DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Inpatient Mental Health Care Coordination and Processes Prior to a Patient's Death by Suicide, Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri

HEALTHCARE INSPECTION | REPORT 20-01521-48 | JANUARY 5, 2021

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to determine the validity of an allegation regarding the mental health care a patient received at the Harry S. Truman Memorial Veterans' Hospital (facility) in Columbia, Missouri, prior to death by suicide within three days of discharge from the facility's Inpatient Mental Health Unit.[1] The OIG reviewed the patient's mental health care coordination, discharge planning, suicide risk screening and evaluation processes, and administrative actions following the patient's death. The OIG team also identified a concern regarding Mental Health Treatment Coordinator (MHTC) assignment.

The OIG substantiated that the patient died by suicide within three days of discharge from the facility's Inpatient Mental Health Unit. The OIG substantiated that the inpatient psychiatry resident physician initiated antidepressant medication and an inpatient registered nurse provided the patient with discharge instructions that included suicide prevention materials, which the OIG determined were consistent with Veterans Health Administration (VHA) guidance.[2] However, the OIG identified care coordination and discharge planning deficiencies including Inpatient Mental Health Unit staff's failure to coordinate the patient's mental health treatment or include Columbia Vet Center staff in discharge planning. In an interview with the OIG, the inpatient psychiatry resident physician did not recall why a release of information was not obtained for the Columbia Vet Center. Failure to engage Columbia Vet Center staff in the discharge planning process resulted in missed opportunities to facilitate the patient's engagement with outpatient resources and timely follow-up.

The OIG found that, although the patient was transferred to the appropriate level of care to address suicidal ideation, facility staff failed to complete the VHA-required comprehensive suicide risk evaluation (comprehensive evaluation) prior to the patient's discharge because of deficiencies in hand-off and care transition processes across clinical settings.[3] Inpatient Mental Health Unit staff were not aware of the patient's positive secondary suicide risk screen in the

[1] The patient was discharged from the Inpatient Mental Health Unit in early 2020. Although an obituary stated that the patient died on the date of discharge, the police found the deceased patient three days following discharge, and the medical examiner did not provide a date of death.

[2] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008, amended on November 16, 2015.

[3] U.S. Department of Health and Human Services, Patient Safety Network, "Handoffs and Signouts," September 2019. For the purpose of this report, "hand-off" encompasses both the process of transferring responsibility for a patient's care and transmitting information about a patient from one provider to another when transferring responsibility for a patient's care. https://psnet.ahrq.gov/primers/primer/9/handoffs-and-signouts. (The website was accessed on June 9, 2020.) Deputy Under Secretary for Health for Operations and Management (10N), *Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) initiatives,* October 17, 2019.

Emergency Department because the information was not included in the hand-off or other care transition processes across clinical settings. The absence of this evaluation may have contributed to missed information to adequately establish the patient's acute and chronic suicide risk factors and risk mitigation plan.

Facility leaders and staff told the OIG that following the patient's death, Inpatient Mental Health Unit nursing leaders implemented a hand-off communication tool, a standardized process to report secondary suicide risk screen results during interdisciplinary team meetings, and an admission note template that included the previous seven days secondary suicide risk screen results. Inpatient Mental Health Unit nursing leaders also implemented a monthly audit to monitor staff compliance, which resulted in 90 percent compliance in March 2020 and 100 percent compliance in April, May, and June 2020.

The OIG found that facility leaders did not establish a policy to guide identification of the MHTC and ensure MHTC assignment for patients awaiting transfer to another level of care, as required.[4] The Mental Health Department Chief told the OIG that a written MHTC policy was not developed, in part, due to confidence in the facility's suicide prevention program, primary therapist assignment process, and interdisciplinary approach to treatment. However, the OIG found that Inpatient Mental Health Unit providers did not assign the patient an MHTC upon discharge, as required by VHA.[5] Facility leaders and staff, in interviews with the OIG, were unsure why staff did not assign an MHTC prior to the patient's discharge.

The absence of a facility policy may have contributed to staff's lack of knowledge regarding the requirements and processes related to the identification and assignment of an MHTC. On July 30, 2020, after the OIG expressed concern about the lack of MHTC policy, the Mental Health Department Chief implemented two standard operating procedures clarifying MHTC assignment processes for (1) all staff, and (2) Inpatient Mental Health Unit social workers. The failure to assign an MHTC may have resulted in the patient not receiving support during the discharge process, which can be critical to a patient's successful transition. Further, lack of an MHTC to support the patient's transition to outpatient mental health treatment may have diminished the likelihood of the patient's engagement and post-discharge outreach.

The OIG found that staff failed to comprehensively and effectively report the patient's one positive suicide risk screening result in an issue brief related to the patient's death.[6] The omission

[4] Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012.

[5] Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012; VHA Handbook 1160.01.

[6] An issue brief is a notification to VISN leaders from facility leaders regarding certain events and is intended to provide "clear, concise and factual information" about the death, review clinical care, and determine compliance with policy requirements. VHA requires submission of an issue brief following a death by suicide within seven days after discharge from a VA inpatient facility.

of suicide risk screening results and use of an unfamiliar term to describe suicide screening results may compromise facility leaders' ability to determine policy compliance and may influence decisions to conduct an institutional disclosure.[7] Additionally, in part based on the issue brief, facility leaders did not make an institutional disclosure to the patient's next of kin.

The OIG found that facility, Veterans Integrated Service Network, and National Center for Patient Safety leaders did not have knowledge of a 2017 Office of Mental Health and Suicide Prevention and Vet Centers memorandum of understanding that required Vet Center representation for shared patients during VHA root cause analyses. The OIG concluded that the lack of broad stakeholder awareness of the root cause analysis requirement may result in VHA medical center staff's failure to include Vet Center staff on a root cause analysis team for shared patients. These failures may lead to incomplete information and understanding of relevant systemic processes.

The OIG made one recommendation to the Under Secretary for Health related to root cause analysis guidance.[8]

The OIG made six recommendations to the Facility Director related to collaboration with Vet Center staff, safety planning, suicide risk assessment and evaluation, MHTC assignment, and issue brief and root cause analysis processes.

Comments

The Executive in Charge, and the Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided acceptable action plans (see appendixes A, B, and C). The OIG will follow up on the planned actions until they are completed.

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[7] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. When completing the issue brief, the Suicide Prevention Counselor used to the term "key indicators" to denote a positive result. However, other staff stated that they were unfamiliar with that term and did not know it represented a positive result.

[8] The Under Secretary for Health recommendation is submitted to the Executive in Charge who has authority to perform the functions and duties of the Under Secretary for Health.

Contents

Abbreviations

MHTC	Mental Health Treatment Coordinator
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to determine the validity of an allegation regarding the mental health care a patient received at the Harry S. Truman Memorial Veterans' Hospital (facility) in Columbia, Missouri, prior to death by suicide within three days after discharge from the facility's Inpatient Mental Health Unit. [1]

Background

The facility, part of the VA Heartland Network, Veterans Integrated Service Network (VISN) 15, is located in Columbia, Missouri, and serves 43 Missouri counties and one Illinois county. The facility offers comprehensive healthcare services including primary care, medical specialties, and behavioral health. From October 1, 2018, through September 30, 2019, the facility served 38,818 patients and had a total of 134 hospital operating beds, including 11 Inpatient Mental Health Unit beds. The facility is affiliated with the University of Missouri's School of Medicine, the Sinclair School of Nursing, the School of Health Professions, and other health-related programs.

