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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in a Behavioral Health Provider's Documentation and Assessments, and Oversight of Nurse Practitioners at the VA Pittsburgh Healthcare System in Pennsylvania

HEALTHCARE INSPECTION | REPORT #21-01712-144 | MAY 3, 2022

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate OIG-identified concerns related to the assessment and documentation practices of a behavioral health certified registered nurse practitioner (BHNP) and leaders' completion of BHNPs' ongoing professional practice evaluations (OPPEs) at the VA Pittsburgh Healthcare System (facility) in Pennsylvania.[1] Given that BHNPs provide a range of healthcare services independently without a requirement for supervision or collaboration with physicians, the BHNPs' assessment and documentation practices as well as the oversight of these responsibilities are essential to ensure effective patient care.[2] During the inspection, the OIG found that the BHNP did not perform thorough suicide risk assessments for a patient who died by suicide.

OIG Findings

The OIG identified multiple deficiencies in the BHNP's assessment and documentation practices including absence of comprehensive suicide risk assessments, failure to complete abnormal involuntary movement and metabolic assessments for patients prescribed certain antipsychotic medication, missing informed consent or a risk-benefit discussion when prescribing off-label medications, failure to resolve rule-out diagnoses, and substantial copy and paste use.[3] The OIG

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. OPPEs are ongoing monitoring of applicable licensed independent practitioners that occur routinely to allows facility leaders "to identify professional practice trends that impact the quality of care and patient safety."

[2] VHA Directive 1350, *Advanced Practice Registered Nurse Full Practice Authority*, September 13, 2017. Nurse practitioners provide a range of healthcare services, including diagnostic and laboratory testing, evaluation and treatment of acute and chronic conditions, medication prescription, and overall management of a patient's care.

[3] Mathews, Maju et al., "Antipsychotic-Induced Movement Disorders: Evaluation and Treatment," *Psychiatry*, March 2005, 36–41, accessed August 24, 2021, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3004713/. Antipsychotic medications are the most common treatment for schizophrenia and other psychotic disorders. U.S. Food and Drug Administration, "Understanding Unapproved Use of Approved Drugs 'Off Label'," accessed March 17, 2021, https://www.fda.gov/ForPatients/Other/OffLabel/default.htm. American Psychological Association, APA Dictionary of Psychology, "differential diagnosis," accessed August 13, 2021, https://dictionary.apa.org/differential-diagnosis. A provider may consider two or more diagnoses if a patient presents with signs or symptoms that are shared by more than one disorder. If additional data is needed to determine the diagnosis, the provider may document diagnoses as *differential* or *rule-out*. The OIG considers the terms *differential* and *rule-out* diagnoses to be equivalent terms. The practice of copy and paste is the copying of text from a completed electronic health record note and pasting of the text into a new electronic health record note.

found adverse clinical outcomes for one of eight patients for whom the BHNP did not document a comprehensive suicide risk assessment, as required by The Joint Commission.[4]

The OIG found that the BHNP did not document a comprehensive suicide risk assessment when patients endorsed suicidal ideation. The OIG determined that the BHNP documented that 8 of the 150 patients' electronic health record (EHRs) reviewed indicated having suicidal ideation.[5] For unclear reasons, the BHNP failed to document suicide risk information for these eight patients including a suicide plan, level of risk, acute or chronic risk status, and current behaviors of concern. Further, the BHNP failed to consistently document intent, risk and protective factors, and a mitigation plan for the eight patients. The BHNP's failure to include sufficient suicide risk assessment documentation may have contributed to an underestimation of a patient's suicide risk level and lack of appropriate intervention, increasing a patient's risk of an adverse clinical outcome. Further, the absence of thorough risk assessment documentation may prevent future providers from obtaining an accurate history of a patient's suicide risk.

The OIG found adverse clinical outcomes for one of the eight patients.

Synopsis of a Patient's 2018–2019 Care

The patient, who was in their 70s, had a reportedly long history of suicide attempts and hospitalizations at a non-VA hospital and the facility, and had 2018 legal charges related to an attempted kidnapping of a prior significant other.[6] In late 2018, the patient was admitted to the facility's inpatient mental health unit for a suicide attempt and then was readmitted involuntarily in early 2019. Following the early 2019 admission, the BHNP met with the patient monthly for four months.

Starting during the patient's late 2018 inpatient admission through mid-spring 2019, a suicide prevention coordinator met with the patient in-person or by telephone multiple times a month. In a mid-spring 2019 note, the suicide prevention coordinator documented "discussed nightmares

[4] The Joint Commission, "Joint Commission FAQs." The Joint Commission is the nation's oldest and largest body that sets standards, "accredits and certifies more than 22,000 health care organizations and programs in the United States…." The Joint Commission, *National Patient Safety Goal for Suicide Prevention*, updated November 20, 2019. Centers for Disease Control and Prevention, *Risk and Protective Factors*, accessed September 23, 2021, https://www.cdc.gov/suicide/factors/index.html. Risk factors for suicide include previous suicide attempt, mental illness, and job problems or loss. Protective factors include supportive relationships, coping skills, and limited access to lethal means. Within the context of this report, the OIG considered an adverse clinical outcome to be harm to self or others including death by suicide.

[5] The OIG reviewed a random sample of 150 patients' EHRs for the BHNP's assessment and documentation practices from October 1, 2018, through March 31, 2021. For analysis of the BHNP's suicide risk assessment documentation, the OIG reviewed EHR documentation from the last two visits with the BHNP in the review period of October 1, 2018–March 31, 2021. The BHNP documented a patient-identified suicidal ideation in both visits for three of the eight unique patients totaling 11 visits reviewed for suicide risk assessment documentation. For those three patients with two consecutive visits presenting with suicidal ideation, the BHNP documented and omitted the same information for both visits.

[6] The OIG uses the singular form of they (their) in this instance to preserve patient privacy.

[the patient] is having concerns [homicidal ideation] towards prior" significant other and that the patient "has no intention to cause harm." Nine days later, the BHNP met with the patient and did not document an assessment of suicide risk although noted the patient had suicidal and not homicidal ideation. Thirteen days later, in a telephone contact note, the suicide prevention coordinator documented that the patient described "doing well." However, three days later, using a firearm, the patient killed the prior significant other and subsequently died by suicide.

Given the patient's history of suicidal and homicidal ideation and behaviors and the BHNP's documentation of the presence of suicidal ideation, the OIG determined that the BHNP, as the primary mental health prescriber with awareness of the patient's Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment (REACH VET) status, should have completed and documented comprehensive suicide risk assessments.[7] Although the BHNP reportedly recognized the patient's high risk for suicide status, the BHNP's lack of comprehensive suicide risk assessments and adherence to REACH VET requirements failed to promote the identification of previously unspecified risk factors, additional treatment, and other resources to support the patient's overall health.[8]

OIG Additional Findings

The OIG also determined that the BHNP did not document required assessments of all health factors for 10 patients for whom the BHNP initiated a second-generation antipsychotic medication or for 32 of the 33 patients engaged in ongoing second-generation antipsychotic medication with the BHNP.[9] The absence of these critical assessments may result in a failure to prevent, identify, and manage side effects of the antipsychotic medication including metabolic disturbances. The BHNP prescribed off-label medications to 14 of 150 patients reviewed and documented informed consent for three of the 14 patients. Additionally, the BHNP documented

[7] In 2016, VHA implemented the REACH VET program that utilizes data to identify veterans currently using VA healthcare services who are statistically at high risk for adverse events including suicide and overdoses. VA Acting Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, *REACH VET: Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment*, August 10, 2016.

[8] VA Acting Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, *REACH VET: Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment*, August 10, 2016. "REACH VET Steps," VHA's Mental Illness Research, Education and Clinical Center. While not in the 2016 10N memorandum, the REACH VET Provider Steps identifies that REACH VET providers are responsible for reviewing a patient's clinical information, enhancing treatment as appropriate, outreaching to the patient, and documenting patient outreach.

