



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Care and
Administrative Processes for
a Patient Who Died by
Suicide, Phoenix VA Health
Care System, Arizona



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Executive Summary

The VA Office of Inspector General (OIG) conducted an inspection to review concerns related to the mental health care provided at the Carl T. Hayden VA Medical Center (facility), to a patient who died by suicide in May 2019.¹ In spring 2020, in connection with work conducted by the Office of Audits and Evaluations, the Office of Healthcare Inspections identified concerns with the patient's mental health care. Specifically, the OIG evaluated if staff (1) offered treatment and monitoring while the patient awaited a community care psychological diagnostic evaluation, (2) returned a call to the patient's family member, (3) scheduled a community care consult in a timely manner, and (4) completed administrative procedures within required time frames.

The patient initially established care at the facility in summer 2017 and participated in mental health treatment intermittently through summer 2018. In early 2019, the patient requested to reestablish mental health care. A social worker entered a consult for psychological diagnostic testing "to rule out schizoid personality disorder or autism spectrum disorder."

The OIG found that facility staff failed to offer the patient mental health treatment although the social worker documented a plan to follow up with the patient by phone while the patient awaited psychological diagnostic testing. Despite the patient's request to reestablish mental health care, potential decompensation, and a family member's report of the patient's threatening gestures and increased stressors, the social worker relied on another social worker's suicide risk assessment completed eight months prior.² In an interview with the OIG, the social worker reported not perceiving the patient as under increased stress. The social worker's failure to obtain a current risk assessment may have resulted in an underestimation of the patient's suicide risk level and consequently the development of a plan that did not mitigate the patient's suicide risk.

A family member called on a Friday afternoon to notify staff that the patient died, and staff returned the call the following Monday. Facility leaders had variable expectations about the timeliness of a clinician's response. The OIG found that the social worker's electronic health record (EHR) documentation did not include essential information of the family member's voicemail message, specifically, that the patient died by suicide. The social worker did not recall why the complete and accurate content of the voicemail message was not included in the EHR documentation. Moreover, a Suicide Prevention Coordinator failed to complete timely documentation of outreach to the patient's family. The Suicide Prevention Coordinator told the OIG that the time frame for outreach is discretionary, reported wanting to allow the family time

¹ The facility is part of the Phoenix VA Health Care System in Arizona.

² American Psychological Association, "APA Dictionary of Psychology," accessed March 10, 2021, <https://dictionary.apa.org/decompensation>. Decompensation is defined as "a breakdown in an individual's defense mechanisms, resulting in progressive loss of normal functioning or worsening of psychiatric symptoms."

to grieve before making outreach attempts, and did not recall the reason for the late documentation of the outreach efforts.

The social worker's failure to accurately and completely document the content of the family member's voicemail message resulted in the omission of critical clinical information in the patient's EHR and precluded other staff's awareness of the patient's death by suicide. Further, the Suicide Prevention Coordinator's nine-day delay in documentation of outreach to the family member also contributed to incomplete EHR documentation, and the OIG determined the delayed documentation did not comply with Veterans Health Administration (VHA) timeliness requirements.

The mental health delegate did not review the patient's initial community care consult within the required time frame.³ The OIG found that the mental health delegate approved the initial community care psychology consult eight business days after initially alerted to the request, which delayed the consult scheduling and exceeded three business days, inconsistent with VHA policy.⁴ The mental health delegate told the OIG that at the time the consult was placed, there was one mental health delegate and this contributed to the delay in clinical review and approval of the subject patient's consult. As of July 2020, there were seven mental health delegates assigned to review community care psychology consults. The General Mental Health Section Chief told the OIG that since increasing the number of mental health delegates, the "majority" of mental health community care consults are reviewed "within 24–48 hours."

The third-party administrator scheduled the patient with a community provider within 30 days of approval, as instructed by VHA.⁵ However, the third-party administrator scheduled the patient for therapy rather than testing, which resulted in the patient not receiving diagnostic testing as requested. Failure to schedule the patient for the requested services may have contributed to a delay in critical treatment and an increase in the patient's stress level.

The OIG found that facility scheduling staff did not complete required outreach efforts when the patient missed a primary care appointment one day prior to the patient's death by suicide. Further, scheduling staff and leaders had inconsistent knowledge of primary care missed appointment procedures.⁶ In an interview with the OIG, the medical support assistant supervisor stated that, based on information from facility trainers, primary care was a low-risk clinic and

³ VHA Office of Community Care, *Field Guidebook*, July 14, 2020. A mental health delegate is assigned authority to determine if the requested services are appropriate to be "authorized for delivery in the community."

⁴ VHA Deputy Under Secretary for Health for Operations and Management Memorandum, *Enhancements to the Community Care Clinical Review Process*, March 24, 2017.

⁵ A third-party administrator is a company that contracts with VA to manage non-VA appointments and scheduling.

⁶ VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016. The directive was in effect at the time of the events in this report and was amended and replaced by VHA Directive 1230(2), *Outpatient Scheduling Processes and Procedures*, amended January 22, 2020. VHA Notice 2019-09(2). *Minimum Scheduling Effort Required for Outpatient Appointments: Updates to VHA Directive 1230 and VHA Directive 1232(1)*, May 8, 2019. Facility Policy 136-83, *Scheduling Policy*, November 14, 2016.

therefore, missed appointment outreach was not required. However, the VHA training protocol did not include primary care on the list of “Current Low Risk Clinics” and the training was consistent with VHA requirements, including two outreach attempts in response to a patient’s missed appointment.⁷ Further, failure to complete telephone outreach in response to the patient’s missed primary care appointment contributed to a missed opportunity to assess the patient’s status and reschedule medical care. Facility staff and leaders’ lack of consistent response to missed primary care appointments may result in failures to provide outreach to patients and ensure appointments are rescheduled as needed.

The OIG found that the Suicide Prevention Coordinator completed the patient’s behavioral health autopsy approximately one year after awareness of the patient’s death by suicide.⁸ The Suicide Prevention Coordinator told the OIG that staffing shortages may have contributed to the oversight. In an interview with the OIG, the Assistant Chief of Social Work agreed that the Suicide Prevention Team’s staffing level and other responsibilities may have contributed to the delay in the behavioral health autopsy completion. The Assistant Chief of Social Work told the OIG that as of October 15, 2020, the Suicide Prevention Team was fully staffed with three case managers, three coordinators, and a supervisor.

The OIG made seven recommendations to the Facility Director related to consideration of administrative action related to the patient’s care, suicide risk assessment, EHR documentation, timely community care authorization, missed appointment procedures, community care scheduling accuracy, and timely completion of behavioral health autopsies.

Comments

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



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⁷ VHA Directive 1230.

⁸ VHA Deputy Under Secretary for Health for Operations and Management Memorandum, *Behavioral Autopsy Program Implementation*, December 11, 2012. A behavioral health autopsy is a “standardized medical record review” using a national template and submitted via an approved suicide prevention SharePoint portal within 30 days of facility staff’s notification of a patient’s death by suicide.

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Abbreviations

EHR	electronic health record
OIG	Office of Inspector General
PTSD	posttraumatic stress disorder
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted an inspection to review concerns related to the mental health care provided at the Carl T. Hayden VA Medical Center (facility) to a patient who died by suicide.¹ Specifically, the OIG evaluated if staff (1) offered treatment and monitoring while the patient awaited a community care psychological diagnostic evaluation, (2) returned a call to the patient’s family member, (3) scheduled a community care consult in a timely manner, and (4) completed administrative procedures within required time frames.