In 1979, Congress established Readjustment Counseling or Vet Centers to respond to Vietnam-era veterans experiencing readjustment problems. Eligibility was extended in the 1990s to include veterans who served during other periods of armed hostilities before and after Vietnam.[2] Vet Centers, aligned under the Veterans Health Administration (VHA) Executive in Charge, are community-based counseling centers that provide readjustment counseling services, outreach, and referrals.[3] From October 1, 2018, through September 30, 2019, 307,737 veterans, active duty service members, and their families received counseling across 300 Vet Centers. The Columbia Vet Center, located in Columbia, Missouri, provides individual, group, and family counseling; bereavement and military sexual trauma counseling; community outreach and education; substance abuse assessment and referral; and employment and VA referrals.[4]

[1] The patient was discharged from the Inpatient Mental Health Unit in early 2020. Although an obituary stated that the patient died on the date of discharge, the police found the deceased patient three days following discharge, and the medical examiner did not provide a date of death.

[2] VA, *Vet Centers (Readjustment Counseling)*. https://www.vetcenter.va.gov/ . (The website was accessed on July 28, 2020.)

[3] VA, *Vet Centers (Readjustment Counseling)*. Readjustment counseling is offered to assist individuals to successfully transition from military to civilian life. https://www.vetcenter.va.gov/About_US.asp. (The website was accessed on May 8, 2020.)

[4] VA, *Vet Centers (Readjustment Counseling)*. Readjustment counseling is offered to assist individuals successfully transition from military to civilian life. https://www.vetcenter.va.gov/About_US.asp. (The website was accessed on May 8, 2020.)

Suicide Risk Assessment

In May 2018, VHA introduced a standardized three-stage suicide risk screening and assessment process that included a primary suicide risk screen, secondary suicide risk screen, and a comprehensive suicide risk evaluation (comprehensive evaluation).[5] As of November 16, 2019, VHA required use of a national comprehensive evaluation note template.[6]

The primary suicide risk screen is positive when the patient acknowledges thoughts of being better off dead or of hurting themself over the past two weeks. A positive primary suicide risk screen requires staff to complete the secondary suicide risk screen that includes more specific questions about the patient's past preparatory or suicidal behavior, current intent, and thoughts of a method and plan. A positive secondary suicide risk screen prompts the comprehensive evaluation that asks more detailed information about the patient's suicidal ideation, previous suicide attempts, warning signs, risk factors, protective factors, clinical impression of acute and chronic risk, and requires the provider to establish a plan to mitigate risk.[7]

VHA designates which staff may complete each screen. Generally, a broad range of licensed and unlicensed staff can complete the primary suicide risk screen, licensed clinicians can complete the secondary suicide risk screen, and a healthcare provider must complete the comprehensive evaluation.[8]

VHA requires emergency department and inpatient mental health unit staff to complete the secondary suicide risk screen and if positive, complete the comprehensive evaluation the same day or within 24 hours. VHA also requires inpatient mental health unit staff to complete the

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[5] Deputy Under Secretary for Health for Operations and Management, *Suicide Risk Screening and Assessment Requirements,* May 23, 2018; Deputy Under Secretary for Health for Operations and Management, *Suicide Risk Screening and Assessment Requirements—Attachment B,* May 23, 2018. The May 23, 2018, memorandum refers to a comprehensive assessment; however, later memoranda refer to a comprehensive evaluation.

[6] Deputy Under Secretary for Health for Operations and Management, *Eliminating Veteran Suicide: Update on Suicide Risk Screening and Evaluation*, February 22, 2019. Deputy Under Secretary for Health for Operations and Management (10N), *Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) initiatives,* October 17, 2019.

[7] The Joint Commission, *National Patient Safety Goal for Suicide Prevention*, November 27, 2018. https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf. (The website was accessed on February 6, 2020.) The comprehensive evaluation uses an evidence-based approach for patients who screen positive for suicidal ideation or exhibit suicidal behavior including directly asking the patient about suicidal ideation, plan, intent, behaviors, risk factors, protective factors, assessing level of risk, developing a mitigation plan, using a classification system of low, intermediate, and high acute and chronic suicide risk.

[8] Deputy Under Secretary for Health for Operations and Management, *Suicide Risk Screening and Assessment Requirements,* May 23, 2018. Deputy Under Secretary for Health for Operations and Management, *Suicide Risk Screening and Assessment Requirements – Attachment B,* May 23, 2018. VHA allows select unlicensed clinicians including addiction therapists, registered nurses, and rehabilitation counselors to complete the secondary suicide risk screen. For the purposes of the comprehensive evaluation, VHA defines healthcare provider as a licensed independent provider or advanced practice provider including physicians, clinical pharmacy specialists, social workers, and nurse practitioners.

secondary suicide risk screen and the comprehensive evaluation, as indicated, within 24 hours of admission and within 24 hours before discharge.

Allegations and Related Concern

On January 10, 2020, the OIG received a complaint that a patient died by suicide after "being seen" at the facility, was "prescribed medication," and "sent home with a suicide packet." In an interview with the OIG, the complainant expressed concern regarding the patient's short length of admission and lack of outreach by facility staff immediately following discharge. The OIG opened a hotline inspection to review the patient's mental health care coordination, discharge planning, and concerns that facility staff failed to adequately complete suicide risk screening and evaluation processes, and administrative actions following the patient's death.

During the inspection, the OIG team identified an additional concern regarding facility staff's failure to assign a Mental Health Treatment Coordinator (MHTC) for the patient, as required by VHA.[9]

Scope and Methodology

The OIG conducted a virtual site visit from March 16 through March 19, 2020.

The OIG interviewed the complainant, the patient's family member, facility leaders and staff familiar with the patient's care and relevant processes, Columbia Vet Center leaders and staff familiar with the patient's care, and leaders from the VHA Office of Mental Health and Suicide Prevention and the National Center for Patient Safety.

The OIG reviewed the patient's electronic health record, Columbia Vet Center health record, autopsy report, facility internal review documents related to the patient's care, and 31 issue briefs submitted to the VISN from October 1, 2018, through July 22, 2020. Additional documents reviewed included VHA directives, handbooks, and memoranda, facility policies and standard operating procedures, and organizational charts.

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 substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take

[9] Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator,* March 26, 2012.

place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, § 7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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 Summary

The patient was in their 50s at the time of death by suicide in early 2020.[10] The patient presented to the Columbia Vet Center in late 2019, after recently relocating from another state.[11] The Columbia Vet Center Director completed an intake assessment during the patient's second visit two days later. The patient reported a prior suicide attempt in 2016, access to "weapons or other lethal means," and denied suicidal ideation. The Columbia Vet Center Director documented that the firearms were "locked up," assessed the patient as "non-lethal," and assigned the patient a readjustment counselor.

Six days after the Vet Center visit, the patient presented to the facility to establish primary care. A licensed practical nurse administered two mental health screening tools that included embedded suicide risk screens. The patient scored positive on one primary suicide risk screen and negative on another. The patient then met with a primary care physician who documented that the patient reported a history of several musculoskeletal problems and requested acupuncture for hand numbness. The patient screened positive for traumatic brain injury, and the primary care physician ordered a neurology consult.[12] The primary care physician documented a negative

[10] The OIG uses the singular form of they (their) in this instance for the purpose of patient privacy.

[11] The patient received medical care including primary care at another VA medical facility in 2011 and then briefly in 2016 and 2017. During the 2019 facility Inpatient Mental Health Unit episode of care, the inpatient psychiatry resident physician documented that the patient's friend reported that the patient received psychiatric care in another state and stopped taking medications.