[9] Of the 150 patients' EHRs reviewed by the OIG, the BHNP prescribed a second-generation antipsychotic medication for 33 patients and initiated the medication for 10 of those 33 patients. Abou-Setta, AM et al., "First-Generation Versus Second-Generation Antipsychotics in Adults: Comparative Effectiveness." Comparative Effectiveness Review No. 63. (Prepared by the University of Alberta Evidence-based Practice Center under Contract No. 290-2007-10021.) AHRQ Publication No. 12-EHC054-EF. Rockville, MD: Agency for Healthcare Research and Quality; August 2012, accessed August 25, 2021, https://www.ncbi.nlm.nih.gov/books/NBK107254/pdf/Bookshelf_NBK107254.pdf. Second-generation antipsychotics or atypical antipsychotics, such as olanzapine, quetiapine, and risperidone, emerged in the 1980s.

discussion of the risks and benefits of the off-label medication with a different 3of the 14 patients; however, one of those three patients' EHR notes appears copied and pasted from another provider's EHR note entered approximately six months earlier.

Consistent with Veterans Health Administration's (VHA) informed consent requirements and off-label medication guidance, as well as the expectations of the facility's Associate Chief of Staff of Behavioral Health, the OIG would expect the BHNP to document informed consent and risks and benefits discussions with patients prescribed off-label medications.[10] Failure to engage in and document these discussions may compromise patients' rights to be made aware of relevant treatment considerations and agree to treatment with full knowledge.

The OIG found that in 14 of the 150 patients' EHRs reviewed, the BHNP documented rule-out diagnoses with no resolution from the first visit to the last visit of the review period. Failure to resolve rule-out diagnoses can contribute to incomplete informed consent processes with patients and subsequently, providers may use inaccurate or outdated information in clinical decision-making. Of the 14 patients, 5 had more than four visits, and rule-out diagnoses were included for over a year with no rationale documented for the continuation of the rule-out diagnoses. The OIG concluded that the BHNP copied and pasted the rule-out diagnoses from one visit's EHR note to the next without resolution or update.

The OIG found that the BHNP copied and pasted significant sections of notes from prior notes within the patient's EHR in 138 (97 percent) of the 143 patients' EHRs reviewed.[11] In an interview with the OIG, the BHNP explained using copy and paste in patients' EHRs to provide a reference for treatment history and changes that occurred since the last visit with a patient. However, as discussed above, the OIG found that the BHNP appeared to copy and paste information that was not reflective of the patient's presentation at the visit including (1) suicide risk assessment information from previous visits without including updated information about relevant behaviors, (2) another provider's assessment of antipsychotic medication side effects for one of the 36 applicable patients, (3) another provider's documentation of a discussion of risks and benefits of taking an off-label medication in one of three applicable patients' EHRs, and (4) rule-out diagnoses without resolution.

[10] VHA Handbook 1004.01(5); VA Center for Medication Safety and VHA Pharmacy Benefits Management Strategic Healthcare Group and the VA Medical Advisory Panel, "Pharmaceutical Use Outside of Approved Indications, Guidance on 'Off-Label' Prescribing," May 2004, accessed March 17, 2021, https://www.pbm.va.gov/PBM/vacenterformedicationsafety/directive/GuidanceOffLabelPrescribing.pdf.

[11] In seven of the 150 patients' EHRs reviewed, the BHNP documented only two notes. Given the insufficient information to determine the use of copy and paste, the OIG excluded these seven patients' EHRs from the review of the BHNP's copy and paste use.

For fiscal year 2018 through the first half of fiscal year 2021, BHNPs' OPPEs included a review of patients' EHRs for "inappropriate use of copy and paste."[12] Beginning in February 2020, facility leaders added a review of a completed safety plan in high risk for suicide patients' EHRs to the BHNPs' OPPEs. Regarding the BHNP reviewed in this report, the Nurse Manager rated the BHNP's use of copy and paste as satisfactory in the six completed OPPEs from November 2018 through May 2021.[13] In fiscal year 2021, the Nurse Manager rated the BHNP satisfactory on the safety plan review element. In an interview with the OIG, the Nurse Manager erroneously reported that Health Information Management Services and the lead BHNPs reviewed the copy and paste and safety plan elements, respectively. The Associate Chief of Staff, a psychiatrist, signed the OPPEs to "validate review." However, as discussed above, the OIG determined that the BHNP used copy and paste substantially and failed to document or comment on safety plans for patients who endorsed suicidal ideation.

The OIG concluded that the Nurse Manager evaluated BHNPs as satisfactory in the OPPE elements of copy and paste use for fiscal year 2018 through the first half of fiscal year 2021, and safety plan completion for high risk for suicide patients for February 2020 through the first half of fiscal year 2021, without these elements being evaluated. Behavioral Health managers' failure to ensure evaluation of OPPE elements significantly compromised the oversight and identification of "professional practice trends that impact the quality of care and patient safety," as required by VHA.[14]

The OIG made five recommendations to the Facility Director related to a comprehensive review of the BHNP's assessment practices regarding the patient who died by suicide, a review of the BHNP's overall assessment and documentation practices, alignment of facility policy and leaders' expectations related to the assessment and documentation of abnormal involuntary movements and metabolic problems for patients prescribed antipsychotic medications, Behavioral Health managers' verification of BHNPs' OPPEs review, and a review of managers' oversight of BHNPs' OPPEs.

[12] A fiscal year is a 12-month cycle that spans October 1 through September 30. Fiscal year 2018 began on October 1, 2017, and ended on September 30, 2018, and fiscal year 2019 began on October 1, 2018, and ended on September 30, 2019. VA/VHA Employee Health Promotion Disease Prevention Guidebook, *VA Finance Terms and Definitions*, July 2011, accessed April 13, 2021, https://www.publichealth.va.gov/docs/employeehealth/14-Finance-Terms.pdf. The Outpatient Nurse Manager, Behavioral Health, told the OIG that the Automated Data Processing Application Coordinator randomly selected five patients' EHRs for OPPE review purposes.

[13] In an interview with the OIG, the Nurse Manager explained being unable to complete the OPPE element reviews due to not being a BHNP.

[14] VHA Handbook 1100.19.

VA Comments

The Veterans Integrated Service Network and Facility Directors concurred with four recommendations and concurred in principle with one recommendation, 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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Contents

Abbreviations

AIMS	Abnormal Involuntary Movement Scale
BHNP	behavioral health certified registered nurse practitioner
EHR	electronic health record
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate OIG-identified concerns related to the assessment and documentation practices of a behavioral health certified registered nurse practitioner (BHNP) and leaders' completion of BHNPs' ongoing professional practice evaluations (OPPEs) at the VA Pittsburgh Healthcare System (facility) in Pennsylvania.[1]

Background

The facility, part of Veterans Integrated Service Network (VISN) 4, includes two medical centers and five community-based outpatient clinics. The facility provides inpatient medical, surgical, and psychiatric care, outpatient services including dental and primary care, and operates a community living center and residential rehabilitation treatment programs. From October 1, 2019, through September 30, 2020, the facility served 71,925 patients and had a total of 549 operating beds. The facility is affiliated with the University of Pittsburgh.

Advanced Practice Registered Nurses

Advanced practice registered nurses, including BHNPs, possess a master's or doctoral degree, receive advanced clinical training, and may achieve national certification. Nurse practitioners provide a range of healthcare services, including diagnostic and laboratory testing, evaluation and treatment of acute and chronic conditions, medication prescription, and overall management of a patient's care.[2]

Effective January 13, 2017, the Veterans Health Administration (VHA) allowed facility leaders to decide whether to implement advanced practice registered nurses' full practice authority.[3] Full practice authority is the ability for advanced practice registered nurses to independently provide patient care up to the highest level of education, training, and certification without a requirement for supervision or collaboration with physicians.[4]

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[1] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. OPPEs are ongoing monitoring of applicable licensed independent practitioners that occur routinely to allow facility leaders "to identify professional practice trends that impact the quality of care and patient safety."