Background

The Phoenix VA Health Care System, comprised of the facility and 10 community-based outpatient clinics, is part of Veterans Integrated Service Network (VISN) 22. The facility is located in Phoenix, Arizona, and provides acute medical, surgical, and inpatient psychiatric care. From October 1, 2018, through September 30, 2019, the Phoenix VA Health Care System served 99,917 patients and had a total of 294 hospital operating beds, including 166 inpatient beds, 24 domiciliary beds, and 104 community living center beds. The Phoenix VA Health Care System is affiliated with several schools including the University of Arizona College of Medicine – Phoenix, Mayo Clinic Medical School, Creighton University/Dignity Health, Maricopa Integrated Healthcare System, and Honors Health.

Prior OIG Reports

In a 2017 review of the Veterans Choice Program implementation, the OIG Office of Audits and Evaluations found that patients encountered “significant barriers including a cumbersome process for scheduling care,” and “inadequate provider networks.”² Further, Veterans Health Administration (VHA) clinicians expressed concerns about third-party administrators scheduling appointments without input from patients’ VHA clinicians and ability to make appropriate referrals.³ The OIG made six recommendations including a recommendation that the Under Secretary for Health streamline processes and procedures for accessing care under the Veterans Choice Program. As of March 7, 2019, the OIG closed all six recommendations.

¹ The patient received care at two Phoenix VA Health Care System sites, the facility and a community-based outpatient clinic.

² VA OIG, *Review of the Implementation of the Veterans Choice Program*, Report No. 15-04673-333, January 30, 2017. Following the enactment of the Veterans Access, Choice, and Accountability Act of 2014, the Veterans Choice Program was established to provide medical services to eligible veterans through non-VA community healthcare providers.

³ A third-party administrator is a company that contracts with VA to manage non-VA appointments and scheduling.

In a September 2020 report, the OIG identified deficiencies in the care coordination between the Memphis VA Medical Center staff, community providers, and third-party administrators and found that clinical delegates failed to provide clinical review of authorizations for community care requests.⁴ Three of the 16 recommendations, verification that patients receive the authorized community care, timely processing of clinical delegate review for authorization, and that behavioral health autopsies are completed according to policy, are relevant to this inspection and remain open as of October 22, 2020.

Concerns

In spring 2020, the OIG Office of Healthcare Inspections provided a consultation with the Office of Audits and Evaluations and identified concerns with a patient's mental health care. Specifically, the OIG evaluated if facility staff

1. Offered treatment and monitoring while the patient awaited scheduling and completion of a community care psychological diagnostic evaluation,
2. Returned a call to the patient's family member,
3. Scheduled a community care consult timely, and
4. Completed administrative procedures related to the patient's missed primary care appointment and the Behavioral Health Autopsy Program.⁵

⁴ VA OIG, Deficiencies in Care, Care Coordination, and Facility Response to a Patient Who Died by Suicide, Memphis VA Medical Center in Tennessee, Report No. 19-09493-249, September 3, 2020.

⁵ VHA Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, *Behavioral Autopsy Program Implementation*, December 11, 2012. VHA implemented the behavioral health autopsy program in 2012 to investigate the circumstances of suicide for quality improvement purposes.

Scope and Methodology

The OIG conducted a virtual site visit from July 6 through 13, 2020.⁶

The OIG interviewed three of the patient's family members, facility leaders, and facility staff familiar with the patient's care and relevant processes. The OIG reviewed the patient's electronic health record (EHR), an issue brief related to the patient's facility care and community care consult request, primary care scheduling training materials, and staff training records.⁷

Additionally, VHA directives, handbooks, and memoranda, facility policies, a facility standard operating procedure, and organizational charts were reviewed.

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).

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, 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.

⁶ The site visit was conducted virtually due to the COVID-19 pandemic. World Health Organization, *Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It*, accessed on November 10, 2020, [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), a newly discovered coronavirus. Merriam Webster, *Definition of pandemic*, accessed November 10, 2020, <https://www.merriam-webster.com/dictionary/pandemic>. A pandemic is a disease outbreak over a wide geographic area that affects a "significant portion" of the population.

⁷ The Program Manager, Quality, Safety, and Improvement Service provided the OIG with training completion information. The OIG was unable to obtain the VHA training records for the medical support assistant who failed to contact the patient, because the medical support assistant was no longer employed at the facility.

Patient Case Summary

The patient was in their 30s at the time of death by suicide in spring 2019. The patient had a mental health diagnostic history of [anxiety](#), [mood](#), and [personality disorders](#).⁸

In summer 2017, the patient initiated mental health care at the facility and screened positive for [posttraumatic stress disorder](#) (PTSD). The outpatient psychiatrist assessed the patient's suicide risk as low, placed a consult for outpatient PTSD treatment, and prescribed an antidepressant medication.

For two months in fall 2017, the patient participated in [cognitive processing therapy](#) group and individual sessions for PTSD with a psychologist. Of the patient's three scheduled appointments in late 2017, the psychologist and patient each canceled one and the patient missed one appointment. Following the missed appointment, the psychologist made three attempts to reach the patient by telephone and left voicemail messages. In early 2018, the psychologist discharged the patient from the PTSD Clinic because the patient had "not responded to outreach attempts to engage in treatment."

The next month, the patient called the psychologist to reestablish care. The psychologist determined that the patient would benefit from treatment for [panic disorder](#) and anger management. A medical support assistant documented that the patient was unable to attend the anger management group due to commute time from work and canceled return to clinic orders for two subsequent individual therapy appointments with the psychologist.

In early spring, the patient's family member called the Veterans Crisis Line expressing concern for the patient's safety due to recent suicidal statements.⁹ The Veterans Crisis Line responder subsequently contacted the patient "due to 3rd party concerns." The responder documented that the patient did not report current suicidal ideation but reported suicidal ideation and three suicide attempts within the past week. The responder initiated a facility transport plan, and the patient's family member brought the patient to the facility's Emergency Department.¹⁰

An Emergency Department physician evaluated the patient and placed an Inpatient Mental Health Unit consult. An Emergency Department social worker documented the patient's three suicide attempts in the past week and one suicide attempt by firearm approximately

⁸ Underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together. The OIG uses the singular form of they (their) in this instance for patient privacy.

⁹ Veterans Crisis Line network website, accessed October 5, 2020, <https://www.veteranscrisisline.net/about/what-is-vcl>. The VCL is a confidential resource available to veterans to provide crisis support and referrals 24 hours a day, seven days a week.

¹⁰ VCL Position Description, *Health Science Specialist*, January 8, 2019. Responders are staff who interact with individuals who contact the Veterans Crisis Line through chats, calls, and texts. A facility transport plan "is a collaboratively developed plan by a Responder and the Caller for the caller to present at a facility for immediate care." VCL, *Health Science Specialist Training Participant Guide*, June 2019.

five months prior. The patient reported that another family member had possession of the firearm. The consulting psychiatrist admitted the patient to the Inpatient Mental Health Unit “for safety.” A nursing assessment indicated that the patient no longer had thoughts of self-harm, and the patient requested discharge the following day. The next day, an inpatient psychiatrist assessed the patient as psychiatrically and medically stable and discharged the patient home with outpatient mental health follow-up, including two future individual appointments with the psychologist. The same day, a Suicide Prevention Coordinator placed a high risk for suicide patient record flag in the patient’s EHR and a Suicide Prevention Case Manager unsuccessfully attempted to reach the patient by telephone.¹¹ Three days after the nursing assessment, the Suicide Prevention Case Manager spoke with the patient, who declined suicide prevention services.