[12] Centers for Disease Control, *Traumatic Brain Injury & Concussion*, March 6, 2019. Dysfunction of normal brain function caused by a blow to the head or penetrating head injury. https://www.cdc.gov/traumaticbraininjury/basics.html. (The website was accessed on August 16, 2020.)

secondary suicide risk screen and referred the patient to a primary care mental health integration psychologist (psychologist).[13]

The psychologist met with the patient that same day and the patient reported interest in therapy services to address the patient's trauma history and relationship issues. The psychologist documented that the patient reported experiencing "intermittent low mood," anxiety, intrusive thoughts, hypervigilance, rumination, worry, feeling cut off from others, difficulty sleeping, and decreased appetite.[14] The patient denied current suicidal ideation and reported a suicide attempt and a psychiatric hospitalization approximately three years prior. The psychologist diagnosed the patient with adjustment disorder with anxiety and depressed mood and assessed the patient as not at "imminent risk to harm self or others." [15] The psychologist referred the patient to the Translating Initiatives for Depression into Effective Solutions program, and placed a consult for outpatient mental health treatment.[16]

Six days following the primary care appointment, a consultant neurologist evaluated the patient and documented that the patient's memory problems were not likely related to traumatic brain injury. The neurologist noted "perhaps [behavioral health] can offer some compensatory strategies," included the psychologist as an additional signer, and discharged the patient from the Neurology Clinic. The same day, a Translating Initiatives for Depression into Effective Solutions registered nurse administered a depression screen by telephone and the patient screened negative for depression. The patient declined to schedule an appointment during the call and the nurse explained that the patient could request the medical support assistant contact the nurse, and the nurse would meet with the patient in primary care when the patient arrived for an appointment later that day.

Also that day, a medical support assistant attempted to reach the patient by telephone to schedule an outpatient mental health appointment, left the patient a voicemail, and sent a letter requesting the patient call to schedule an appointment. After scheduling attempts on three consecutive days

[13] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008, amended on November 16, 2015. Primary care mental health integration is co-located in primary care clinics to provide essential elements of mental health programming including assessment and psychosocial treatment.

[14] National Institute of Mental Health, *Anxiety Disorders*. Anxiety is an expected part of life that involves worry or fear. In individuals with an anxiety disorder, it can worsen over time and can interfere with daily activities to include job performance, schoolwork, and relationships. https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml. (The website was accessed on May 5, 2020.)

[15] Mayo Clinic, *Adjustment Disorder*. Adjustment disorder is a stress-related condition that occurs when individuals experience increased stress in response to an unexpected event such as work problems, illness, or death of a close family member. https://www.mayoclinic.org/diseases-conditions/adjustment-disorders/symptoms-causes/syc-20355224. (The website was accessed on June 12, 2020.)

[16] VHA Handbook 1160.01. VHA requires primary care clinics to provide integrated mental health care including a care management component. The Translating Initiatives for Depression into Effective Solutions model, a mental health care management program designed to monitor a patient's treatment engagement and outcomes, provides patient education, and facilitates specialty mental health care when needed. At the facility, a registered nurse serves as the care coordinator for Translating Initiatives for Depression into Effective Solutions.

failed, the medical support assistant discontinued the outpatient mental health consult for late 2019, per VHA policy.[17] Throughout the remainder of the month, the patient attended facility specialty medical care appointments including speech pathology and physical medicine and rehabilitation.

During a 19-day period at the end of 2019, the patient attended three group and three individual treatment visits at the Columbia Vet Center. Columbia Vet Center staff documented that the patient appeared guarded and tense during individual sessions and did not report suicidal ideation at any visit.

On a day, early in 2020 (day 1), the patient presented to the facility's Emergency Department with a chief complaint of suicidal ideation. An Emergency Department registered nurse documented that the patient reported thoughts of self-harm and denied a specific plan. The patient screened positive on the secondary suicide risk screen. The patient was placed on suicide precautions including one-to-one observation. The Medical Officer on Duty completed a medical evaluation and entered a psychiatric consult. An inpatient psychiatry resident physician met with the patient in the Emergency Department and documented the patient's "poor" mood and interest, guilt, anxiety, and non-combat-related posttraumatic stress disorder symptoms including nightmares, flashbacks, and hypervigilance. The inpatient psychiatry resident physician documented that the patient had suicidal ideation, no plan or intent, wanted "to be in a safe place," and "was ambivalent about starting medications and very interested in using hypnosis." The patient denied access to weapons or pills at home and reported seeing a therapist at the Columbia Vet Center. The inpatient psychiatry resident physician assessed the patient's insight and judgment as "limited;" diagnosed the patient with major depressive disorder, severe, recurrent, without psychosis; and, in consultation with an attending psychiatrist, initiated antidepressant medication and admitted the patient to the Inpatient Mental Health Unit.[18]

Approximately four hours after initial presentation on day 1, as part of an inpatient registered nurse's admission assessment, the patient's repeated secondary suicide risk screen was negative. The inpatient registered nurse documented the patient's report of suicidal ideation as "higher than normal" and two past suicide attempts—in 1986 by overdose, and in 2016 by a "wrist slice." The inpatient registered nurse documented suicide risk factors within the past six months including feelings of hopelessness; impulsive or aggressive tendencies; and relational, social, work, or financial loss. The inpatient registered nurse also documented the patient's protective factors of receiving clinical care, interpersonal support, ongoing medical and mental health care relationships, and problem solving and conflict resolution skills.

[17] VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016.

[18] National Institute of Mental Health, *Major Depression*. Major depressive disorder is characterized by depressed mood, loss of interest or pleasure in daily activities, problems with sleep, eating, and concentration lasting at least two weeks.https://www.nimh.nih.gov/health/statistics/major-depression.shtml. (The website was accessed on May 5, 2020.)

On day 2, at the interdisciplinary team meeting, a staff member reported the negative secondary suicide risk screen from the inpatient registered nurse's admission assessment. Later the same day, the inpatient social worker repeated the secondary suicide risk screen and the patient screened negative. The patient was hesitant to speak with the inpatient social worker and expressed a wish to be discharged. The inpatient social worker discontinued the assessment due to the patient's need for "redirection following statements made to provider in hostile tone."

Throughout day 2, an inpatient psychiatry resident physician evaluated the patient multiple times because of the patient's irritability and requests to terminate interviews. The patient requested not to be asked about suicidality. The inpatient psychiatry resident physician obtained collateral information from the patient's friend who reported that the patient stopped taking antidepressant medication in spring 2019, and expressed worry over the patient's increased irritability, depression, paranoia, and grandiose thoughts.[19] Additionally, the patient's friend reported the patient had not mentioned suicidal thoughts "in the past other than yesterday." The inpatient psychiatry resident physician noted plans to rule out a bipolar affective disorder diagnosis and obtain a release of information for prior medical records from the patient's psychiatrist in another state.[20] The patient requested to be discharged but agreed to stay after speaking with the inpatient attending psychiatrist. The inpatient attending psychiatrist documented a plan to monitor the patient's medication response and obtain additional collateral information.

On day 3, in the inpatient interdisciplinary team meeting, the inpatient social worker documented a plan to discharge the patient. The inpatient attending psychiatrist met with the patient prior to discharge, clarified information from the patient's friend that suggested possible paranoid or grandiose thinking, and noted that the patient "exhibits good future oriented planning." The patient reported a plan to move back to another state to be closer to family and engage in treatment at the VA medical center. The inpatient attending psychiatrist noted the patient's stability "in the past 24 hours," improved mood with no irritability, resolved suicidal ideation, and compliance with medications.

The inpatient psychiatry resident physician also met with the patient prior to discharge. The patient denied access to weapons or pills and the inpatient psychiatry resident physician discharged the patient with antidepressant medication. The inpatient social worker scheduled the patient for three follow-up mental health appointments within 30 days at the facility and provided contact information for another VA medical center. The inpatient social worker

[19] Collateral information is patient information obtained from a secondary source, including family members, friends, or other providers.

[20] Diagnostic and Statistical Manual of Mental Disorders, *Bipolar Disorder*. Bipolar disorder is associated with mood swings in the form of depression or mania that may last for specified lengths of time. https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm03. (The website was accessed on May 5, 2020.)

documented that the patient's negative secondary suicide risk screens were completed within one day of discharge and, therefore, a comprehensive evaluation was not required.

An inpatient registered nurse documented the patient's safety plan including no access to firearms or opioids, and Veterans Crisis Line and facility Emergency Department contact information. The registered nurse provided a copy of the safety plan to the patient. The patient was discharged on day 3.