[2] American Association of Nurse Practitioners, "What's a Nurse Practitioner (NP)?" accessed November 9, 2021, https://www.aanp.org/about/all-about-nps/whats-a-nurse-practitioner.

[3] 81 Fed. Reg. 90,198, 90,199 (December 14, 2016) (to be codified at 38 C.F.R. pt. 17). VHA Directive 1350, *Advanced Practice Registered Nurse Full Practice Authority*, September 13, 2017.

[4] VHA Directive 1350, *Advanced Practice Registered Nurse Full Practice Authority*, September 13, 2017.

The facility established full practice authority for advanced practice registered nurses in July 2017.[5] On October 31, 2019, VHA required all facilities to implement full practice authority for advanced practice registered nurses by September 30, 2020.[6] VHA requires clinical service chiefs to oversee advanced practice registered nurses' professional competence and performance including completion of OPPEs.[7]

Prior OIG Reports

In a July 2020 report, the OIG made two recommendations that addressed a facility provider's electronic health record (EHR) documentation error and lack of knowledge about documentation correction procedures.[8] Both recommendations were closed as of January 2021.

Concerns

During review of a complaint received on January 26, 2021, the OIG identified concerns regarding a BHNP's assessment and documentation practices and BHNPs' oversight. On March 8, 2021, the OIG initiated a healthcare inspection specifically to evaluate

- the BHNP's
  - assessment of suicide risk,
  - assessment of abnormal involuntary movement and metabolic problems for patients prescribed antipsychotics,
  - informed consent for off-label medication use,[9]
  - resolution of rule-out diagnoses, and[10]
  - use of copy and paste function; and[11]
- leaders' oversight of BHNPs' OPPEs.

[5] Facility Bylaws and Rules of the Medical Staff, July 17, 2017.

[6] Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, *Implementation Guidance for Veterans Health Administration (VHA) Directive 1350, Advanced Practice Registered Nurse Full Practice Authority*, October 31, 2019.

[7] VHA Directive 1350; VHA Handbook 1100.19.

[8] VA OIG, *Deficiencies in Evaluation, Documentation, and Care Coordination for a Bariatric Surgery Patient at the VA Pittsburgh Healthcare System in Pennsylvania*, Report No. 19-09436-185, July 1, 2020.

[9] U.S. Food and Drug Administration, "Understanding Unapproved Use of Approved Drugs 'Off Label'," accessed March 17, 2021, https://www.fda.gov/ForPatients/Other/OffLabel/default.htm.

[10] American Psychological Association, APA Dictionary of Psychology, "differential diagnosis," accessed August 13, 2021, https://dictionary.apa.org/differential-diagnosis. A provider may consider two or more diagnoses if a patient presents with signs or symptoms that are shared by more than one disorder. If additional data is needed to determine the diagnosis, the provider may document diagnoses as *differential* or *rule-out*. The OIG considers the terms *differential* and *rule-out* diagnoses to be equivalent terms.

[11] The practice of copy and paste is the copying of text from a completed EHR note and pasting of the text in a new EHR note.

Scope and Methodology

The OIG conducted a virtual site visit from May 3–6, 2021.[12]

The OIG interviewed facility staff and leaders familiar with BHNPs' documentation practices and professional practice oversight processes. The OIG reviewed a random sample of 150 patients' EHRs for the BHNP's assessment and documentation practices from October 1, 2018, through March 31, 2021.[13] The OIG also reviewed BHNPs' OPPEs completed from October 1, 2017, through March 30, 2021.[14] Additionally, relevant VHA directives, handbooks, and memoranda, and facility policies 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. 1101, 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.

[12] The site visit was conducted virtually due to the Coronavirus (COVID-19) pandemic. World Health Organization (WHO), "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020," March 11, 2020, accessed November 10, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020. *Merriam-Webster.com Dictionary, "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 most of the population. World Health Organization, *Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It,* accessed 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. COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

[13] The OIG included patients who had three or more visits with the BHNP from October 1, 2018, through March 31, 2021.

[14] Of the 13 BHNPs in the role at the time of the OIG review of OPPES, five BHNPs did not have OPPEs completed based on dates of employment and therefore were excluded.

Inspection Results

Deficiencies in a BHNP's Assessment and Documentation Practices

The OIG identified multiple deficiencies in a BHNP's assessment and documentation practices including absence of comprehensive suicide risk assessments, failure to complete abnormal involuntary movement and metabolic assessments for patients prescribed certain antipsychotic medication, missing patients' informed consents or risk-benefit discussions when prescribing off-label medications, failure to resolve rule-out diagnoses, and substantial copy and paste use.

During EHR reviews, the OIG found adverse clinical outcomes for one of the eight patients for whom the BHNP did not document a comprehensive suicide risk assessment (see Patient 8 case summary below), as required by The Joint Commission.[15]

VHA requires that providers document patient care in accordance with The Joint Commission standards.[16] Clinical records need to include information

- "to support the patient's diagnosis and condition,"
- "to justify the patient's care, treatment, or services,"
- "that documents the course and result of the patient's care, treatment, or services," and
- "that promotes continuity of care among providers."[17]

Suicide Risk Assessment

In a Suicide Risk Assessment Guide, VHA advises "it is important to ask a screening set of questions whenever the clinical situation or presentation warrants it."[18] The Joint Commission requires a comprehensive suicide risk evaluation for patients who screen positive for suicidal ideation or exhibit suicidal behavior that includes directly asking the patient about suicidal

[15] The Joint Commission, "Joint Commission FAQs," accessed on November 17, 2021, https://www.jointcommission.org/about-us/facts-about-the-joint-commission/joint-commission-faqs/. The Joint Commission is the nation's oldest and largest body that sets standards, "accredits and certifies more than 22,000 health care organizations and programs in the United States…." The Joint Commission, *National Patient Safety Goal for Suicide Prevention*, updated November 20, 2019. Centers for Disease Control and Prevention, *Risk and Protective Factors*, accessed September 23, 2021, https://www.cdc.gov/suicide/factors/index.html. Risk factors for suicide include previous suicide attempt, mental illness, and job problems or loss. Protective factors include supportive relationships, coping skills, and limited access to lethal means. Within the context of this report, the OIG considered an adverse clinical outcome to be harm to self or others including death by suicide.

[16] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015. This handbook was in effect for the time frame of the events discussed in this report. It was rescinded and replaced by VHA Directive 1907.01, *VHA Health Information Management and Health Records*, April 5, 2021. The 2015 handbook and 2021 policies contain similar information regarding the requirement to meet The Joint Commission standards.

[17] The Joint Commission E-dition, March 14, 2021, Ambulatory Accreditation Requirements, "Record of Care, Treatment, and Services."

[18] VHA Mental Health, "Suicide Risk Assessment Guide."

ideation, plan, intent, behaviors, risk factors, protective factors, and documenting overall level of suicide risk, and developing a mitigation plan.[19]

The OIG found that the BHNP did not document comprehensive suicide risk assessments when patients endorsed suicidal ideation. The OIG determined that the BHNP documented that eight of the 150 patients' EHRs reviewed indicated suicidal ideation.[20] For unclear reasons, the BHNP failed to document suicide risk information for these eight patients, including a suicide plan, level of risk, acute or chronic risk status, and current behaviors of concern. Further, the BHNP failed to consistently document intent, risk and protective factors, and a mitigation plan for the eight patients (see table 1).

