 1999 with a goal of improving patient safety and preventing harm to patients. VHA Handbook 1050.01. VHA Directive 1026.

[27] VA Deputy Under Secretary for Health for Operations and Management Memorandum, *Behavioral Autopsy Program Implementation*, December 11, 2012.

[28] VHA Directive 2008-036.

[29] VA Office of Inspector General, *Delay in Diagnosis and Subsequent Suicide at a Veterans Integrated Service Network 15 Medical Facility*, Report No. 19-00022-153, June 26, 2019.

VHA is unable to accurately track suicide-related events or evaluate the incident for quality improvement purposes.

Conclusion

Facility oncology service staff demonstrated compliance with psychosocial distress screening SOPs applicable at the time of both patients' visits. However, the OIG was unable to determine if a mental health evaluation completed prior to one of the patients leaving the clinic would have changed the patient's outcome. Completion of a mental health evaluation may have identified additional risk factors and provided opportunity for suicide prevention interventions prior to the patient's leaving the clinic.

Facility oncology service nursing staff were unclear about the definition of a pivotal visit nor did they have sufficient information at the beginning of a patient's visit to determine if any given appointment was a pivotal visit. Thus, nursing practice in the facility oncology service exceeded the facility SOP requirements and essentially provided the National Comprehensive Cancer Network ideal standard of care. The alignment of the SOP with the ideal standard and current practice is critical to ensure clear guidance to staff regarding the completion of the psychosocial Distress Thermometer.

The facility Patient Safety Manager did not monitor progress toward root cause analysis action item completion. Following the OIG team's expressed concern about this deficiency, the Patient Safety Manager implemented a tracking tool that same month.

After a patient's death by suicide in 2017, the Acting Suicide Prevention Coordinator did not complete a Suicide Behavior Report or Behavioral Health Autopsy, as required by VHA.

The OIG made four recommendations.

Recommendations 1–4

1. The Veterans Integrated Service Network Medical 15 Facility Director conducts an evaluation of radiation oncology clinic mental health consultation and treatment program needs and adjusts mental health provider coverage as warranted.
2. The Veterans Integrated Service Network Medical 15 Facility Director ensures that all components of the oncology service psychosocial distress screening standard operating procedures include screening frequency consistent with National Comprehensive Cancer Network's ideal standards.
3. The Veterans Integrated Service Network Medical 15 Facility Director guarantees that the patient safety program maintains effective processes to track action items to completion and monitors compliance.

4. The Veterans Integrated Service Network Medical 15 Facility Director ensures that staff complete Suicide Behavior and Overdose Reports and Behavioral Health Autopsies, as required by the Veterans Health Administration.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 1, 2019

From: Director, VA Heartland Network (10N15)

Subj: Healthcare Inspection—Alleged Deficiencies in Oncology Psychosocial Distress Screening and Root Cause Analysis Processes at a Veterans Integrated Service Network 15 Medical Facility

To: Director, Office of Healthcare Inspections (54MH00)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. Attached is the VAOIG Hotline Draft Report.
2. I have reviewed and concur with the facility's response.
3. For additional questions, please feel free to contract Michelle Boylan, VISN 15 Quality Management Officer.

(*Original signed by:*)

William P. Patterson, MD, MSS
Network Director

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 30, 2019

From: Director, VISN 15 Medical Facility

Subj: Healthcare Inspection—Alleged Deficiencies in Oncology Psychosocial Distress Screening and Root Cause Analysis Processes at a VISN 15 Medical Facility

To: Director, VA Heartland Network (10N15)

I have reviewed the findings within the report referenced in the subject line. I am in agreement with the findings of the review.

Corrective action plans have been established with planned completion dates outlined in this report.

(*Original signed by:*)

Director, VISN 15 Medical Facility

Facility Director's Response

Recommendation 1

The Veterans Integrated Service Network 15 Medical Facility Director conducts an evaluation of radiation oncology clinic mental health consultation and treatment program needs and adjusts mental health provider coverage as warranted.

Concur.

Target date for completion: May 2020

Director Comments

The Primary Screen (i.e., Patient Health Questionnaire [PHQ] Item 9) and the Secondary Screen (i.e., Columbia-Suicide Severity Rating Scale [C-SSRS]) of the VACO Suicide Risk Identification Strategy (SRIS) are completed and documented in the electronic health record as needed. Currently, there is an agreement between Mental Health, Radiation Oncology, and the Transition Service Line, (who has oversight of Social Worker responsibilities), for the third stage (i.e., Comprehensive Suicide Risk Evaluation [CSRE]) to be completed, when indicated, by either a Mental Health provider or an Oncology Social Worker, prior to the patient leaving the Radiation Oncology clinic.

Mental Health / Quality, Safety, and Value will monitor compliance of radiation oncology clinic mental health consultation and treatment program needs by completing chart audits. A random sample of 30 charts will be audited each month until a compliance of 90% or greater is achieved for six consecutive months. The population (denominator) will be all Comprehensive Suicide Risk Evaluations (CSRE) that were positive from the random sample. The sample size (numerator) will be all applicable Comprehensive Suicide Risk Evaluations that were positive that did not receive follow-up. Monitoring data will be reported to the Executive Committee of the Medical Staff.

In addition, there is active recruitment for a full-time Mental Health provider to be on-site at the Radiation Oncology clinic who will be available when a Comprehensive Suicide Risk Evaluation or other acute mental health care intervention is needed. The full-time provider is expected to be hired / onboarded by February 2020.