Three days following the patient's discharge, on the morning of day 6, a registered nurse care coordinator placed a post-discharge follow-up call and left a voicemail message for the patient. Later that evening, the Columbia Police Department notified the facility's administrator on duty of the patient's death. The administrator on duty notified the patient's primary care physician, inpatient attending psychiatrist, inpatient psychiatry resident physician, facility care coordinator, and the health benefits coordinator of the patient's death through a note in the electronic health record.

Per the autopsy report that was issued approximately seven weeks later, the medical examiner determined the patient's cause of death was a gunshot wound to the head and the manner of death was suicide.

Inspection Results

1. Care Coordination and Discharge Planning

The OIG substantiated that the patient died by suicide within three days of discharge from the facility's Inpatient Mental Health Unit. The OIG substantiated that the inpatient psychiatry resident physician initiated antidepressant medication and an inpatient registered nurse provided the patient with discharge instructions that included suicide prevention materials, which the OIG determined were consistent with VHA guidance.[21] However, the OIG identified deficiencies in care coordination and discharge planning between the Inpatient Mental Health Unit and Columbia Vet Center staff. Although aware of the patient's Columbia Vet Center treatment, Inpatient Mental Health Unit staff failed to coordinate the patient's mental health treatment or include Columbia Vet Center staff in discharge planning.

Care Coordination

The American Psychiatric Association suggests that a provider gain or corroborate information from prior medical records and other treating clinicians.[22] VA highlights continuity of care as

[21] VHA Handbook 1160.01.

[22] The American Psychiatric Association, "Practice Guidelines for the Psychiatric Evaluation of Adults," third edition, 2016. https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426760. (The website was accessed on April 27, 2020.)

critical in the national strategy for suicide prevention.[23] This is particularly salient since a patient's suicide risk is higher following an inpatient mental health unit discharge, with the greatest risk in the first three months after discharge.[24]

For a patient receiving care at a VHA facility and a Vet Center, Vet Center staff have access to the patient's VHA electronic health record. However, VHA staff must obtain a written release of information to access a patient's Vet Center health records.[25] The OIG found that although aware that the patient received counseling at the Columbia Vet Center, facility Inpatient Mental Health Unit staff did not attempt to obtain a written release of information from the patient to access the Columbia Vet Center health records.

In late 2019, the patient presented to the Columbia Vet Center and told the Columbia Vet Center Director about a past suicide attempt and access to "weapons or other lethal means." When interviewed in 2020, the Columbia Vet Center Director told the OIG that the patient reported that the firearms were not loaded, were locked up, and stored separately from ammunition. The patient did not report suicidal ideation to Columbia Vet Center staff at any time during the course of treatment.

On day 1, the patient presented to the Emergency Department and reported suicidal ideation with no specific plan and "was trying to think of ways" not to engage in self-harm. The inpatient psychiatry resident physician, in consultation with the attending psychiatrist, evaluated the patient for admission to the Inpatient Mental Health Unit and documented that the patient received care at the Columbia Vet Center. The inpatient psychiatry resident physician prescribed an antidepressant medication and admitted the patient to the Inpatient Mental Health Unit. During the patient's admission, the inpatient psychiatry resident physician and an attending psychiatrist documented that the patient denied any thoughts of suicide and that the patient received care at the Columbia Vet Center. The patient provided written releases of information for two friends, allowing "contact related to discharge planning." The inpatient psychiatry resident physician spoke with one of the patient's friends and obtained additional information about the patient's mental health symptom history. The inpatient psychiatry resident physician and the patient's friend told the OIG that they did not discuss the patient's access to lethal means.[26] The inpatient psychiatry resident physician documented a plan to obtain medical records; however, the OIG found no evidence that facility staff requested the patient sign a

[23] VA, National Strategy for Preventing Veteran Suicide, 2018-2028.

[24] Daniel Thomas Chung, Christopher James Ryan, Dusan Hadzi-Pavolvic, et al., "Suicide Rates after Discharge from a Psychiatric Facility: A Systematic Review and Metanalysis," *JAMA Psychiatry* 74, no. 7, (July 2017): 694-702.

[25] 38 C.F.R. § 17.2000(e), *Vet Center Services,* amended August 4, 2015.

[26] The OIG did not find electronic health record documentation about attempts to contact the patient's other friend listed on the release of information. The inpatient psychiatry resident physician told the OIG that if there was an attempt to contact the other friend, there would have been documentation.

release of information for the Columbia Vet Center or other non-VA medical records. In an interview with the OIG, the inpatient psychiatry resident physician did not recall why a release of information was not obtained for the Columbia Vet Center.

Discharge Planning

Discharge planning is a process by which the patient and healthcare staff work together to facilitate a care transition and provide continuity of care to meet a patient's unique needs.[27] Discharge planning must include the patient or an authorized surrogate, as well as any other individuals that the patient identifies and consents to having participate in the process.[28]

VHA requires that a patient's discharge planning begins promptly after a mental health unit admission and that the facility or program "to which the patient is being discharged must be actively involved in the process to facilitate patient engagement and timely follow-up."[29]

The inpatient social worker met with the patient for discharge planning and scheduled outpatient mental health follow-up appointments, as required by VHA.[30] The patient reported plans to return to another state and the inpatient social worker also provided contact information for other VA medical centers. In an interview with the OIG, the inpatient social worker reported providing the patient with a folder upon discharge that included local and state mental health resources, VA phone numbers, transportation information, Veterans Crisis Line information, and a list of follow-up appointments. The complainant and the patient's family member told the OIG that they found discharge papers in the patient's home, which included suicide prevention information. In interviews with the OIG, the inpatient social worker and Columbia Vet Center counselor reported that the patient's Columbia Vet Center counselor was not involved in the discharge planning process.

The OIG found that Inpatient Mental Health Unit staff did not attempt to include the patient's Columbia Vet Center counselor in the patient's discharge planning. Failure to engage Columbia Vet Center staff in the discharge planning process resulted in missed opportunities to facilitate the patient's engagement with outpatient resources and timely follow-up.

Safety Planning

VHA and facility policies require that Inpatient Mental Health Unit staff collaboratively develop a safety plan prior to discharge for patients at risk for suicide.[31] The basic components of the safety plan include warning signs, coping strategies, social contacts, family and friend contacts,

[27] Facility Medical Staff Bylaws, November 2016.

[28] VHA Handbook 1160.06, *Inpatient Mental Health Services,* September 16, 2013.

[29] VHA Handbook 1160.06.

[30] VHA Handbook 1160.06.

[31] VHA Handbook 1160.06.

professional contacts, and reducing access to lethal means.[32] VA instructs clinicians to ask patients directly what means they might use for self-harm and collaboratively identify ways to secure or limit access to lethal means.[33]

When interviewed in 2020, the Deputy Director of the Office of Mental Health and Suicide Prevention and the Facility Director told the OIG that safety planning should be a collaborative process between staff and the patient rather than a reliance on paper safety plan forms.

On day 2, an inpatient registered nurse provided the patient with the safety plan paper form and "instructions to complete." On day 3, another inpatient registered nurse briefly reviewed the safety plan with the patient. The plan noted that the patient did not have access to firearms and listed a friend as a protective factor from "having access to dangerous items." However, in an interview with the OIG, the inpatient registered nurse who reviewed the safety plan with the patient reported not specifically asking if the patient had guns, because the patient marked 'no' on the paper safety plan form item that asked if the patient had access to firearms. Furthermore, Inpatient Mental Health Unit staff did not document attempts to contact one of the patient's friends whom the patient listed as a protective factor. The inpatient registered nurse and inpatient social worker provided the patient with a copy of the safety plan that included the Veterans Crisis Line number.