Table 1. BHNP's Suicide Risk Assessment Documentation

Patient Number	Suicide Plan, Level of Risk	Intent	Risk Factors	Protective Factors	Behaviors*	Mitigation Plan
1	No	No	No	No	No	No
2	No	No	Yes	Yes	Historical	No
3	No	No	No	No	Historical	Yes
4	No	Yes	No	No	Historical	No
5†	No	No	No	Yes	Historical	No
6	No	No	No	No	No	Yes
7†	No	No	No	No	Historical	No
8†	No	No	No	No	Historical	No

Source: OIG analysis of BHNP's EHR documentation from October 1, 2018, through March 31, 2021.

* The OIG noted the BHNP's documentation of a patient's past behaviors using the term *Historical*.

† Patient presented with suicidal ideation in the last two visits of the review period, and the BHNP documented and omitted the same information for both visits.

The OIG also found that the BHNP appeared to copy and paste suicide risk assessment information from previous visits and did not include updated information about relevant behaviors in six of the eight patients' EHRs. The OIG team was unable to determine the

[19] The Joint Commission, *National Patient Safety Goal for Suicide Prevention*, updated November 20, 2019. Centers for Disease Control and Prevention, *Risk and Protective Factors*, accessed September 23, 2021, https://www.cdc.gov/suicide/factors/index.html. Risk factors for suicide include previous suicide attempt, mental illness, and job problems or loss. Protective factors include supportive relationships, coping skills, and limited access to lethal means. VHA refers to a mitigation plan as a suicide prevention safety plan.

[20] For analysis of the BHNP's suicide risk assessment documentation, the OIG reviewed EHR documentation from the last two visits with the BHNP in the review period of October 1, 2018–March 31, 2021. The BHNP documented a patient identified suicidal ideation in both visits for three of the eight unique patients totaling 11 visits reviewed for suicide risk assessment documentation. For those three patients with two consecutive visits presenting with suicidal ideation, the BHNP documented and omitted the same information for both visits.

accuracy and relevancy of the information for the patients' status at the time of the visit because information appeared to have been copied and pasted from previous visits.

Additionally, patients 3, 5, 6, and 7 were seen for mental health treatment solely by the BHNP; therefore, the BHNP was the responsible provider to conduct suicide risk assessments and safety plan reviews. As discussed in the patient case summary below, the OIG found adverse clinical outcomes for one of the eight patients (Patient 8).

The BHNP's failure to include sufficient suicide risk assessment documentation may contribute to an underestimation of a patient's suicide risk level and lack of appropriate intervention, increasing a patient's risk of an adverse clinical outcome. Further, the absence of thorough risk assessment documentation may prevent future providers from obtaining an accurate history of a patient's suicide risk.

Patient 8 Case Summary and BHNP Documentation Deficiencies

Patient 8, who was in their 70s, had a reportedly long history of suicide attempts and hospitalizations at a non-VA hospital and the facility, and had 2018 legal charges related to an attempted kidnapping of a prior significant other.[21] In late 2018, Patient 8 was admitted to the facility's inpatient mental health unit for a suicide attempt.

On the day of discharge from the 12-day admission, the suicide prevention coordinator completed a suicide prevention safety plan with Patient 8 and placed a high risk for suicide patient record flag in Patient 8's EHR.[22] The safety plan identified the BHNP, who was scheduled to meet with Patient 8 for the first time in early 2019, as Patient 8's "mental health professional." However, four days prior to that scheduled meeting, Patient 8 was involuntarily committed to the inpatient mental health unit for homicidal ideation. The following month, Patient 8 requested and initiated care at the facility's adult day healthcare program, which Patient 8 attended regularly until mid-spring 2019.[23]

Following Patient 8's early 2019 inpatient discharge, five days after admission, the BHNP met with Patient 8 monthly for four months in 2019. The BHNP documented "Yes" to suicidal ideation and "No" to homicidal ideation in each of Patient 8's monthly visit notes. However, the BHNP did not document a suicide risk assessment or review of Patient 8's safety plan in any of the notes. In an interview with the OIG, the BHNP initially did not recall why Patient 8's suicide

[21] The OIG uses the singular form of they (their) in this instance to preserve patient privacy.

[22] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. VA Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, *Update to High Risk for Suicide Patient Record Flag Changes*, January 16, 2020. VHA uses a Patient Record Flag Category II High Risk for Suicide to identify a patient as high risk for suicide in the EHR and requires re-evaluation at least every 90 days.

[23] VHA's adult day health care program provides daily social and recreational activities for patients who are isolated or require help with daily living activities such as dressing or fixing meals. Patient 8 was scheduled to attend this program twice a week.

risk was not assessed and that a patient saying "I want to die, I wish I was dead" did not prompt further assessment. About Patient 8, the BHNP stated, "I would have put 'no'….In my thinking back it's, 'I wish I was dead'." After review of Patient 8's EHR documentation, the OIG concluded that the BHNP copied and pasted prior visit documentation regarding Patient 8's suicidal and homicidal ideation in each note and failed to indicate if the information was updated, or document Patient 8's statements that may have reflected suicidal ideation. Failure to document Patient 8's current thoughts about death and follow up on statements, such as "I wish I was dead," may have contributed to an inadequate understanding of Patient 8's risk of self-harm and appropriate interventions, and consequently increased Patient 8's risk of an adverse clinical outcome.

Starting during Patient 8's late 2018 inpatient admission through mid-spring 2019, the suicide prevention coordinator met with Patient 8 in-person or by telephone multiple times a month. In a mid-spring note, the suicide prevention coordinator documented that Patient 8 "discussed nightmares [Patient 8] is having concerns [homicidal ideation] towards prior" significant other and that Patient 8 "has no intention to cause harm." Nine days later, the BHNP met with Patient 8 and did not document an assessment of suicide risk although noted Patient 8 had suicidal and not homicidal ideation. Thirteen days later, in a telephone contact note, the suicide prevention coordinator documented that Patient 8 described "doing well." Three days later, using a firearm, Patient 8 killed the prior significant other and subsequently died by suicide.

Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment Processes and Documentation

In 2016, VHA implemented the Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment (REACH VET) program that utilizes data to identify veterans currently using VA healthcare services who are statistically at high risk for adverse events including suicide and overdoses.[24] The REACH VET coordinator assigns a REACH VET provider for each identified REACH VET patient. The REACH VET provider is responsible for reviewing a patient's EHR, enhancing treatment as appropriate, informing the patient about REACH VET, and documenting patient outreach.[25]

Soon after Patient 8's second monthly visit, in early 2019, the BHNP was assigned as Patient 8's REACH VET provider. In the visit on the following month, the BHNP did not document introducing Patient 8 to the REACH VET program or conducting an EHR review, as instructed by the REACH VET coordinator. The next month, a second REACH VET coordinator requested

[24] VA Acting Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, *REACH VET: Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment*, August 10, 2016.

[25] "REACH VET Steps," VHA's Mental Illness Research, Education and Clinical Center. While not in the 2016 10N memorandum, the REACH VET Provider Steps identifies that REACH VET providers are responsible for reviewing a patient's clinical information, enhancing treatment as appropriate, outreaching to the patient, and documenting patient outreach.

the BHNP review Patient 8's EHR "to re-evaluate the Veteran's care, and introduce the REACH VET program to the Veteran." In response, the BHNP documented that a "comprehensive assessment will not be repeated," and planned to review REACH VET status at Patient 8's next visit. The REACH VET coordinator told the OIG about completing the REACH VET provider template based on the BHNP's February and March visit notes since the BHNP did not use the proper note template. The REACH VET coordinator documented that the BHNP "conducted a comprehensive chart review" and that it was determined that Patient 8 "would benefit from enhanced care through: safety planning, increased monitoring of stressful life events, and improved coping skills." Although the REACH VET coordinator ensured the correct REACH VET provider template was completed, the OIG did not find evidence of the BHNP's comprehensive chart review or identification of the enhanced care areas that the REACH VET coordinator documented.