At the patient’s outpatient appointment the next day, the psychologist noted that the patient “presents with a complicated diagnostic presentation,” and considered a [borderline personality disorder](#) diagnosis. Approximately a week later, the patient agreed to participate in [dialectical behavior therapy](#) and an outpatient social worker contacted the patient to schedule an orientation appointment.

Eight days later, a Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment (REACH VET) coordinator documented that the patient was identified as a patient “who might benefit from enhanced treatment” and assigned the outpatient psychiatrist as the REACH VET provider.¹² Six days later, the patient attended a dialectical behavior therapy orientation group and agreed to the “full” dialectical behavior therapy program including a minimum of 28 weeks of group and weekly individual therapy sessions. Five days later, the outpatient psychiatrist completed a REACH VET provider note, documented review of the patient’s EHR, and determined that the patient’s care was appropriate and “no changes are indicated.” The same day, the psychologist met with the patient, and noted that the patient “completed treatment with this writer” and planned to begin dialectical behavior therapy with an individual session scheduled with the outpatient social worker the following day. Approximately two weeks later, the patient met with the outpatient psychiatrist for medication management.

¹¹ VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. The purpose of a high risk for suicide patient record flag is to alert VA staff to a patient’s high risk for suicide status for consideration in clinical decision-making.

¹² VHA implemented the REACH VET program in 2016 using a statistical model to identify patients at increased risk for suicide behavior and other adverse outcomes. The REACH VET Coordinator is responsible for training appropriate staff in their responsibilities for the program and notifying providers of patients’ REACH VET status. REACH VET providers are responsible for reviewing patients’ clinical information, enhancing treatment as appropriate, outreaching the patient, and documenting patient outreach within one week of notification. VHA Acting DUSHOM Memorandum, *REACH VET: Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment*, August 10, 2016. “Provider Steps At-a-Glance,” accessed August 5, 2020, <http://vaww.mirecc.va.gov/reachvet/tools.asp#steps>. (This is an internal VA website and not publicly accessible.)

The patient continued to engage in weekly individual dialectical behavior therapy with the outpatient social worker through early summer. The patient canceled the next scheduled group and individual therapy appointments due to illness. A week later, the day of the canceled individual appointment, the outpatient social worker called the patient. The patient reported being ill the week prior and planned to attend the group session in two days. The outpatient social worker scheduled an individual therapy appointment for the same day as the group appointment; however, the patient attended the group appointment but missed the individual appointment. When the social worker called, the patient apologized and reported being “confused and thought the appointment was for next week.”

That same day, the Suicide Emergency Committee determined that the patient could safely discharge from the Suicide Prevention Program since the patient was “clinically stable,” “independently participating in necessary treatments,” and not “currently at high risk” or “relying on extensive inpatient or emergency services.”¹³ The patient intermittently participated in housing and vocational assistance programs until the following day when a compensated work therapy social worker documented discharging the patient due to being “unable to locate” the patient. Three days later, the Suicide Prevention Coordinator who placed the high risk for suicide patient record flag, removed the flag from the patient’s EHR.

The next month, the patient engaged in dialectical behavior therapy. However, at the end of that month and throughout the next month, the patient either missed or canceled group and individual therapy appointments. The patient then decided to discontinue dialectical behavior therapy due to not wanting to “drive out here twice a week” and being “okay with [the patient’s] recovery meetings in the community.”

In early spring 2019, a medical support assistant alerted the psychologist that the patient presented to a community-based outpatient clinic to reestablish mental health care. The psychologist called the patient two days later, and the patient described interpersonal problems and interest in resuming dialectical behavior therapy. The psychologist entered a consult, and a social worker called the patient regarding dialectical behavior therapy. The patient reported that a family member was worried about the patient, denied substance use and “risk,” and agreed to individual treatment. The social worker suggested an online resource for family members of individuals with a personality disorder and scheduled the patient for an appointment for the following day.

¹³ The Assistant Chief of Social Work told the OIG that the Suicide Emergency Committee reviews patients who are high risk for suicide and is comprised of a psychiatrist, psychologist, mental health nurse, the suicide prevention supervisor, suicide prevention coordinators, and suicide prevention case managers. This meeting was attended by a psychiatrist and three members of the Suicide Prevention Team. The psychologist, mental health nurse, and two Suicide Prevention Team members were “not available.”

During the appointment, the social worker assessed the patient and noted that the patient was unlikely to engage in treatment if not for the encouragement of the family member. The social worker noted that the patient discontinued the antidepressant medication and exhibited social awkwardness such as not picking up on social cues and failure to recognize inappropriate behavior. In the *Suicidal ideation/suicide attempts* section of the template, the social worker documented “denies, past attempt,” and that the patient did not endorse access to firearms. The social worker also documented that the patient had “dime sized marks on arms and legs (wearing shorts) that look like friction burns.” The social worker did not document a current suicide risk assessment; however, the social worker documented “Agree with Risk Level” and referenced a prior suicide risk assessment completed by a previous outpatient social worker who assessed the patient’s suicide risk as “LOW” in mid-summer 2018. The patient consented to “testing, return to [dialectical behavior therapy]” and scheduled a follow-up appointment with the social worker for the following week. The social worker entered a consult for psychological testing to assess the patient for [autism spectrum disorder](#) versus [schizoid personality disorder](#).

A psychologist discontinued the consult, because the facility psychologists did not conduct autism spectrum disorder evaluations, and five days after the appointment, the social worker entered a psychology community care consult requesting “testing to rule out schizoid personality disorder or autism spectrum disorder.” The next day, a community care nurse requested authorization approval, and two days later, a voucher examiner alerted the mental health staff member, who had delegated clinical review authority (mental health delegate), that the consult was awaiting authorization.¹⁴

Three days later, the social worker met with the patient and the family member. The family member was tearful and discussed the patient’s interpersonal issues with neighbors and family and at school, as well as recent legal and family-relationship problems. The social worker explained the consult process and time frames to the patient and family member and planned to call the patient in approximately two weeks “to check in for next steps.”

Nine days later, the patient left a voicemail for the social worker stating that the patient had not yet been contacted regarding testing. The social worker returned the call and left a voicemail message about a plan to follow up on the consult and an offer to “schedule during interim.” On the same day, the social worker added a consult comment requesting consideration of the consult, the mental health delegate approved the community care consult. The next day, the voucher examiner added the authorization number and scheduling telephone number to the consult, and the social worker left the patient a voicemail message with the information. The patient returned the social worker’s telephone call, denied “risk,” reported talking to the

¹⁴ VHA Office of Community Care, *Field Guidebook*, July 14, 2020. The delegate is assigned authority to determine if the requested services are appropriate to be “authorized for delivery in the community.” A voucher examiner is responsible for processing requests and ensuring that eligible veterans have access to community care services.

third-party administrator, and expected to be contacted “soon” to schedule testing. About three and a half weeks later, the voucher examiner noted that the “Community Care Appointment has been scheduled,” and the social worker confirmed with the patient that the appointment was scheduled for four days later.