The OIG found that Inpatient Mental Health Unit staff did not collaboratively develop a safety plan with the patient and relied, primarily, on the patient's self-report on a paper safety plan form. Further, the OIG found that reliance on the paper safety plan form resulted in a failure of Inpatient Mental Health Unit staff to ask the patient directly about lethal means access and, thus, not discussing ways to secure or limit access to lethal means. Inpatient Mental Health Unit staff's failure to collaboratively develop a safety plan and ask directly about lethal means access may have resulted in inadequate safety planning and a missed opportunity to discuss limiting access to lethal means.

[32] VHA *Suicide Prevention Coordinator Guide*, June 19, 2015. The manual is available on an internal VA website that is not available to the public.

[33] VA Manual, Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version, August 20, 2008.

2. Suicide Risk Screening and Evaluation Processes

The OIG found that facility staff failed to complete the VHA-required comprehensive evaluation of suicide risk prior to the patient's discharge because of deficiencies in hand-off and care transition processes across clinical settings.[34]

Upon presenting to the Emergency Department on day 1, the patient reported thoughts of self-harm. The patient screened positive on the secondary suicide risk screen; the registered nurse placed the patient on "suicide precautions and 1:1 observation" and documented that the positive secondary suicide risk screen "requires same-day completion" of the comprehensive evaluation. The Medical Officer on Duty completed a medical evaluation and entered a psychiatric consult. The inpatient psychiatry resident physician admitted the patient to the Inpatient Mental Health Unit but did not complete the comprehensive evaluation. In an interview with the OIG, the inpatient psychiatry resident physician stated that Emergency Department staff conveyed that the patient was experiencing suicidal ideation but did not specifically report the positive secondary suicide risk screen. The inpatient psychiatry resident physician reported being unaware that a positive secondary suicide risk screen required completion of a comprehensive evaluation. Facility leaders and staff told the OIG that the attending psychiatrist is responsible for training residents on the suicide risk assessment process including the comprehensive evaluation.

The inpatient psychiatry resident physician discussed the patient with the attending psychiatrist who concurred with starting an antidepressant medication. The inpatient psychiatry resident physician admitted the patient to the Inpatient Mental Health Unit under the care of the attending psychiatrist. The attending psychiatrist told the OIG that although the inpatient psychiatry resident did not explicitly communicate the secondary suicide risk screen result, the attending psychiatrist was responsible for obtaining that information. The attending psychiatrist further reported that the clinical focus was on the patient's need for inpatient admission and that nurses would communicate the positive secondary suicide risk screen during the hand-off process and that the inpatient social worker would complete the comprehensive evaluation the following day.

The Emergency Department registered nurse completed a transfer note that listed suicidal ideation as the reason for admission but did not note the unresolved comprehensive evaluation. The Emergency Department registered nurse told the OIG that when a patient screens positive on the secondary suicide risk screen in the Emergency Department prior to admission, the comprehensive evaluation is typically completed after the patient is transferred to the Inpatient

[34] U.S. Department of Health and Human Services, Patient Safety Network, "Handoffs and Signouts," September 2019. For the purpose of this report, "hand-off" encompasses both the process of transferring responsibility for a patient's care and transmitting information about a patient from one provider to another when transferring responsibility for a patient's care. https://psnet.ahrq.gov/primers/primer/9/handoffs-and-signouts. (The website was accessed on June 9, 2020.) Deputy Under Secretary for Health for Operations and Management (10N), *Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) initiatives,* October 17, 2019.

Mental Health Unit. The inpatient registered nurse who received the verbal hand-off and completed the patient's admission assessment told the OIG that the expectation was that an inpatient social worker would complete the patient's comprehensive evaluation the following day.

On day 2, the inpatient social worker completed a social work evaluation and repeated the secondary suicide risk screen with the patient. The patient screened negative on the secondary suicide risk screen. The next day, the inpatient social worker documented "these screenings did not necessitate completion of the Comprehensive Suicide Evaluation."

Facility leaders and staff told the OIG that, at that time of the patient's admission, staff did not include prior suicide risk assessment results in the Inpatient Mental Health Unit admission note or the nurse-to-nurse hand-off communication. Further, facility staff and leaders reported that it was standard practice for Inpatient Mental Health Unit staff to repeat the suicide risk screening and evaluation process upon admission and rely on those results and not prior screenings. Consistent with this practice, in interviews with the OIG, Inpatient Mental Health Unit staff reported considering only the patient's negative secondary suicide risk screen results that the inpatient social worker obtained. The patient was discharged without a comprehensive evaluation.

The OIG found that Inpatient Mental Health Unit staff were not aware of the patient's positive secondary suicide risk screen in the Emergency Department because the information was not included in the hand-off or other care transition processes across clinical settings. Although the patient was transferred to the appropriate level of care to address suicidal ideation, deficiencies in the hand-off and care transition resulted in providers' failure to complete the comprehensive evaluation, as required. The absence of this evaluation may have contributed to missed information to adequately establish the patient's acute and chronic suicide risk factors and risk mitigation plan.

Facility leaders and staff told the OIG that although the comprehensive evaluation was not completed, providers documented equivalent information in the patient's electronic health record. The OIG determined that the patient's electronic health record included 7 of the 23 comprehensive evaluation components. Notably, the patient's electronic health record did not include a clinical impression of acute and chronic suicide risk or a plan to mitigate suicide risk.

Facility leaders and staff told the OIG that following the patient's death, Inpatient Mental Health Unit nursing leaders implemented a hand-off communication tool for transitions across clinical settings that included secondary suicide risk screen results from both the Inpatient Mental Health Unit admission assessment and the prior seven days. Additionally, Inpatient Mental Health Unit nursing leaders implemented (1) a standardized form to report patient information, including secondary suicide risk screen results, during the interdisciplinary team meetings; and (2) an admission note template that included the previous seven days secondary suicide risk screen results and prompted completion of the comprehensive evaluation, as indicated. Inpatient Mental

Health Unit nursing leaders also implemented a monthly audit to monitor staff compliance in completion of the comprehensive evaluation, when required. The facility's monthly audit results indicated 90 percent compliance in March 2020, and 100 percent compliance in April, May, and June 2020.

In March 2020, a facility psychiatrist emailed consulting psychiatric resident physicians information about the three-stage suicide risk screening process and instructions to determine each patient's secondary suicide risk screen results and complete the comprehensive evaluation, as required. In April 2020, the Mental Health Department Chief informed the OIG that the suicide risk screening and comprehensive evaluation instructions were posted on a facility SharePoint site for consulting psychiatric resident physicians. The Mental Health Department Chief also reported that the facility's suicide prevention policy was being revised to include staff responsibilities for suicide risk screening and the comprehensive evaluation.

3. MHTC Policy and Assignment

As of 2012, VHA requires that staff assign an MHTC to every patient prior to the patient's discharge from an inpatient mental health unit. The MHTC's goal is to ensure continuity of care during care transitions, collaborate with the suicide prevention coordinator to ensure increased monitoring and enhanced care for patients at risk for suicide, and assist a patient's engagement in treatment.[35] Inpatient mental health unit staff are required to identify the MHTC using a nationally standardized note template. VHA also requires that each medical center establishes a policy that guides identification of the MHTC and ensures that an MHTC is assigned to all patients waiting to transition to another level of care.[36]

MHTCs are expected to maintain regular contact with the patient as clinically indicated, coordinate treatment plan development with patient input, and communicate with the patient about problems or concerns with treatment.

The OIG found that facility leaders did not establish a policy to guide identification of the MHTC and ensure MHTC assignment for patients awaiting transfer to another level of care, as required.[37] The Mental Health Department Chief told the OIG that a written MHTC policy was not developed, in part due to confidence in the facility's suicide prevention program, primary therapist assignment process, and interdisciplinary approach to treatment. However, the OIG

[35] Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012; VHA Handbook 1160.01.

[36] In 2012, VHA replaced the term Principal Mental Health Provider with Mental Health Treatment Coordinator. Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012; VHA Handbook 1160.01.