At Patient 8's next visit, approximately two weeks later, the BHNP did not document an EHR review or discussion with Patient 8 about the REACH VET program. When asked by the OIG about the REACH VET follow-up, the BHNP reported that Patient 8 was receiving "everything we could put around [Patient 8]," and that "the REACH [VET] standards were in place for" Patient 8. The BHNP stated, "But as far as if there was a titled REACH VET note…I don't know why there wasn't one at the time. Did I know [Patient 8] was high-risk? Of course. Was I acting and looking at [Patient 8] in that those [*sic*] terms? Yes." The BHNP also noted that "all that literature was coming out and there was confusion around who had to do it, when it had to be done."

Given Patient 8's history of suicidal and homicidal ideation and behaviors and the BHNP's documentation of the presence of suicidal ideation, the OIG determined that the BHNP, as the primary mental health prescriber with awareness of Patient 8's REACH VET status, should have completed and documented comprehensive suicide risk assessments. Although the BHNP reportedly recognized Patient 8's high risk for suicide status, the BHNP's lack of comprehensive suicide risk assessments and adherence to REACH VET requirements failed to promote the identification of previously unspecified risk factors, additional treatment, and other resources to support Patient 8's overall health.[26]

[26] VA Acting Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, *REACH VET: Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment*, August 10, 2016. "REACH VET Steps," VHA's Mental Illness Research, Education and Clinical Center.

Assessment of Abnormal Involuntary Movement and Metabolic Problems

Antipsychotic medications are the most common treatment for schizophrenia and other psychotic disorders.[27] First generation antipsychotics, also known as typical antipsychotics, were developed in the 1950s and include perphenazine and haloperidol. Second-generation antipsychotics or atypical antipsychotics, such as olanzapine, quetiapine, and risperidone, emerged in the 1980s.[28]

Potential side effects of these medications include a variety of movement disorders, such as tardive dyskinesia, and metabolic problems including weight gain and high blood sugar.[29] The American Psychiatric Association advises that "monitoring for the presence of side effects is also important throughout the course of antipsychotic treatment."[30]

Facility policy requires the completion of the Abnormal Involuntary Movement Scale (AIMS) for tardive dyskinesia symptoms when an antipsychotic medication is prescribed initially and then at specified intervals.[31] The policy specifically states that "AIMS testing should be

[27] Mathews, Maju et al., "Antipsychotic-Induced Movement Disorders: Evaluation and Treatment," *Psychiatry*, March 2005, 36–41, accessed August 24, 2021, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3004713/.

[28] Abou-Setta, AM et al., "First-Generation Versus Second-Generation Antipsychotics in Adults: Comparative Effectiveness." Comparative Effectiveness Review No. 63. (Prepared by the University of Alberta Evidence-based Practice Center under Contract No. 290-2007-10021.) AHRQ Publication No. 12-EHC054-EF. Rockville, MD: Agency for Healthcare Research and Quality; August 2012, accessed August 25, 2021, https://www.ncbi.nlm.nih.gov/books/NBK107254/pdf/Bookshelf_NBK107254.pdf.

[29] Mayo Clinic, *What causes tardive dyskinesia?*, accessed September 7, 2021, https://www.mayoclinic.org/diseases-conditions/tardive-dyskinesia/in-depth/what-causes-tardive-dyskinesia/art-20460032?p=1 (web page discontinued). Tardive dyskinesia is "a nervous system disorder that causes repeated, uncontrolled movements" and can be caused by first- or second-generation antipsychotics. Tschoner et al., "Metabolic side effects of antipsychotic medication," *International Journal of Clinical Practice*, 61, (2007): 1356–1370, accessed September 21, 2021, https://pubmed.ncbi.nlm.nih.gov/17627711/#:~:text=Abstract.%20The%20use%20of%20second-generation%20antipsychotics%20%28SGAs%29%20is,may%20also%20impair%20the%20patient%27s%20adherence%20to%20treatment. Mathews, Maju et al., "Antipsychotic-Induced Movement Disorders: Evaluation and Treatment," *Psychiatry*, March 2005, 36–41, accessed August 24, 2021, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3004713/.

[30] The American Psychiatric Association Practice Guideline for the Treatment of Patients With Schizophrenia, Third Edition, *American Psychiatric Association*, 2021, Pharmacotherapy, Statement 4: Antipsychotic Medications, Monitoring During Treatment With an Antipsychotic Medication, pages 66–67, accessed May 26, 2021, https://www.psychiatryonline.org/doi/full/10.1176/appi.books.9780890424841.Schizophrenia03.

[31] Facility Memorandum TX-154, *Use of Psychopharmacologic Agents*, December 20, 2018. Patients "will be screened" for tardive dyskinesia symptoms every three months following initial prescription for first generation antipsychotics and at three months and then every six months for second generation antipsychotics. Mathews, Maju et al., Antipsychotic Induced Movement Disorders: Evaluation and Treatment, *Psychiatry*, March 2005, 36–41, accessed August 24, 2021, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3004713/. AIMS, a 12-item scale, is the "most popular" tool used to assess abnormal involuntary movements associated with tardive dyskinesia.

documented using the clinical reminder" in the EHR.[32] The Chief of Staff told the OIG that completion of the AIMS was "needed annually" and that the clinical reminder was "available to providers" but "not used regularly" at the facility. The Associate Chief of Staff of Behavioral Health (Associate Chief of Staff) reported that providers receive "six monthly alerts" in the EHRs of patients diagnosed with schizophrenia and who are prescribed an antipsychotic medication. However, the facility's Clinical Informatics Manager told the OIG that the AIMS national clinical reminder, which is not required to be used, is not in use at the facility. The inconsistencies between facility policy and leaders' understandings of requirements and processes may have contributed to providers' misinformation and inadequate assessment and documentation of abnormal involuntary movements for patients prescribed antipsychotic medication.

BHNP's Assessment and Documentation Deficiencies

From October 1, 2018, through March 31, 2021, the BHNP prescribed antipsychotic medications for 36 of the 150 reviewed patients' EHRs.[33] In an interview with the OIG, the BHNP reported documenting a patient's new or persistent tardive dyskinesia symptom. The OIG found that the BHNP documented the assessment of side effects for one of the 36 patients in two consecutive notes. However, this information appeared copied and pasted from another provider's notes from approximately six and 10 months earlier, and therefore, did not reflect the BHNP's independent assessment at the time of the patient's visit, as required.[34]

For patients prescribed second-generation antipsychotic medications, facility policy also required baseline screening and ongoing monitoring of specified health factors (see table 2). Of the 36 patients, the BHNP prescribed a second-generation antipsychotic medication for 33 patients and initiated the prescription for 10 of those 33 patients.

[32] Facility Memorandum TX-154; VA Office of Information and Technology, *Clinical Reminders Manager's Manual*, March 2005, revised May 2021. Clinical reminders are used to assist clinical decision-making and improve follow-up by ensuring that timely interventions, such as tests or evaluations, are conducted and documented.

[33] Of the 36 patients, three patients were prescribed first-generation, 32 patients were prescribed second-generation, and one patient was prescribed a first- and a second-generation antipsychotic medication.

[34] Facility Memorandum TX-154.

Table 2. BHNP's Documentation Compliance with Facility Policy for Assessment of Health Factors During Second-Generation Antipsychotic Medication Treatment

Assessment Requirement	Documented	Not Documented
Baseline screening:		
Obesity	1	9
Diabetes*	1	9
Dyslipidemia†	4	6
Smoking	1	9
High blood pressure	3	7
Cardiovascular disease	1	9
Weight	1	9
Body mass index‡	0	10
Blood pressure	1	9
A1C§	1	9
Lipid levels	0	10
Reassessment:		
Weight	2	31
Fasting plasma glucose, blood pressure, A1C, and lipid levels‖	1	32

Source: OIG analysis of patients' EHRs.