Recommendation 2

The Veterans Integrated Service Network 15 Medical Facility Director ensures that all components of the oncology service psychosocial distress screening standard operating procedures include screening frequency consistent with National Comprehensive Cancer Network's ideal standards.

Concur.

Target date for completion: July 2020

Director Comments

The Oncology service's Psychosocial Services Standard Operating Procedure (SOP) will be amended by the Cancer Committee's Psychosocial Services Coordinator for consistency with the National Comprehensive Cancer Network Clinical Practice Guidelines in Oncology: Distress Management, Version 3.2019. The updated SOP will be submitted to the Cancer Committee for review and final approval at the next meeting that is scheduled in December 2019. Once the SOP is approved by the Cancer Committee, oncology service staff will be trained on the new requirements.

Recommendation 3

The Veterans Integrated Service Network 15 Medical Facility Director guarantees that the patient safety program maintains effective processes to track action items to completion and monitors compliance.

Concur.

Target date for completion: May 2020

Director Comments

The Patient Safety Manager developed an Action and Outcome Measure tracking tool for the completion and compliance of all recommended Root Cause Analyses actions and outcomes. The tracking tool was developed in April 2019. The Patient Safety Manager will be responsible for updating the tracking tool and implementing follow-up actions from Root Cause Analyses. The tracking tool will be updated a minimum of once monthly based on completion of Root Cause Analyses and their respective follow-up actions.

The Patient Safety Manager / Risk Manager will monitor compliance by completing monthly audits of the tracking tool. Compliance will be monitored for a minimum of 6-months with a goal of 90% compliance. The population (denominator) will be the total number of Root Cause Analyses action / outcome measures being tracked each month for open Root Cause Analyses. The sample size (numerator) will be the will be number of Root Cause Analyses action /outcome measures completed on time each month for open Root Cause Analyses. Monthly results will be reported to the Chief, Quality, Safety, and Value and the Executive Leadership Team.

Recommendation 4

The Veterans Integrated Service Network 15 Medical Facility Director ensures that staff complete Suicide Behavior Reports and Behavioral Health Autopsies, as required by the Veterans Health Administration.

Concur.

Target date for completion: May 2020

Director Comments

The Suicide Prevention Team is developing a Standard Operating Procedure (SOP) that will address the VHA and Office of Mental Health and Suicide Prevention (OMHSP) requirements for completion of Suicide Behavior and Overdose Reports and Behavioral Health Autopsies. This SOP will be finalized and implemented in November 2019.

In order to monitor compliance for this recommendation, the Suicide Prevention Team will conduct monthly internal audits to correlate the names of Veterans who died by suicide in that calendar month and ensure the corresponding Suicide Behavior and Overdose Report(s) and Behavioral Health Autopsy(ies) have been completed per Office of Mental Health and Suicide Prevention guidelines. Any required missing reports will be completed by the Suicide Prevention Team.

Compliance will be monitored for a minimum of 6-months with a goal of 90% compliance. The population (denominator) will be the total number of reported veteran suicides each month. The sample size (numerator) will be the number of completed required reports.

Results will be reported to key stakeholders (i.e., Chief, Mental Health Services; the Chief of Staff; and Quality, Service, and Value).

Glossary

code blue. A is "cardiac or pulmonary arrest event." A "code blue team" is activated to respond to the event.[30]

CT scan. A cross-sectional, three-dimensional image of an internal body part produced by computed tomography chiefly for diagnostic purposes.[31]

leukemia. An acute or chronic disease in humans characterized by an abnormal increase in the number of white blood cells in the tissues and often in the blood.[32]

lymphadenopathy. An abnormal enlargement of the lymph nodes.[33]

National Comprehensive Cancer Network. A "not-for-profit alliance of 28 leading cancer centers devoted to patient care, research, and education….By defining and advancing high-quality cancer care, NCCN promotes the importance of continuous quality improvement and recognizes the significance of creating clinical practice guidelines appropriate for use by patients, clinicians, and other health care decision-makers around the world."[34]

oropharyngeal cancer. Cancer relating to the mouth and pharynx.[35]

pivotal visit. Facility SOP defines as "a medical visit…determined by the [facility] cancer committee to be a pivotal time for the distress screening process. A pivotal visit can include times of greater risk for distress."[36]

Problem List. The National Comprehensive Cancer Network Distress Problem List is self-report screening that inquires about practical, family, emotional, spiritual/religious, and physical problems that may cause distress.[37]

rapid response. Alert systems "to improve recognition of and response to deterioration of patients [in hospitals], with the goal of reducing the incidence of cardiorespiratory arrest and hospital mortality."[38]

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[30] Facility Policy 11-111-032, *Cardiac or Respiratory Arrest Policy*, April 24, 2015.

[31] https://www.merriam-webster.com/dictionary/CT%20scan. (The website was accessed on June 27, 2019.)

[32] https://www.merriam-webster.com/dictionary/leukemia. (The website was accessed on June 27, 2019.)

[33] https://www.merriam-webster.com/dictionary/lymphadenopathy. (The website was accessed on June 27, 2019.)

[34] National Comprehensive Cancer Network, *About NCCN,* 2019. https://www.nccn.org/about/default.aspx. (The website was accessed on June 25, 2019.)

[35] https://www.merriam-webster.com/dictionary/oropharyngeal. (The website was accessed on June 27, 2019.)

[36] Facility SOP, *Psychosocial Services: Oncology*, November 28, 2018.

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