[37] Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012.

found that Inpatient Mental Health Unit providers did not assign the patient an MHTC upon discharge, as required by VHA.[38]

Facility leaders and staff, in interviews with the OIG, were unsure why staff did not assign an MHTC prior to the patient's discharge. The Facility Director speculated that due to the patient's discharge on a Friday there may have been a plan to assign the MHTC the following Monday or that staff failed to document MHTC assignment. The Mental Health Department Chief told the OIG that staff did not assign an MHTC because the patient voiced a plan to return to another state and had not established care at the facility. VHA Office of Mental Health and Suicide Prevention leaders told the OIG that an MHTC assignment was required prior to discharge from an inpatient mental health unit including when the patient is not engaged in outpatient mental health care and that staff would be expected to assign a temporary MHTC until a permanent outpatient provider was assigned.

The absence of a facility policy may have contributed to staff's lack of knowledge regarding the requirements and processes related to the identification and assignment of an MHTC. On July 30, 2020, after the OIG expressed concern about the lack of MHTC policy, the Mental Health Department Chief implemented two standard operating procedures clarifying MHTC assignment processes for (1) all staff, and (2) Inpatient Mental Health Unit social workers.

The failure to assign an MHTC may have resulted in the patient not receiving support during the discharge process, which can be critical to a patient's successful transition. Further, lack of an MHTC to support the patient's transition to outpatient mental health treatment may have diminished the likelihood of the patient's engagement and post-discharge outreach.

4. Administrative Actions Following a Patient's Death

The OIG found that the facility's Suicide Prevention Coordinator failed to document that the patient had a positive secondary suicide risk screen in an issue brief completed in response to the patient's death. Additionally, in part based on the issue brief, facility leaders did not make an institutional disclosure to the patient's next of kin.[39]

The OIG found that VHA failed to adequately disseminate written guidance to all stakeholders regarding the role of Vet Center staff in medical center root cause analysis.

Issue Brief and Institutional Disclosure

VHA requires completion of an issue brief following a death by suicide within seven days after discharge from a VA inpatient facility. Facility leaders submit issue briefs to VISN leaders prior

[38] Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012; VHA Handbook 1160.01.

[39] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

to submission to VHA leaders.[40] Issue briefs are intended to provide "clear, concise and factual information" about the death, review clinical care, and determine compliance with policy requirements.[41] Issue briefs related to suicide require information about (1) suicide risk assessments completed within the last two years, (2) the last mental health screening date and results, and (3) a determination on whether an institutional disclosure is indicated.[42]

An institutional disclosure is a formal process for facility leaders and clinicians to inform the patient or patient's personal representative that an adverse event occurred during the patient's treatment that may have contributed to serious risk of future health issues or death.[43] The institutional disclosure must be completed regardless of when the adverse event is discovered and "includes specific information about the patient's rights and recourse."[44]

Three days after facility staff discharged the patient from the Inpatient Mental Health Unit, the local police notified facility staff of the patient's death. The Suicide Prevention Coordinator completed an issue brief within the time frame required by VHA.[45] However, the Suicide Prevention Coordinator did not include the patient's positive Emergency Department secondary suicide risk screen that was conducted on day 1 in the list of suicide risk assessments completed with the patient within the last two years. During interviews with the OIG, the Mental Health Department Chief and behavioral health clinical manager reported that they were not aware of the omission of the positive Emergency Department secondary suicide risk screen in the issue brief list of suicide risk assessments within the past two years.

Although not included in the issue brief list of suicide risk assessments, the Suicide Prevention Coordinator included the patient's Emergency Department secondary suicide risk screen conducted on day 1 in the issue brief list of last mental health screenings, and documented "key indicators" as the result. The Suicide Prevention Coordinator told the OIG that key indicators indicated a positive result. However, an Inpatient Mental Health Unit Assistant Nurse Manager and the VISN Quality Management Officer told the OIG that they did not know that "key indicators" meant "positive."[46] Of the 31 issue briefs submitted to the VISN from October 1, 2018, through July 22, 2020, only the issue brief regarding the patient's suicide used the term "key indicator." Facility leaders told the OIG that an institutional disclosure was not considered, in part, because staff completed elements of the comprehensive evaluation even though the

[40] 10N Guide to VHA Issue Briefs, May 12, 2017.

[41] 10N Guide to VHA Issue Briefs.

[42] VHA Directive 1004.08.

[43] VHA Handbook 1004.08, VHA defines an adverse event as harmful or potentially harmful incident associated with care delivered by VA providers.

[44] VHA Directive 1004.08.

[45] 10N Guide to VHA Issue Briefs.

[46] The Inpatient Mental Health Unit Assistant Nurse Manager learned that key indicators represented a positive screen after asking the Suicide Prevention Coordinator.

required template was not utilized. The Facility Director told the OIG that Inpatient Mental Health Unit staff ensured appropriate discharge planning for the patient, which supported the determination not to complete an institutional disclosure.

The OIG found that staff failed to comprehensively and effectively report the patient's one positive suicide risk screening result in the issue brief related to the patient's death. The omission of suicide risk screening results and use of an unfamiliar term to describe suicide screening results may compromise facility leaders' ability to determine policy compliance and may influence decisions to conduct an institutional disclosure.[47]

Root Cause Analysis

In a 2010 Vet Center Program handbook, VHA required medical center staff to include Vet Center staff on root cause analysis teams and provide relevant root cause analysis outcomes to Vet Center staff regarding shared patients.[48] The 2011 VHA National Patient Safety Program requires medical center staff to complete a root cause analysis for any death by suicide within 72 hours of discharge from an inpatient unit.[49] A 2017 memorandum of understanding between the Office of Mental Health and Suicide Prevention and Vet Centers was established to "formalize and enhance the shared responsibility for suicide prevention," and requires medical center staff to invite Vet Center staff to serve on the root cause analysis team for shared patients who died by suicide.[50] The former Facility Director received the memorandum of understanding from the VISN on November 13, 2017, the former Facility Director's administrative staff member reported compliance with the memorandum of understanding to the VISN on February 9, 2018.[51]

Office of Mental Health and Suicide Prevention leaders told the OIG that the Mental Health Department Chief is responsible for consulting with quality improvement staff and ensuring compliance with the 2017 memorandum of understanding. In interviews with the OIG, the VISN Patient Safety Officer and VISN Quality Management Officer, a facility patient safety staff member, the Mental Health Department Chief, and the Chief of Staff reported not being aware of the memorandum of understanding or the requirement to include Vet Center staff on root cause analysis teams for shared patients who died by suicide. Additionally, National Center for Patient

[47] VHA Directive 1004.08.

[48] VHA Handbook 1500.01, Readjustment Counseling Services Vet Center Program, September 8, 2010.

[49] VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, March 4, 2011.

[50] VA Memorandum, Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services, November 13, 2017.

[51] VA Memorandum, Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services, November 13, 2017. The current Facility Director was appointed in September 2019.

Safety leaders told the OIG that they were not aware of the 2017 memorandum of understanding.[52]

The OIG found that facility, VISN, and National Center for Patient Safety leaders did not have knowledge of a 2017 Office of Mental Health and Suicide Prevention and Vet Centers memorandum of understanding that requires medical center staff to include Vet Center representation for shared patients during VHA root cause analyses. The OIG concluded that the lack of broad stakeholder awareness of the root cause analysis requirement may result in VHA medical center staff's failure to include Vet Center staff on a root cause analysis team for shared patients. These failures may lead to incomplete information and understanding of relevant systemic processes.

Conclusion

The OIG substantiated that the patient died by suicide within three days of discharge from the facility's Inpatient Mental Health Unit. The OIG substantiated that the inpatient psychiatry resident physician initiated antidepressant medication and an inpatient registered nurse provided the patient with discharge instructions that included suicide prevention materials, which the OIG determined were consistent with VHA guidance.[53] However, the OIG identified care coordination and discharge planning deficiencies including Inpatient Mental Health Unit staff's failure to coordinate the patient's mental health treatment or include Columbia Vet Center staff in discharge planning. In an interview with the OIG, the inpatient psychiatry resident physician did not recall why a release of information was not obtained for the Columbia Vet Center. Failure to engage Columbia Vet Center staff in the discharge planning process resulted in missed opportunities to facilitate the patient's engagement with outpatient resources and timely follow-up.