Note: Facility Memorandum TX-154; The BHNP initiated second-generation antipsychotic medication for 10 patients and provided ongoing second-generation antipsychotic medication for an additional 23 patients; therefore, the OIG expected reassessment of the 33 patients.

** Mayo Clinic, "diabetes," accessed September 7, 2021, https://www.mayoclinic.org/diseases-conditions/diabetes/symptoms-causes/syc-20371444. Diabetes is a disease that affects how the body uses blood sugar and leads to an excess sugar level in the blood.*

† Merriam-Webster.com Medical Dictionary, "dyslipidemia," accessed October 13, 2021, https://www.merriam-webster.com/medical/dyslipidemia. Dyslipidemia is "a condition marked by abnormal concentrations of lipids or lipoproteins in the blood."

‡ Merriam-Webster.com Dictionary, "body mass index," accessed September 21, 2021, https://www.merriam-webster.com/dictionary/body%20mass%20index#:~:text=%3A%20a%20measure%20of%20body%20fat,of%20its%20height%20in%20meters. Body mass index is a measure of body fat derived as a ratio of body weight and height.

§ Centers for Disease Control and Prevention, "All About Your A1C," accessed September 8, 2021, https://www.cdc.gov/diabetes/managing/managing-blood-sugar/a1c.html. A1C is a blood test that measures the patient's average blood sugar levels for the prior three months and is used to diagnose prediabetes and diabetes.

|| The OIG considered these laboratory results as completed if all results were documented. American Diabetes Association, "Understanding A1C: Diagnosis," accessed January 24, 2022, https://www.diabetes.org/a1c/diagnosis. Fasting Plasma Glucose is a test of a person's blood sugar levels "after not having anything to eat or drink (except water) for at least 8 hours before the test."

The OIG determined that the BHNP did not document required assessments of all health factors for the 10 patients for whom the BHNP initiated a second-generation antipsychotic medication or for 32 of the 33 patients engaged in ongoing second-generation antipsychotic medication with the BHNP. The absence of these critical assessments may result in a failure to prevent, identify, and manage side effects of an antipsychotic medication, including metabolic disturbances.

Informed Consent for Off-Label Medication Use

VHA requires that providers obtain voluntary, informed consent from a patient prior to performing any medical treatment or procedure and when there is a significant change to the patient's treatment plan.[35] Patients have the right to refuse any recommended medical treatment or procedure.[36] Providers must document a patient's consent to a medical treatment or procedure in the EHR.[37]

When informing a patient to gain consent the practitioner must (1) provide detailed information to support an informed decision, (2) explain the relation between the diagnosis and the treatment, (3) describe the course of treatment along with any associated benefits or risks, (4) discuss alternatives, and (5) advise if the treatment is either nontraditional or lacking evidence of efficacy.[38]

Providers may prescribe a medication off-label to treat a medical condition that the drug was not approved to treat.[39] VHA does not specifically require providers to discuss off-label use of medication with patients and advises that "Evidence of benefit (and importantly, risk) should be explicitly reviewed."[40] In an interview with the OIG, the Associate Chief of Staff described the expectation that prescribing providers document informed consent and discussion of medication risks and benefits with patients when prescribing off-label medication and when prescribing a new medication.

The OIG found that the BHNP prescribed off-label medications to 14 of 150 patients reviewed and documented informed consent for three of the 14 patients. Additionally, the BHNP documented discussion of the risks and benefits of the off-label medication with a different three

[35] VHA Handbook 1004.01(5), *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009, amended September 17, 2021.

[36] VHA Handbook 1004.01(5).

[37] VHA Handbook 1004.01(5).

[38] VHA Handbook 1004.01(5).

[39] U.S. Food and Drug Administration, "Understanding Unapproved Use of Approved Drugs 'Off Label'," accessed March 17, 2021, https://www.fda.gov/ForPatients/Other/OffLabel/default.htm.

[40] VA Center for Medication Safety And VHA Pharmacy Benefits Management Strategic Healthcare Group and the VA Medical Advisory Panel, "Pharmaceutical Use Outside of Approved Indications, Guidance on 'Off-Label' Prescribing," May 2004, accessed March 17, 2021, https://www.pbm.va.gov/PBM/vacenterformedicationsafety/directive/GuidanceOffLabelPrescribing.pdf. VHA Handbook 1907.01; VHA Directive 1907.01.

of the 14 patients, however, as mentioned above, one of those three EHR notes appears copied and pasted from another provider's EHR note entered approximately six months earlier.

Consistent with VHA's informed consent requirements and off-label medication guidance, as well as the Associate Chief of Staff's expectations, the OIG would expect the BHNP to document informed consent and risks and benefits discussions with patients prescribed off-label medications.[41] Failure to engage in and document these discussions may compromise patients' rights to be made aware of relevant treatment considerations and agree to treatment with full knowledge.

Rule-Out Diagnoses Resolution

Facility Bylaws and Rules of the Medical Staff (facility bylaws) require providers to complete accurate and timely documentation including a final diagnosis.[42] A provider may consider two or more diagnoses if a patient presents with signs or symptoms that are shared by more than one disorder. If additional data is needed to resolve a diagnosis and eliminate a possible disorder, the provider may document diagnostic considerations as *differential* or *rule-out* diagnoses.[43] The American Psychiatric Association notes that "appropriate treatment will be an outgrowth of the patient's diagnosis as determined during the psychiatric evaluation."[44] The American Psychiatric Association and facility bylaws advise providers to inform patients of their diagnosis and treatment options.[45] Therefore, when clinically indicated, rule-out diagnoses should be resolved to ensure accuracy of documented diagnoses and provision of appropriate treatment. Further, resolution of rule-out diagnoses in the patient's EHR ensures other clinicians may access an up-to-date assessment of the patient's condition in the event of a need for medical decision-making.

Rule-out diagnoses may be documented over several visits as a provider obtains additional clinical data, consultations, or specialty evaluations to distinguish between disorders with similar

[41] VHA Handbook 1004.01(5); VA Center for Medication Safety And VHA Pharmacy Benefits Management Strategic Healthcare Group and the VA Medical Advisory Panel, "Pharmaceutical Use Outside of Approved Indications, Guidance on 'Off-Label' Prescribing," May 2004, accessed March 17, 2021, https://www.pbm.va.gov/PBM/vacenterformedicationsafety/directive/GuidanceOffLabelPrescribing.pdf.

[42] Facility Bylaws, *Bylaws and Rules of the Medical Staff,* July 17, 2017. The 2017 bylaws were in effect for a portion of the time frame of the events discussed in this report. It was replaced by Facility Bylaws, *Bylaws and Rules of the Medical Staff*, February 15, 2019, and then Facility Bylaws, *Bylaws and Rules of the Medical Staff,* April 17, 2020. The 2019 and 2020 bylaws have the same or similar language as the 2017 bylaws related to accurate and timely documentation including a final diagnosis.

[43] American Psychological Association, APA Dictionary of Psychology, "differential diagnosis," accessed August 13, 2021, https://dictionary.apa.org/differential-diagnosis.

[44] American Psychiatric Association, Psychiatry Online, *Practice Guidelines for the Psychiatric Evaluation of Adults, Third Edition,* accessed September 21, 2021, https://psychiatryonline.org/doi/full/10.1176/appi.books.9780890426760.pe02.

[45] American Psychiatric Association, Psychiatry Online, *Practice Guidelines for the Psychiatric Evaluation of Adults, Third Edition,* accessed September 21, 2021, https://psychiatryonline.org/doi/full/10.1176/appi.books.9780890426760.pe02. Facility Bylaws July 17, 2017; February 15, 2019; and April 17, 2020.

symptomatology. However, when a provider repeatedly copies and pastes multiple sections of text, to include rule-out diagnoses, without additional explanation of ongoing observations or clinical rationale for the working diagnosis, it becomes difficult to determine if the processes to reconcile diagnostic information and communicate the most up-to-date information to the patient have been completed.