During the appointment, a non-VA social worker completed a counseling intake with the patient.¹⁵ Later the same day, the social worker received a voicemail message from the patient stating that the community agency did not provide testing. The social worker informed the patient that a testing consult would be expedited, noted that the patient “denies risk,” and planned to follow up with the patient after the social worker’s planned leave.

Four days later, a community care nurse completed the psychology community care consult and uploaded the four-day-earlier community provider therapy evaluation note. Ten days later, the social worker entered a neurology community care consult for psychological testing and spoke with the patient who was pleasant, “denies risk,” reported living with the family member, and had difficulty finding employment.

Five days later, the patient presented as a walk-in to a community-based outpatient clinic, and a registered nurse evaluated the patient. The patient denied suicidal or homicidal ideations and complained of a urinary tract infection. The registered nurse scheduled the patient for an appointment the next day with a primary care physician. The patient missed the scheduled primary care appointment.

The next Friday, the social worker documented that the patient’s family member left a voicemail message sharing “concerns with [the patient’s] treatment.” The social worker consulted with the Assistant Chief of Social Work and the Suicide Prevention Team and noted that the Suicide Prevention Team “agreed to contact” the patient’s family member.

The following Monday, the Suicide Prevention Coordinator completed a Suicide Behavior and Overdose Report that confirmed through the county medical examiner’s website that the patient died by suicide the previous Friday. Approximately two weeks later, the Suicide Prevention Coordinator documented a Monday attempt to return the family member’s call from the previous Friday.

¹⁵ The OIG was not successful in contacting the non-VA provider.

Inspection Results

1. Inadequate Mental Health Treatment and Monitoring Plan

The OIG found that facility staff failed to offer the patient treatment for approximately one month while awaiting diagnostic testing, although the social worker did document a plan to follow up with the patient by telephone. However, the social worker's failure to complete a current suicide risk assessment may have contributed to an underestimation of the patient's suicide risk and therefore an inadequate follow-up plan.¹⁶

As of December 31, 2018, VHA mandated the use of a standardized suicide risk screening tool for all mental health intake evaluations at least annually following the initial evaluation.¹⁷ VHA instructs that suicide risk screening should be completed "based on clinical judgment, when there are stressors, warning signs for suicide, or worsening clinical conditions."¹⁸ Facility policy requires completion of a suicide risk assessment, and using the designated note template whenever a patient for whom suicide risk is clinically relevant "undergoes significant clinical decompensation or is judged to be under increased stress."¹⁹

A social worker evaluated the patient for reengagement in dialectical behavior therapy in early spring 2019, seven months after the patient's last in-person mental health appointment. During those seven months, the patient reported interpersonal problems and that a family member was worried, which are possible signs of clinical decompensation. The social worker did not complete a suicide risk screening or assessment despite the patient's report of increased stressors including difficulty maintaining employment and housing, academic and interpersonal problems, and family distancing themselves. Further, the social worker did not inquire about marks on the patient's limbs resembling "friction burns" to determine if they were a result of self-harm or other high-risk behaviors. The social worker documented "Agree with Risk Level" regarding another social worker's summer 2018 assessment of the patient's "LOW" suicide risk, over eight months prior.

In an interview with the OIG, the social worker reported not perceiving the patient as under increased stress. However, during the spring 2019 therapy session, the patient's family member reported concerns about the patient's financial, educational, and social problems including

¹⁶ VHA DUSHOM Memorandum, Eliminating Veteran Suicide: Implementation of Suicide Risk Screening and Evaluation, November 2, 2018. Facility Policy 122-19, Suicide and Suicide-Related Behavior, March 15, 2017.

¹⁷ VHA DUSHOM Memorandum, Eliminating Veteran Suicide.

¹⁸ VHA DUSHOM Memorandum, Suicide Risk Screening and Assessment Requirements—Attachment B, May 23, 2018.

¹⁹ Facility Policy 122-19. American Psychological Association, "APA Dictionary of Psychology," accessed March 10, 2021, <https://dictionary.apa.org/decompensation>. Decompensation is defined as "a breakdown in an individual's defense mechanisms, resulting in progressive loss of normal functioning or worsening of psychiatric symptoms."

examples of the patient's "threatening gestures." The social worker did not, however, document a risk assessment of harm to self or others. Although the patient expressed a desire to reestablish mental health treatment, the social worker documented that it was the "Writer's preference" to "coordinate care here depending on results" of testing in the community, and a plan to check in with the patient in the spring.

The social worker documented providing outreach to the patient and noted that the patient "denies risk" on four different days in spring 2019 while the patient was awaiting consult scheduling. In an interview with the OIG, the social worker did not recall asking the patient specifically about thoughts of hurting or killing oneself, but reported that the EHR documentation of the patient's denial of risk reflected that the patient was likely asked directly about self-harm. In late spring, the social worker documented, "Specifically ask if [the patient] is ok, how [the patient] is doing. [The patient] says [the patient] is fine, will talk soon." The OIG team did not find evidence that the social worker asked the patient specifically about thoughts of harm toward self or others. Further, based on the family member's report of the patient's threatening gestures and increased stressors, the OIG would have expected the social worker to assess the patient's risk of harm to self and others and provide supportive treatment to manage stressors while awaiting diagnostic testing. Alternatively, the social worker could have referred the patient to another provider for risk assessment and treatment.

Despite the patient's request to reestablish mental health care, potential decompensation, and a family member's report of the patient's threatening gestures and increased stressors, the social worker relied on another social worker's suicide risk assessment completed eight months prior. The failure to obtain a current risk assessment may have resulted in an underestimation of the patient's suicide risk level and consequently the development of a plan that did not mitigate the patient's suicide risk.

2. Delayed Staff Response to a Family Member's Phone Call

The OIG determined that a family member called on a Friday afternoon to notify staff that the patient died, and staff returned the call the following Monday. Further, the social worker's EHR documentation did not include essential information of the family member's voicemail message, specifically, that the patient died by suicide, and a Suicide Prevention Coordinator failed to complete timely documentation of outreach to the patient's family.

VHA and facility policies require that clinical staff's EHR documentation is complete, timely, accurate, and readily accessible.²⁰ VHA requires that late documentation includes the actual date of the event and "notation as to the reason for the delay."²¹

In late spring 2019, the social worker documented that the patient's family member left a voicemail message expressing "concern with [the patient's] treatment." Although not in the documentation, the social worker told the OIG that in the voicemail message, the family member was upset and reported that the patient died by suicide. The social worker did not recall why the complete and accurate content of the voicemail message was not included in the EHR documentation.

On the day of the call, the social worker consulted with the Assistant Chief of Social Work and the Suicide Prevention Coordinator and documented that the Suicide Prevention Team would contact the patient's family member. In an interview with the OIG, the Assistant Chief of Social Work reported informing the social worker that the Suicide Prevention Team would conduct outreach to the family member. In an EHR note entered in early summer 2019, the Suicide Prevention Coordinator documented unsuccessful outreach attempts to two of the patient's family members nine business days earlier.