The OIG found that facility staff failed to complete the VHA-required comprehensive evaluation of suicide risk prior to the patient's discharge because of deficiencies in hand-off and care transition processes across clinical settings.[54] Inpatient Mental Health Unit staff were not aware

[52] VHA established the National Center for Patient Safety in 1999 to create a culture of safety and to guide patient safety efforts, such as root cause analyses, with the goal to decrease and prevent inadvertent adverse patient events resulting from medical care. VA, "National Center for Patient Safety Brochure," 2016. https://www.patientsafety.va.gov/docs/2016_VA_NCPS_Marketing_Brochure_508_FINAL%20-%20Copy.pdf. (The website was accessed on April 13, 2020.)

[53] VHA Handbook 1160.01.

[54] U.S. Department of Health and Human Services, Patient Safety Network, "Handoffs and Signouts," September 2019. For the purpose of this report, "hand-off" encompasses both the process of transferring responsibility for a patient's care and transmitting information about a patient from one provider to another when transferring responsibility for a patient's care. https://psnet.ahrq.gov/primers/primer/9/handoffs-and-signouts. (The website was accessed on June 9, 2020.) Deputy Under Secretary for Health for Operations and Management (10N), *Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) initiatives,* October 17, 2019.

of the patient's positive secondary suicide risk screen in the Emergency Department because the information was not included in the hand-off or other care transition processes across clinical settings. Although the patient was transferred to the appropriate level of care to address suicidal ideation, deficiencies in the hand-off and care transition resulted in providers' failure to complete the comprehensive evaluation, as required. The absence of this evaluation may have contributed to missed information to adequately establish the patient's acute and chronic suicide risk factors and risk mitigation plan.

Facility leaders and staff told the OIG that following the patient's death, Inpatient Mental Health Unit nursing leaders implemented a hand-off communication tool, a standardized process to report secondary suicide risk screen results during interdisciplinary team meetings, and an admission note template that included the previous seven days secondary suicide risk screen results. Inpatient Mental Health Unit nursing leaders also implemented a monthly audit to monitor staff compliance, which resulted in 90 percent compliance in March 2020, and 100 percent compliance in April, May, and June 2020.

The OIG found that facility leaders did not establish a policy to guide identification of the MHTC and ensure MHTC assignment for patients awaiting transfer to another level of care, as required.[55] The Mental Health Department Chief told the OIG that a written MHTC policy was not developed, in part due to confidence in the facility's suicide prevention program, primary therapist assignment process, and interdisciplinary approach to treatment. However, the OIG found that Inpatient Mental Health Unit providers did not assign the patient an MHTC upon discharge, as required by VHA.[56] Facility leaders and staff, in interviews with the OIG, were unsure why staff did not assign an MHTC prior to the patient's discharge.

The absence of a facility policy may have contributed to staff's lack of knowledge regarding the requirements and processes related to the identification and assignment of an MHTC. On July 30, 2020, after the OIG expressed concern about the lack of an MHTC policy, the Mental Health Department Chief implemented two standard operating procedures clarifying MHTC assignment processes for (1) all staff, and (2) Inpatient Mental Health Unit social workers. The failure to assign an MHTC may have resulted in the patient not receiving support during the discharge process, which can be critical to a patient's successful transition. Further, lack of an MHTC to support the patient's transition to outpatient mental health treatment may have diminished the likelihood of the patient's engagement and post-discharge outreach.

The OIG found that staff failed to comprehensively and effectively report the patient's one positive suicide risk screening result in the issue brief related to the patient's death. The omission

[55] Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012.

[56] Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012; VHA Handbook 1160.01.

of suicide risk screening results and use of an unfamiliar term to describe suicide screening results may compromise facility leaders' ability to determine policy compliance and may influence decisions to conduct an institutional disclosure.[57] Additionally, in part, based on the issue brief, facility leaders did not make an institutional disclosure to the patient's next of kin.

The OIG found that facility, VISN, and National Center for Patient Safety leaders did not have knowledge of a 2017 Office of Mental Health and Suicide Prevention and Vet Centers memorandum of understanding that requires Vet Center representation for shared patients during VHA root cause analyses. The OIG concluded that the lack of broad stakeholder awareness of the root cause analysis requirement may result in VHA medical center staff's failure to include Vet Center staff on a root cause analysis team for shared patients. These failures may lead to incomplete information and understanding of relevant systemic processes.

Recommendations 1–7

1. The Harry S. Truman Memorial Veterans' Hospital Director strengthens the processes for collaboration between Inpatient Mental Health Unit staff and Vet Center providers for shared patients including for collateral information and discharge planning.
2. The Harry S. Truman Memorial Veterans' Hospital Director ensures that Inpatient Mental Health Unit staff collaboratively develop safety plans with patients, including asking the patient directly about access to lethal means.
3. The Harry S. Truman Memorial Veterans' Hospital Director continues to monitor the communication of suicide risk assessment results in the hand-off process across clinical settings and takes action as necessary.
4. The Harry S. Truman Memorial Veterans' Hospital Director monitors compliance with Mental Health Treatment Coordinator standard operating procedures to ensure that Inpatient Mental Health Unit staff assign a Mental Health Treatment Coordinator, as required.
5. The Harry S. Truman Memorial Veterans' Hospital Director ensures that issue briefs are comprehensive and accurate.
6. The Harry S. Truman Memorial Veterans' Hospital Director conducts a full review of the patient's final episode of care and determines whether an institutional disclosure is warranted.

[57] VHA Directive 1004.08.

7. The Under Secretary for Health disseminates written guidance broadly to Veterans Health Administration stakeholders to ensure that Vet Center staff are included in the root cause analysis process for suicide-related events of shared patients.[58]

[58] The recommendation directed to the Under Secretary for Health was submitted to the Executive in Charge who has the authority to perform the functions and duties of the Under Secretary for Health.

Appendix A: Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: October 22, 2020

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: Healthcare Inspection—Deficiencies in Inpatient Mental Health Care Coordination and Processes Prior to a Patient's Death by Suicide, Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri

To: Assistant Inspector General of Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report titled, Deficiencies in Inpatient Mental Health Care Coordination and Processes Prior to a Patient's Death by Suicide, Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri. The Veterans Health Administration (VHA) concurs with recommendation 7 and provides the attached action plan.
2. Responses were provided by the Facility Director of the Harry S. Truman Memorial Veterans' Hospital and are attached for recommendations 1 through 6.
3. If you have any questions, please contact Karen Rasmussen, M.D., Director, GAO OIG Accountability Liaison Office at VHA10BGOALAction@va.gov.

(*Original signed by*:)

Richard A. Stone, M.D.

Executive in Charge Response

Recommendation 7

The Under Secretary for Health disseminates written guidance broadly to Veterans Health Administration stakeholders to ensure that Vet Center staff are included in the root cause analysis process for suicide-related events of shared patients.

Concur.

Target date for completion: January 2021

Executive in Charge Comments

The Veterans Health Administration Readjustment Counseling Service, National Center for Patient Safety, and Office of Mental Health and Suicide Prevention will collaborate to disseminate written guidance broadly to Veterans Health Administration stakeholders.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 30, 2020

From: Director, VA Heartland Network (10N15)

Subj: Healthcare Inspection—Deficiencies in Inpatient Mental Health Care Coordination and Processes Prior to a Patient's Death by Suicide, Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri

To: Executive in Charge, Office of the Under Secretary for Health (10)
Director, Office of Healthcare Inspections (54MH00)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. Attached is the facility's comments to the draft report Deficiencies in Inpatient Mental Health Care Coordination and Processes Prior to a Patient's Death by Suicide, Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri.
2. I have reviewed and concur with the facility's comments.
3. For additional questions, please feel free to contact Michelle Boylan, VISN 15 Quality Management Officer.