The OIG found that in 14 of the 150 patients' EHRs reviewed, the BHNP documented rule-out diagnoses with no resolution from first visit to the last visit of the review period. Of the 14 patients, five had more than four visits and the rule-out diagnoses were included for over a year with no rationale documented for the continuation of the rule-out diagnoses. The OIG concluded that the BHNP copied and pasted the rule-out diagnoses from one visit's EHR note to the next without resolution or update. Failure to resolve rule-out diagnoses can contribute to incomplete informed consent processes with patients and subsequently, providers may use inaccurate or outdated information in clinical decision-making.

Copy and Paste

The OIG team determined that the BHNP's substantial use of copy and paste contributed to lengthy notes and cumbersome and time-consuming reading that created difficulties in accessing the current visit clinical information.

The use of copy and paste may result in clinical, ethical, and legal problems if the copied text suggests the provider "obtained historical information, performed an exam, or documented a plan of care" when the information was not collected "at the time the visit is documented."[46] VHA advises that within the EHR

> Repeating information does not provide any advantage, but instead makes reading the charts more difficult and time consuming; copied portions of notes and other data is overwhelming to the reader and dwarfs the remaining information within the note.[47]

Providers are responsible to use "clinical judgment to ensure that copied and pasted" EHR entries "are relevant, timely and specific to the occasion of service being documented."[48] Further, VHA copy and paste guidance notes that "casually used it may

[46] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015. This handbook was in effect for the time frame of the events discussed in this report. It was rescinded and replaced by VHA Directive 1907.01, *VHA Health Information Management and Health Records*, April 5, 2021. The 2021 directive does not include information about copy and paste. However, the facility's Assistant Chief, Health Information Management, told the OIG that although no longer specified in the directive, the facility policy regarding copy and paste use did not change.

[47] VHA Handbook 1907.01; This handbook was in effect for the time frame of the events discussed in this report. It was rescinded and replaced by VHA Directive 1907.01; The 2021 directive does not include information about copy and paste.

[48] "HIM Practice Brief #9, Monitoring Copy and Paste," VHA Health Information Management SharePoint.

lead to redundant, misleading, inaccurate and non-essential documentation that may jeopardize quality care."[49]

Consistent with VHA guidance, facility policy cautions that inappropriate use of copy and paste

> may lead to redundant, misleading, inaccurate, non-essential documentation that could jeopardize quality care by repeating information that does not enhance patient care, but instead makes reading a chart more cumbersome and time consuming for other providers.[50]

The OIG found that the BHNP copied and pasted significant sections of notes in 138 (97 percent) of the 143 patients' EHRs reviewed.[51] In an interview with the OIG, the BHNP explained using copy and paste in patients' EHRs to provide a reference for treatment history and changes that occurred since the last visit with a patient. As discussed above, the OIG also found that the BHNP appeared to copy and paste (1) suicide risk assessment information from previous visits without including updated information about relevant behaviors, (2) another provider's assessment of antipsychotic medication side effects for one of the 36 applicable patients, (3) another provider's documentation of a discussion of risks and benefits of taking an off-label medication in one of three applicable patients' EHRs, and (4) rule-out diagnoses without resolution.

Inadequate Oversight of BHNPs' OPPEs

Given that BHNPs provide a range of healthcare services independently without a requirement for supervision or collaboration with physicians, the BHNPs' assessment and documentation practices as well as the oversight of these responsibilities are essential to ensure effective patient care. OPPEs allow facility leaders "to identify professional practice trends that impact the quality of care and patient safety."[52] VHA requires that facility service chiefs complete an OPPE for providers on a regular basis with the specific time frame determined by facility leaders. OPPEs may include several activities that assist in the completion of the evaluation, such as direct observation and clinical reviews.[53]

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[49] "HIM Practice Brief #9," VHA Health Information Management. This guidance was in place during the OIG study time frame.

[50] Facility Memorandum IM-037, *Copying and Pasting of Medical Record Documentation*, November 3, 2016. This memorandum was in effect for the time frame of the events discussed in this report until it was rescinded and replaced by Facility Memorandum IM-037, *Copying and Pasting of Medical Record Documentation*, October 17, 2019. The 2019 memorandum has the same or similar language as the 2016 memorandum related to inappropriate use of copy and paste.

[51] In seven of the 150 patients' EHRs reviewed, the BHNP documented only two notes. Given the insufficient information to determine the use of copy and paste, the OIG excluded the seven patients' EHRs from the review of the BHNP's copy and paste use.

[52] VHA Handbook 1100.19.

[53] VHA Handbook 1100.19.

Facility policy requires completion of OPPEs every six months.[54] Behavioral Health leaders completed BHNPs' OPPEs applicable for the October 1, 2017, through March 31, 2021, review period.[55] For fiscal year 2018 through the first half of fiscal year 2021, the BHNPs' OPPEs included a review of patients' EHRs for "inappropriate use of copy and paste."[56] Beginning in February 2020, facility leaders added a review of a completed safety plan in high risk for suicide patients' EHRs to the BHNPs' OPPEs.

The Associate Chief of Staff told the OIG that leaders initiated revised "processes for orientation, evaluation and supervision" to provide additional oversight of BHNPs on September 1, 2021. The Associate Director—Patient Care Services told the OIG that in applicable services, including Behavioral Health, lead nurse practitioners were identified to assist with nurse practitioners' orientation and completing privileges. The Nurse Manager for Outpatient Behavioral Health (Nurse Manager) who served as the BHNPs' supervisor, told the OIG that the responsible BHNP lead was expected to complete an EHR review form that listed elements to be reviewed in a specific, dated EHR note for five identified patients. In an interview with the OIG, the Nurse Manager explained being unable to complete the OPPE element reviews due to not being a BHNP. The Nurse Manager reported receiving the completed review forms from the lead BHNPs and then assigning supervisory ratings of satisfactory or unsatisfactory for the OPPE elements. The Associate Chief of Staff explained to the OIG that the applicable section chief or a designated psychiatrist was expected to review the lead BHNP's EHR reviews.

The OIG found that despite marking the elements as satisfactory, Behavioral Health managers did not ensure completion of reviews of inappropriate copy and paste use for fiscal years 2018–2021 and beginning in February 2020, safety plan completion for the high risk for suicide patient element in BHNPs' OPPEs. The Associate Chief of Staff told the OIG that the lead BHNPs completed these two EHR review elements for the OPPEs. However, the OIG found that these elements were not included on the lead BHNPs' review form. One of the two lead BHNPs reported completing the review form but did not complete EHR reviews for copy and paste use or safety planning. The second lead BHNP told the OIG about not completing EHR reviews and

[54] Facility Bylaws, *Bylaws and Rules of the Medical Staff,* July 17, 2017. These bylaws were in effect for a portion of the time frame of the events discussed in this report. They were replaced by Facility Bylaws, *Bylaws and Rules of the Medical Staff*, February 15, 2019, and then Facility Bylaws, *Bylaws and Rules of the Medical Staff,* April 17, 2020. The 2019 and 2020 bylaws have the same or similar language as the 2017 bylaws related to OPPEs.

[55] The OIG reviewed the OPPE that covered the time frame of November 2020 through May 2021 for the BHNP discussed in this report.