The Chief of Social Work told the OIG that there was no facility policy guiding time frames for returning telephone calls. During interviews with the OIG, the Chief of Staff, Chief of Social Work, and Assistant Chief of Social Work expressed expectations that a clinician would quickly respond to a family member's telephone call, but they had variable expectations about the timeliness of a clinician's response. The Chief of Staff expected that a clinician would respond after speaking with a supervisor and within 24 hours; the Chief of Social Work expected that the clinician would take enough time to obtain accurate information; and the Assistant Chief of Social Work expected that a clinician would respond by the next business day.

The Suicide Prevention Coordinator told the OIG that the time frame for outreach is discretionary and reported wanting to allow the family time to grieve before making outreach attempts. The Suicide Prevention Coordinator did not recall the reason for the late documentation of the outreach efforts.

The social worker's failure to accurately and completely document the content of the family member's voicemail message resulted in the omission of critical clinical information in the patient's EHR and precluded other staff's awareness of the patient's death by suicide. Further, the Suicide Prevention Coordinator's nine-day delay in documentation of outreach to the family member also contributed to incomplete EHR documentation, and the OIG determined the

²⁰ Facility Policy HIMS-01, *Medical Record Management*, February 10, 2014. VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

²¹ VHA Handbook 1907.01.

delayed documentation did not meet VHA standards for documentation being complete, timely, accurate, and readily accessible.²²

3. Delays in Community Care Consult Management

The OIG found that a mental health delegate did not review the patient's initial community care consult within the required time frame. The third-party administrator scheduled the patient within 30 days of approval, consistent with VHA expectations. However, the third-party administrator erroneously scheduled the patient for therapy rather than the requested diagnostic testing.

The Veterans Access, Choice, and Accountability Act of 2014 established the Veterans Choice Program to provide medical services to eligible veterans through non-VA community healthcare providers.²³ The Office of Community Care was established "to deliver a single, consolidated community care program that is easy to understand, simple to administer, and meets the needs of Veterans, their families, community providers, and VA staff."²⁴ In September 2017, VHA implemented a standardized consult model for non-VA care that required a single consult to follow the patient's episode of care until "care is completed."²⁵

VHA staff may request non-VA community care for a patient when service cannot be provided within the VA facility.²⁶ VHA requires that staff with delegated review authority complete a clinical review of the community care consult request within three business days.²⁷ The Chief, Community Care told the OIG that a patient should be scheduled within 30 days of authorization.

In early spring 2019, the social worker placed a psychology community care consult. The next day, a community care coordinator verified the patient's eligibility, selected a standard episode of care that included psychological testing, and requested authorization approval. Two days later, a voucher examiner noted that the community care consult was "awaiting authorization" and sent

²² Facility Policy HIMS-01; VHA Handbook 1907.01.

²³ VHA Directive 1700, *Veterans CHOICE Program*, October 25, 2016.

²⁴ VHA Office of Community Care, *Field Guidebook*, July 14, 2020. The Field Guidebook is consistently updated with new and updated information. The OIG did not have access to the Field Guidebook version that was in effect at the time of the patient's care.

²⁵ VHA DUSHOM Memorandum, *National Deployment of One Consult Model*, September 8, 2017. "Veteran Community Care General Information," U.S. Department of Veterans Affairs, accessed November 13, 2020, https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/VHA-FS_MISSION-Act.pdf. "The VA MISSION Act of 2018," United States Senate Committee on Veterans' Affairs, accessed November 13, 2020, https://www.veterans.senate.gov/imo/media/doc/One%20Pager_The%20VA%20MISSION%20Act%20of%202018.pdf. The Veterans Choice Program ended on June 6, 2019, and was replaced by the new veterans' community care program under the VA MISSION Act, which streamlined seven VA community care programs. The episode of care and the patient's death was prior to implementation of the VA MISSION ACT and therefore not relevant to this report.

²⁶ VHA Directive 1232 (2), *Consult Processes and Procedures*, August 24, 2016, amended June 28, 2019.

²⁷ VHA DUSHOM Memorandum, *Enhancements to the Community Care Clinical Review Process*, March 24, 2017.

an alert to the mental health delegate. Eight business days after the consult was placed, the social worker added a comment to the consult requesting information regarding the patient's approval for community care and communicating availability to discuss the consult request. The same day, the mental health delegate approved the consult for community care for "evaluation and treatment of autism spectrum disorder/[Asperger](#) Disorder."²⁸ The next day, the voucher examiner documented the authorization number, and noted that the patient could call the third-party administrator for "scheduling assistance." The social worker called the patient and left a message regarding the authorization and telephone numbers.

About a month later, the social worker called the patient and confirmed the community care appointment for four days later. That day, the patient completed the community care appointment, and the patient left a voicemail for the social worker and stated that the community care office staff reported "we don't do that testing," and that "the office scheduled [the patient] for therapy." The social worker contacted the third-party administrator to clarify the patient's need for diagnostic testing. The VHA Office of Community Care told the OIG that third-party administrator staff informed the social worker that they would "relay the information to the appropriate scheduling hub for response."

The VHA Office of Community Care reported that two weeks later, the social worker again contacted the third-party administrator and was advised to place a new consult for community care neurology. The social worker placed a community care neurology consult requesting diagnostic assessment. Four days later, a community care nurse documented, "The Chief of Staff has delegated authority to process this referral without additional clinical review." The next day, a neurologist approved the consult for non-VA community care and three days later, the day of the patient's death, a voucher examiner left a voicemail message to inform the patient of "eligibility, referral and approval."

The OIG found that the mental health delegate approved the initial community care psychology consult eight business days after initially alerted to the request, which delayed the consult scheduling and exceeded three business days, inconsistent with VHA policy.²⁹ The mental health delegate told the OIG that at the time the consult was placed, there was one mental health delegate and this contributed to the delay in clinical review and approval of the subject patient's consult. The Chief of Quality, Safety, and Improvement confirmed that at the time the consult was placed, there was one mental health delegate and one "ad hoc" delegate who reviewed all community care psychology consults. As of July 2020, there were seven mental health delegates assigned to review community care psychology consults. The General Mental Health Section

²⁸ The proper term is Asperger syndrome.

²⁹ VHA DUSHOM Memorandum, Enhancements to the Community Care.

Chief told the OIG that since increasing the number of mental health delegates, the “majority” of mental health community care consults were reviewed “within 24–48 hours.”

The OIG found that the third-party administrator scheduled the patient with a community provider within 30 days of approval, as instructed by VHA. However, the third-party administrator scheduled the patient for therapy rather than testing, which resulted in the patient not receiving diagnostic testing as requested. Failure to schedule the patient for the requested services may have contributed to a delay in critical treatment and an increase in the patient’s stress level. An Office of Community Care Program Analyst told the OIG that, in early June 2019, VHA initiated medical centers’ responsibility for care coordination and scheduling of community care consults. As of August 25, 2020, the facility began scheduling Community Care Network consults. Between August 25 and October 22, 2020, the facility scheduled 59 percent of mental health community care consults placed.

4. Deficient Administrative Procedures

The OIG determined that staff did not comply with primary care missed appointment procedures and did not complete the behavioral health autopsy in a timely manner following the patient’s death.