(*Original signed by*:)

William P Patterson, M.C., MSS
Network Director
VA Heartland Network (VISN 15)

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 5, 2020

From: Director, Harry S Truman Memorial Veterans' Hospital, Columbia, Missouri (589A4/00)

Subj: Healthcare Inspection—Deficiencies in Inpatient Mental Health Care Coordination and Processes Prior to a Patient's Death by Suicide, Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri

To: Director, VA Heartland Network (10N15)

1. Thank you for the opportunity to review and respond to the Health Inspection regarding deficiencies in inpatient mental health care coordination and processes prior to a patient's death by suicide involving Harry S. Truman Memorial Veterans' Hospital.
2. I have reviewed and concur with the recommendations in the report. Corrective action plans have been developed or implemented and are outlined in the attached report.
3. If you have any questions, please contact April Leverett, Chief, Quality Management.

(*Original signed by*:)

Patricia L. Hall, PhD, FACHE

Facility Director Response

Recommendation 1

The Harry S. Truman Memorial Veterans' Hospital Director strengthens the processes for collaboration between Inpatient Mental Health Unit staff and Vet Center providers for shared patients including for collateral information and discharge planning.

Concur.

Target date for completion: Action complete. Will monitor for continued compliance until May 1, 2021.

Director Comments

Actions Completed:
Assessment questions have been added to nursing admission note in the Computerized Patient Record System (CPRS) to identify Veterans who are receiving treatment at the Vet Center:

"Do you receive treatment at the Vet Center? If so, do you want them involved in treatment and discharge planning?

Are you willing to sign a release of information, so we are able to gather and share information with them?"

Monitoring:

Compliance has been and will continue to be monitored by the Nurse Manager of the Acute Psychiatric Care Unit with evidence for compliance submitted by May 1, 2021.

Measure: Denominator = # of CO-BH NURSING NOTE PSYCH ADMISSION ASSESSMENT notes; Numerator = # of notes with fields utilized.

Target = 90%

Actions Completed:

The answers to the above-mentioned questions have been added to the Interdisciplinary Team note to guide discharge planning. Acute Psychiatric Care Unit employees were trained on these changes.

Monitoring:

Compliance will be monitored by Chief, Behavioral Health with evidence for compliance submitted by May 1, 2021.

Measure: Denominator = # CO-BH INTERDISCIPLINARY CARE/DISCHARGE PLANNING Notes; Numerator = # of notes with fields utilized.

Target = 90%

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 2

The Harry S. Truman Memorial Veterans' Hospital Director ensures that Inpatient Mental Health Unit staff collaboratively develop safety plans with patients, including asking the patient directly about access to lethal means.

Concur.

Target date for completion: Action complete. Will monitor for training completion by October 23, 2020.

Director Comments

Actions Completed:
Medical Center Policy (MCP) 461 has been updated to further define responsibilities for safety plan completion as a collaborative process between Veteran and staff. The MCP defines expectations related to assessment of firearms, discussion of firearm access by Interdisciplinary Team for discharge planning purposes, and connection of initial assessment to safety plan before discharge. Training has been initiated with 76% of Acute Psychiatric Care Unit employees having received training.

Monitoring:

100% of the employees of the Inpatient Acute Psychiatric Unit will be trained on these changes. Training roster will be completed by the Nurse Manager of the Acute Psychiatric Care Unit with evidence provided by October 23, 2020.

Measure: Denominator = # Acute Psychiatric Care Unit employees; Numerator = # employees who have completed training.

Target = 100%

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 3

The Harry S. Truman Memorial Veterans' Hospital Director continues to monitor the communication of suicide risk assessment results in the hand-off process across clinical settings and takes action as necessary.

Concur.

Target date for completion: Action complete. Will monitor for continued compliance until May 1, 2021

Director Comments

Actions Completed:

Medical Center Policy (MCP) 461 provides detailed information about the suicide risk assessment screens that are completed in all areas of the medical center.

CPRS note templates have been changed to auto-populate the last 7 days of Columbia screens into the nursing admission assessment to reduce the risk of misinformation or error in identifying positive screens.[59]

MCP 461 describes the process for completion of Comprehensive screens during the week and off-tour.[60] MCP 461 describes discussion of positive Columbia screens and completion of Comprehensive screens at every Interdisciplinary Team meeting where screening of new patients is covered.

Monitoring:

This will be monitored for 6 months to ensure 100% accuracy of completion within 24 hours of positive Columbia Screen. Compliance will be monitored by Chief, Behavioral Health with evidence for compliance submitted by May 1, 2021.

Measure: Denominator = # CO-BH NURSING NOTE PSYCH ADMISSION ASSESSMENT notes; Numerator = # Notes with auto-populated Columbia Screens

Target = 100%

[59] The Columbia Screen refers to the secondary suicide risk screen discussed in the report from the Office of Inspector General.
[60] Comprehensive screen refers to the comprehensive suicide risk evaluations discussed in the report from the Office of Inspector General.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 4

The Harry S. Truman Memorial Veterans' Hospital Director monitors compliance with Mental Health Treatment Coordinator standard operating procedures to ensure that Inpatient Mental Health Unit staff assign a Mental Health Treatment Coordinator, as required.

Concur.

Target date for completion: Action complete. Will monitor for continued compliance until May 1, 2021.

Director Comments

Actions Completed:

The inpatient Standard Operating Procedure has been updated to assign a Mental Health Treatment Coordinator (MHTC) upon admission.

Monitoring:

Medical records will be monitored for six months to ensure compliance. Compliance will be monitored by Chief, Behavioral Health with evidence for compliance submitted by May 1, 2021.

Measure: Denominator = # Veterans admitted to acute psychiatric care unit; Numerator = # Veteran medical records with MHTC assignment.

Target = 90%

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 5

The Harry S. Truman Memorial Veterans' Hospital Director ensures that issue briefs are comprehensive and accurate.

Concur.

Target date for completion: Action complete. Will monitor for continued compliance until May 1, 2021.

Director Comments

Actions Completed:
The information in the original Issue Brief was complete. Information entered in some fields was not carried over to additional fields. Had this information been carried over to additional fields, the additional fields would have been considered complete, however the information would have been redundant. We have added additional reviewers to the routing process to ensure the information is documented in all required fields. As has been the practice of Harry S. Truman Memorial Veterans' Hospital, future Issue Briefs will be monitored for accuracy and completion of all required fields. Issue Briefs related to Completed Suicides will be monitored for accuracy and completion of all required fields in the following ways:

- All results of the Columbia Suicide Severity Rating Scale (CSSRS) will be described as positive or negative.[61] At no time will "Key Indicator" be used to describe results.
- All CSSRS results listed in box 11 will also be listed in box 8 of the Issue Brief.

Monitoring:
Compliance will be monitored by the Medical Center Director with evidence for compliance submitted by May 1, 2021.

Measure: Denominator = # of Issue Briefs related to completed suicide; Numerator = # of Issue Briefs with CSSRS results described only as negative or positive.

Measure: Denominator = # of Issue Briefs related to completed suicide with positive CSSRS listed in box 11; Numerator = # of Issue Briefs with CSSRS results listed in box 11 and box 8.

Target for both measures = 100%

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 6

The Harry S. Truman Memorial Veterans' Hospital Director conducts a full review of the patient's final episode of care and determines whether an institutional disclosure is warranted.

Concur.

Target date for completion: Complete

[61] The Columbia Suicide Severity Rating Scale is referred to as the secondary suicide risk screen in the report from the Office of Inspector General.

Director Comments

A full review was conducted, and it was determined an Institutional Disclosure is not appropriate.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

OIG Contact and Staff Acknowledgments

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