Missed Appointment Procedures

The OIG found that facility scheduling staff did not complete required outreach efforts when the patient missed a primary care appointment and that scheduling staff and leaders had inconsistent knowledge of primary care missed appointment procedures.³⁰

Since 2016, VHA has required staff to complete and document outreach attempts following a patient’s missed appointment with a minimum of two contacts—one telephone call and one letter.³¹ Staff may call the patient the day of the missed appointment or the following business day and the letter can be mailed the same day as the telephone call.³² Consistent with VHA requirements, facility policy also requires scheduling staff to make two documented attempts to reschedule a patient’s missed appointment, including one telephone call and one letter.³³

³⁰ VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016. The 2016 directive was in effect at the time of the events in this report and was amended and replaced by VHA Directive 1230(2), *Outpatient Scheduling Processes and Procedures*, amended on January 22, 2020. VHA Notice 2019-09(2). *Minimum Scheduling Effort Required for Outpatient Appointments: Updates to VHA Directive 1230 and VHA Directive 1232(1)*, May 8, 2019. Facility Policy 136-83, *Scheduling Policy*, November 14, 2016.

³¹ VHA Directive 1230; VHA Notice 2019-09(2).

³² VHA Directive 1230; VHA Notice 2019-09(2).

³³ Facility Policy 136-83.

At the patient's late spring 2019 unscheduled primary care visit, a registered nurse noted that the patient denied suicidal or homicidal ideation. The primary care physician documented that the patient missed the scheduled next-day appointment and did not document outreach to the patient. Two days later, a medical support assistant administratively closed the appointment as a "no-show." The medical support assistant did not make a telephone call or send a letter to the patient to reschedule the missed appointment, as required by VHA and facility policies.³⁴

The medical support assistant told the OIG that medical support assistants were not required to conduct outreach in response to missed appointments, which is contrary to VHA and facility policies.³⁵ Another medical support assistant and a medical support assistant supervisor also told the OIG that, in the absence of provider instruction, medical support assistants were not required to complete telephone outreach in response to patients' missed primary care appointments. In contrast, two medical support assistants, the Assistant Chief of Scheduling Operations, and two facility medical administrative specialists responsible for training, told the OIG that medical support assistants must make one telephone call and send one letter in response to a primary care missed appointment.

In an interview with the OIG, the medical support assistant supervisor stated that, based on information from facility trainers, primary care was a low-risk clinic and therefore missed appointment outreach was not required. However, the VHA training protocol did not include primary care on the list of "Current Low Risk Clinics." Further, the training was consistent with VHA requirements and included two outreach attempts, one telephone call and one letter in response to a patient's missed appointment.³⁶ The OIG reviewed the training records of 68 medical support assistants responsible for scheduling as of May 20, 2019, and found that all medical support assistants completed VHA scheduling training.

The OIG found that a medical support assistant did not complete required outreach efforts following the patient's missed primary care appointment due to the medical support assistant's erroneous belief that missed primary care appointments did not require follow-up outreach.³⁷ Failure to complete telephone outreach in response to the patient's missed primary care appointment contributed to a missed opportunity to assess the patient's status and reschedule medical care. Facility staff and leaders' lack of consistent response to missed primary care appointments may result in failures to outreach patients and ensure appointments are rescheduled as needed.

³⁴ VHA Directive 1230; VHA Notice 2019-09(2); Facility Policy 136-83.

³⁵ VHA Directive 1230; VHA Notice 2019-09(2); Facility Policy 136-83.

³⁶ VHA Directive 1230; VHA Notice 2019-09(2); VHA Directive 1232(2).

³⁷ VHA Directive 1230; VHA Notice 2019-09(2); Facility Policy 136-83.

Behavioral Health Autopsy

The OIG found that the Suicide Prevention Coordinator completed the patient's behavioral health autopsy approximately one year after awareness of the patient's death by suicide.³⁸

In 2012, VHA implemented the Behavioral Health Autopsy Program and required that suicide prevention coordinators complete a behavioral health autopsy report within 30 days of becoming aware of a patient's death by suicide.³⁹ Information obtained from the behavioral health autopsy was intended to "be used for quality improvement efforts and program evaluation services."⁴⁰

The facility's Suicide Prevention Coordinator reported completing a behavioral health autopsy in early summer 2020, approximately one year after facility staff were notified of the patient's death. The Suicide Prevention Coordinator told the OIG that the behavioral health autopsy was completed after notification of the OIG inspection regarding the patient's care. Failure to submit a timely behavioral health autopsy may result in incomplete information for suicide prevention quality improvement and program evaluation processes.

The Suicide Prevention Coordinator told the OIG that failure to complete the behavioral health autopsy report within 30 days was an error, and suicide prevention staffing shortages may have contributed to the oversight. In an interview with the OIG, the Assistant Chief of Social Work agreed that the Suicide Prevention Team's staffing level and other responsibilities may have contributed to the delay in the behavioral health autopsy completion. The Assistant Chief of Social Work told the OIG that at the time of the patient's death, the Suicide Prevention Team included two case managers and two coordinators. The Assistant Chief of Social Work told the OIG that as of October 15, 2020, the Suicide Prevention Team was fully staffed with three case managers, three coordinators, and a supervisor.

Conclusion

The OIG found that facility staff failed to offer the patient mental health treatment although the social worker did document a plan to follow up with the patient by phone while the patient awaited psychological diagnostic testing. Despite the patient's request to reestablish mental health care, potential decompensation, and a family member's report of the patient's threatening gestures and increased stressors, the social worker relied on another social worker's suicide risk assessment completed eight months prior. The social worker's failure to obtain a current risk

³⁸ VHA DUSHOM Memorandum, *Behavioral Autopsy Program Implementation*. A behavioral health autopsy is a "standardized medical record review" utilizing a national template and submitted via an approved suicide prevention SharePoint portal.

³⁹ VHA DUSHOM Memorandum, *Behavioral Autopsy Program*.

⁴⁰ VHA DUSHOM Memorandum, *Behavioral Autopsy Program*.

assessment may have resulted in an underestimation of the patient's suicide risk level and consequently the development of a plan that did not mitigate the patient's suicide risk.

A family member called on a Friday afternoon to notify staff that the patient died, and the Suicide Prevention Coordinator returned the call the following Monday. Facility leaders had variable expectations about the timeliness of a clinician's response. The OIG found that the social worker's EHR documentation misrepresented the content of the family member's voicemail message, and a Suicide Prevention Coordinator failed to complete timely documentation of outreach to the patient's family. The social worker's failure to accurately and completely document the content of the family member's voicemail message resulted in the omission of critical clinical information in the patient's EHR and precluded other staff's awareness of the patient's death by suicide. Further, the Suicide Prevention Coordinator's nine-day delay in documentation of outreach to the family member also contributed to incomplete EHR documentation and did not comply with VHA timeliness requirements.

The mental health delegate did not review the patient's initial community care consult within the required time frame. The OIG found that the mental health delegate approved the initial community care psychology consult eight business days after initially alerted to the request which delayed the consult scheduling and exceeded three business days, inconsistent with VHA policy.⁴¹ The mental health delegate told the OIG that at the time the consult was placed there was one mental health delegate and this contributed to the delay in clinical review and approval of the subject patient's consult. As of July 2020, there were seven mental health delegates assigned to review community care psychology consults. The General Mental Health Section Chief told the OIG that since increasing the number of mental health delegates, the "majority" of mental health community care consults were reviewed "within 24–48 hours."

The third-party administrator scheduled the patient with a community provider within 30 days of approval, as instructed by VHA. However, the third-party administrator scheduled the patient for therapy rather than testing, which resulted in the patient not receiving diagnostic testing as requested. Failure to schedule the patient for the requested services may have contributed to a delay in critical treatment and an increase in the patient's stress level. An Office of Community Care Program Analyst told the OIG that, in early June 2019, VHA initiated medical centers' responsibility for care coordination and scheduling of community care consults. As of August 25, 2020, the facility began scheduling Community Care Network consults. Between August 25 and October 22, 2020, the facility scheduled 59 percent of mental health community care consults placed.

The OIG found that facility scheduling staff did not complete required outreach efforts when the patient missed a primary care appointment and that scheduling staff and leaders had inconsistent

⁴¹ VHA DUSHOM Memorandum, Enhancements to the Community Care.

knowledge of primary care missed appointment procedures.⁴² Failure to complete telephone outreach in response to the patient's missed primary care appointment contributed to a missed opportunity to assess the patient's status and reschedule medical care. Facility staff and leaders' lack of consistent response to missed primary care appointments may result in failures to outreach patients and ensure appointments are rescheduled as needed.

The OIG found that the Suicide Prevention Coordinator completed the patient's behavioral health autopsy approximately one year after awareness of the patient's death by suicide.⁴³ The Suicide Prevention Coordinator told the OIG that staffing shortages may have contributed to the oversight. In an interview with the OIG, the Assistant Chief of Social Work agreed that the Suicide Prevention Team's staffing level and other responsibilities may have contributed to the delay in the behavioral health autopsy completion. The Assistant Chief of Social Work told the OIG that as of October 15, 2020, the Suicide Prevention Team was fully staffed with three case managers, three coordinators, and a supervisor.

⁴² VHA Directive 1230; VHA Notice 2019-09(2); Facility Policy 136-83.

⁴³ VHA DUSHOM Memorandum, *Behavioral Autopsy Program*. A behavioral health autopsy is a "standardized medical record review" utilizing a national template and submitted via an approved suicide prevention SharePoint portal.

Recommendations 1–7

1. The Phoenix VA Health Care System Director conducts a full review of the patient’s care to determine if administrative action is warranted, consulting with Human Resources and General Counsel offices as appropriate.
2. The Phoenix VA Health Care System Director ensures that staff complete suicide risk assessments consistent with Veterans Health Administration and Phoenix VA Health Care System policies.
3. The Phoenix VA Health Care System Director ensures timely and accurate completion of electronic health record documentation.
4. The Phoenix VA Health Care System Director evaluates the community care psychology consult authorization timeliness and takes action as warranted.
5. The Phoenix VA Health Care System Director conducts a review of Primary Care Clinic missed appointment procedures and ensures patient follow-up and staff training, as appropriate.
6. The Phoenix VA Health Care System Director evaluates scheduling accuracy of mental health community care psychology consults and takes action as appropriate.
7. The Phoenix VA Health Care System Director ensures timely completion of behavioral health autopsies, consistent with Veterans Health Administration policy, and monitors for ongoing compliance.

Glossary

To go back, press “alt” and “left arrow” keys.

anxiety. 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.⁴⁴

Asperger syndrome. A developmental disorder characterized by an obsessive focus on one topic or object to the exclusion of others.⁴⁵

autism spectrum disorder. A developmental disorder with a wide range of symptoms, generally appearing by the age of two, that affects a person’s communication and behavior.⁴⁶

borderline personality disorder. An illness characterized by patterns of intense and changing moods, behaviors and self-image which often result in impulsivity and relationship problems.⁴⁷

cognitive processing therapy. A specific, time-limited, cognitive behavioral therapy for the treatment of posttraumatic stress disorder.⁴⁸

dialectical behavior therapy. A type of psychotherapy used to treat borderline personality disorder that encourages awareness, attentiveness, and skill building to address intense emotions, self-destructive behaviors, and improve relationships.⁴⁹

mood disorder. A mental illness affecting a person’s emotional state.⁵⁰

panic disorder. An anxiety disorder marked by sudden attacks of panic characterized by sudden intense fear that causes a variety of symptoms including sweating, increased heart rate, and feelings of impending doom.⁵¹

⁴⁴ National Institute of Mental Health, “Anxiety Disorders,” accessed September 2, 2020, <https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml>.

⁴⁵ National Institute of Neurological Disorders and Stroke, “Asperger Syndrome,” accessed September 2, 2020, <https://www.ninds.nih.gov/Disorders/All-Disorders/Asperger-Syndrome-Information-Page>.

⁴⁶ National Institute of Mental Health, “Autism Spectrum Disorder,” accessed September 2, 2020, <https://www.nimh.nih.gov/health/topics/autism-spectrum-disorders-asd/index.shtml>.

⁴⁷ National Institute of Mental Health, “Borderline Personality Disorder,” accessed September 2, 2020, <https://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml>.

⁴⁸ Department of Veterans Affairs National Center for PTSD, “Cognitive Processing Therapy for PTSD,” accessed September 3, 2020, https://www.ptsd.va.gov/understand_tx/cognitive_processing.asp.

⁴⁹ National Institute of Mental Health, “Borderline Personality Disorder,” accessed September 3, 2020, <https://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml>.

⁵⁰ National Institute of Mental Health, “Any Mood Disorder,” accessed September 2, 2020, <https://www.nimh.nih.gov/health/statistics/any-mood-disorder.shtml>.

⁵¹ National Institute of Mental Health, “Anxiety Disorders,” accessed September 3, 2020, <https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml>.

personality disorder. Lasting patterns of personal internal experiences and behaviors that differ from the expectations of one's culture and lead to distress.⁵²

posttraumatic stress disorder. A disorder that develops in some people who experience a scary or dangerous event and continue to feel stressed or frightened, despite no longer being in danger.⁵³

schizoid personality disorder. An uncommon condition characterized by a limited range of emotional expression, avoidance of social interacting, and difficulty developing relationships with others.⁵⁴

⁵² National Institute of Mental Health, "Personality Disorders," accessed September 2, 2020, <https://www.nimh.nih.gov/health/statistics/personality-disorders.shtml>.)

⁵³ National Institute of Mental Health, "Post-Traumatic Stress Disorder," accessed September 2, 2020, <https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>.)

⁵⁴ Mayo Clinic, "Schizoid personality disorder," accessed September 3, 2020, <https://www.mayoclinic.org/diseases-conditions/schizoid-personality-disorder/symptoms-causes/syc-20354414>.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: January 29, 2021

From: Director, VA Desert Pacific Health Care Network (10N22)

Subj: Healthcare Inspection—Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix VA Health Care System, Arizona

To: Director, Office of Healthcare Inspection (54MH00)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I have reviewed and concur with Phoenix's actions and recommendations on Healthcare Inspection - Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix VA Health Care System, Arizona.
2. If you have any additional questions, please contact me. Thank you.

(Original signed by:)

Michael W. Fisher
VISN 22 Network Director (10N22)
VA Desert Pacific Healthcare Network

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: January 29, 2021

From: Director, Phoenix VA Health Care System (644/00)

Subj: Healthcare Inspection—Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix VA Health Care System, Arizona

To: Director, VA Desert Pacific Health Care Network (10N22)

1. Thank you for the opportunity to review and respond to the draft report, Healthcare Inspection - *Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix VA Health Care System, Arizona*.
2. I have reviewed and concur with the recommendations 1-7 in the draft report. Corrective actions have been developed or implemented and are identified in the Director Comments.
3. If you have any additional questions, please contact the Chief, Quality Safety and Improvement.

(Original signed by:)

ALYSHIA SMITH, DNP, RN
Phoenix VA Health Care System Director

Facility Director Response

Recommendation 1

The Phoenix VA Health Care System Director conducts a full review of the patient's care to determine if administrative action is warranted, consulting with Human Resources and General Counsel offices as appropriate.

Concur.

Target date for completion: February 26, 2021

Director Comments

A full review of the Veterans electronic health record was completed by Phoenix VA Healthcare System (PVAHCS) Mental Health leadership. It was determined that a Peer Review was warranted for two, related to the Veteran's re-engagement in care after an eight-month lapse in mental health care and reports of increased stressors. Consistent with the tenets of a Just Culture, PVAHCS is reviewing the episode of care to determine any additional actions.

OIG Comment

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

Recommendation 2

The Phoenix VA Health Care System Director ensures that staff complete suicide risk assessments consistent with Veterans Health Administration and Phoenix VA Health Care System policies.

Concur.

Target date for completion: May 30, 2021

Director Comments

PVAHCS will conduct a retrospective review of risk assessment completions to determine compliance with policy reassessment requirements and update any suicide risk assessments accordingly. For sustainment, the Ongoing Professional Practice Evaluation (OPPE) will be updated to include this element as part of the provider review.

Action Plan: Retrospective review will be completed. A spreadsheet of patients with a diagnosis of 'attempted suicide' or 'suicidal thoughts' in their problem list for calendar year 2020 will be obtained. A random audit of 10% of these records will be conducted to identify whether these

patients received appropriate timely suicide risk assessment, in accordance with VHA DUSHOM [Deputy Under Secretary for Health for Operations and Management] Memorandum, *Suicide Risk Screening and Assessment Requirements – Attachment B*, dated May 23, 2018 and the PVAHCS Policy Memorandum 122-19, *Suicide and Suicide-Related Behavior*, dated March 15, 2017.

Monitoring: An element will be included in the Ongoing Professional Practice Evaluation (OPPE) every six months for mental health providers to identify whether appropriate follow-up care was offered to patients expressing increased stressors.

Recommendation 3

The Phoenix VA Health Care System Director ensures timely and accurate completion of electronic health record documentation.

Concur.

Target date for completion: May 30, 2021

Director Comments

Action Plan: PVAHCS will use standard documentation to ensure all critical elements are completed within 24 hours of notification of a death by suicide. The Suicide Prevention Coordinator designee will maintain data of deaths by suicide to include a chart review to assure the notification of suicide is entered into the Veterans electronic health record within 24 hours of notification. Documentation in the record will reflect the critical elements of Veteran's date of death, manner of death, and who reported the death.

Monitoring: An audit of timeliness and documentation of critical elements will be completed for 100% suicide cases for three consecutive months then quarterly, with 90% compliance. These will be reported to the Mental Health Core. Any trend that falls below expected goals will be addressed with appropriate actions to include service and individual interventions to maintain accurate quality documentation consistent with guidance.

Recommendation 4

The Phoenix VA Health Care System Director evaluates the community care psychology consult authorization timeliness and takes action as warranted.

Concur.

Target date for completion: July 30, 2021

Director Comments

During the time of this Veteran's Community Care (CC) consult TriWest was scheduling appointments in the community and oversight for items that fell out of compliance for timeliness or quality of scheduling service were not expediently communicated to the agency.

Action Plan: Phoenix VA Health Care System now schedules all psychology appointments that can be scheduled for under 20 days since May of 2020. TriWest will only assist with scheduling of those appointments that cannot be achieved in under 20 days.

Monitoring: Community Care will audit 100% of the Psychology consults on a monthly basis for scheduling timeliness until they achieve greater than 90% compliance rate with CC standards for three consecutive months. CC will report this compliance rate to the VA Community Care Oversight Committee (VACCOC). After achieving three consecutive months of greater than 90% scheduling compliance, reporting will then occur quarterly to the VACCOC for verification of sustained progress.

Recommendation 5

The Phoenix VA Health Care System Director conducts a review of Primary Care Clinic missed appointment procedures and ensures patient follow-up and staff training, as appropriate.

Concur.

Target date for completion: February 28, 2021

Director Comments

Actions Completed: The Phoenix VA Health Care System utilized the VSSC [VHA Support Service Center] COVID Cancellation report (inclusive of all No-show appointments) to complete a retrospective analysis and assess compliance with the no-show process for Primary Care. PVAHCS currently demonstrates a rate of 90.3% (n=10,518) from reporting period July 21, 2020 – January 27, 2021 this rate demonstrates a successful process for reviewing and addressing follow up for no-show patient appointments in the primary clinics. (National goal for overall cancellations which now includes no-shows is 80%.)

HAS [Health Administration Services] held a series of refresher training events on August 19-21, 2020 with Primary Care AMSAs [Advanced Medical Support Assistants]. 74 Primary Care AMSAs out of 112 (66%) attended the refresher training. The 38 remaining AMSA's requiring training will be completed by February 28, 2021. All staff holding a key for scheduling are required to take the National TMS [Talent Management System] training before assignment of privilege.

Monitoring: This VSSC COVID Cancellation report will be reviewed weekly by the Group Practice Management office with outliers being shared with the Health Administration Services (HAS) for patient and staff follow up. Additional focused training will be provided to staff identified in the reporting.

OIG Comment

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

Recommendation 6

The Phoenix VA Health Care System Director evaluates scheduling accuracy of mental health community care psychology consults and takes action as appropriate.

Concur.

Target date for completion: Action completed.

Director Comments

Actions Completed: An evaluation of the current PVAHCS CC psychology consults was completed on January 25, 2021 consisting of an audit of 50 consults (16%) out of the total of 314 CC psychology consults scheduled over the past three months (October 1, 2020 through January 1, 2021).

The audit evaluated the following criteria: 1) Referred/Scheduled into Wrong Service, 2) Appointment Time Incorrect, and 3) No Authorization for Service. The audit found no scheduling errors, yielding a 100% accuracy rating.

Monitoring: Community Care will continue to audit 25% of the psychology consults over the next three months with a target of 90% or greater scheduling accuracy and report the results to the VACCOC monthly.

OIG Comment

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

Recommendation 7

The Phoenix VA Health Care System Director ensures timely completion of behavioral health autopsies, consistent with Veterans Health Administration policy, and monitors for ongoing compliance.

Concur.

Target date for completion: Action completed.

Director Comments

Actions completed: Following the death of a Veteran by suicide, the SPC [Suicide Prevention Coordinator] enters the Behavioral Health Autopsy Program (BHAP) post-mortem data and other relevant information within 30 days of learning of the Veteran's passing.

A comprehensive review of data from September 25, 2020 through December 2020 was completed. In this review, there was 100% compliance with the SPC entry into the Behavioral Health Autopsy Program (BHAP) within 30 days of learning of the Veterans' passing. This demonstrates compliance with the VHA DUSHOM Memorandum, Behavioral Autopsy Program Implementation, dated December 11, 2012 guidelines and Phoenix VA Health Care System is managing the review of BHAP and monitoring for ongoing compliance with the expectations of the guidelines supporting completion of this recommendation.

Monitoring: The suicide prevention coordinator will report a monthly reconciliation of suicides and policy compliance through the PVAHCS governance structure.

OIG Comment

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

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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