[56] A fiscal year is a 12-month cycle that spans October 1 through September 30. Fiscal year 2018 began on October 1, 2017, and ended on September 30, 2018, and fiscal year 2019 began on October 1, 2018, and ended on September 30, 2019. VA/VHA Employee Health Promotion Disease Prevention Guidebook, *VA Finance Terms and Definitions*, July 2011, accessed April 13, 2021, https://www.publichealth.va.gov/docs/employeehealth/14-Finance-Terms.pdf. The Outpatient Nurse Manager, Behavioral Health, told the OIG that the Automated Data Processing Application Coordinator randomly selects five patients' EHRs for OPPE review purposes.

that the Nurse Manager completed the EHR reviews. However, the Nurse Manager provided the OIG with a review form completed by the second lead BHNP.

The Nurse Manager explained to the OIG that Health Information Management Services monitored copy and paste use and alerted the BHNP or a service line supervisor if a BHNP was "trying to cut, copy, and paste," although noted, "I don't know what the rules are because I'm not a provider." The facility's Chief of Health Information Management Services told the OIG that they did not do a review specific for the OPPEs. The OIG concluded that the Nurse Manager rated the BHNPs' OPPE copy and paste review element as satisfactory without an EHR review of BHNPs' copy and paste use.

The Nurse Manager told the OIG that if the lead BHNP did not add a comment to the review form about the safety plan "then everything is satisfactory." In interviews with the OIG, the Nurse Manager reported not having knowledge about safety plan delinquencies and appeared to not understand the distinct requirements for suicide risk assessments, contact with high risk for suicide patients, and mental health treatment plans.

Regarding the BHNP reviewed in this report, the Nurse Manager rated the BHNP's use of copy and paste as satisfactory in the six completed OPPEs from November 2018 through May 2021.[57] In fiscal year 2021, the Nurse Manager rated the BHNP as satisfactory on the safety plan review element. The Associate Chief of Staff, a psychiatrist, signed the OPPEs to "validate review." However, as discussed above, the OIG determined that this BHNP used copy and paste substantially and failed to document or comment on safety plans for patients who endorsed suicidal ideation.

The OIG concluded that the Nurse Manager evaluated BHNPs as satisfactory in the OPPE elements of copy and paste use from fiscal year 2018 through the first half of fiscal year 2021, and safety plan completion for high risk for suicide patients for February 2020 through the first half of fiscal year 2021, without these elements being evaluated. Behavioral Health managers' failure to ensure evaluation of OPPE elements significantly compromised the oversight and identification of "professional practice trends that impact the quality of care and patient safety," as required by VHA.[58]

[57] Although the Nurse Manager reported oversight responsibility at the time of the BHNP's November through May 2018 OPPE, the OPPE was missing the Nurse Manager's signature. When asked by the OIG, the Nurse Manager reported being unable to explain why the BHNP's May 2018 OPPE did not include the signature.

[58] VHA Handbook 1100.19.

Conclusion

The OIG identified multiple deficiencies in a BHNP's assessment and documentation practices including absence of comprehensive suicide risk assessments, failure to complete abnormal involuntary movement and metabolic assessments for patients prescribed certain antipsychotic medication, missing informed consent or a risk-benefit discussion when prescribing off-label medications, failure to resolve rule-out diagnoses, and substantial copy and paste use. The OIG found adverse clinical outcomes for one of eight patients for whom the BHNP did not document a comprehensive suicide risk assessment, as required by The Joint Commission.[59]

The OIG found that the BHNP did not document a comprehensive suicide risk assessment when patients endorsed suicidal ideation. The OIG determined that the BHNP documented that eight of the 150 patients' EHRs reviewed indicated having suicidal ideation.[60] For unclear reasons, the BHNP failed to document suicide risk information for these eight patients including a suicide plan, level of risk, acute or chronic risk status, and current behaviors of concern. Further, the BHNP failed to consistently document intent, risk and protective factors, and a mitigation plan for the eight patients. The BHNP's failure to include sufficient suicide risk assessment documentation may have contributed to an underestimation of a patient's suicide risk level and lack of appropriate intervention, increasing a patient's risk of an adverse clinical outcome. Further, the absence of thorough risk assessment documentation may prevent future providers from obtaining an accurate history of a patient's suicide risk.

The OIG found adverse clinical outcomes for Patient 8. Given Patient 8's history of suicidal and homicidal ideation and behaviors and the BHNP's documentation of the presence of suicidal ideation, the OIG determined that the BHNP, as the primary mental health prescriber with awareness of Patient 8's REACH VET status, should have completed and documented comprehensive suicide risk assessments. Although the BHNP reportedly recognized Patient 8's high risk for suicide status, the BHNP's lack of comprehensive suicide risk assessments and adherence to REACH VET requirements failed to promote the identification of previously

[59] The Joint Commission, "Joint Commission FAQs." The Joint Commission is the nation's oldest and largest body that set standards, "accredits and certifies more than 22,000 health care organizations and programs in the United States…." The Joint Commission, *National Patient Safety Goal for Suicide Prevention*, updated November 20, 2019. Centers for Disease Control and Prevention, *Risk and Protective Factors*, accessed September 23, 2021, https://www.cdc.gov/suicide/factors/index.html. Risk factors for suicide include previous suicide attempt, mental illness, and job problems or loss. Protective factors include supportive relationships, coping skills, and limited access to lethal means. Within the context of this report, the OIG considered an adverse clinical outcome to be harm to self or others including death by suicide.

[60] For analysis of the BHNP's suicide risk assessment documentation, the OIG reviewed EHR documentation from the last two visits with the BHNP in the review period of October 1, 2018–March 31, 2021. The BHNP documented that a patient identified suicidal ideation in both visits for three of the eight unique patients totaling 11 visits reviewed for suicide risk assessment documentation. For those three patients with two consecutive visits presenting with suicidal ideation, the BHNP documented and omitted the same information for both visits.

unspecified risk factors, additional treatment, and other resources to support Patient 8's overall health.[61]

The OIG determined that the BHNP did not document required assessments of all health factors for 10 patients for whom the BHNP initiated a second-generation antipsychotic medication or for 32 of 33 patients engaged in ongoing second-generation antipsychotic medication with the BHNP. The absence of these critical assessments may result in a failure to prevent, identify, and manage side effects of the antipsychotic medication including metabolic disturbances.

The OIG found that the BHNP prescribed off-label medications to 14 of 150 patients reviewed and documented informed consent for three of the 14 patients. Additionally, the BHNP documented discussion of the risks and benefits of the off-label medication with a different three of the 14 patients, however, as mentioned above, one of those three EHR notes appears copied and pasted from another provider's EHR note entered approximately six months earlier.

Consistent with VHA's informed consent requirements and off-label medication guidance, as well as the Associate Chief of Staff's expectations, the OIG would expect the BHNP to document informed consent and risks and benefits discussions with patients prescribed off-label medications.[62] Failure to engage in and document these discussions may compromise patients' rights to be made aware of relevant treatment considerations and agree to treatment with full knowledge.

The OIG found that in 14 of the 150 patients' EHRs reviewed, the BHNP documented rule-out diagnoses with no resolution from first visit to the last visit of the review period. Of the 14 patients, five had more than four visits and the rule-out diagnoses were included for over a year with no rationale documented for the continuation of the rule-out diagnoses. The OIG concluded that the BHNP copied and pasted the rule-out diagnoses from one visit's EHR note to the next without resolution or update. Failure to resolve rule-out diagnoses can contribute to incomplete informed consent processes with patients and subsequently, providers may use inaccurate or outdated information in clinical decision-making.

The OIG found that the BHNP copied and pasted significant sections of notes in 138 (97 percent) of the 143 patients' EHRs reviewed.[63] In an interview with the OIG, the BHNP explained using copy and paste in patients' EHRs to provide a reference for treatment history and changes that

[61] VA Acting Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, *REACH VET: Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment*, August 10, 2016. "REACH VET Steps," VHA's Mental Illness Research, Education and Clinical Center.

[62] VHA Handbook 1004.01(5); VA Center for Medication Safety And VHA Pharmacy Benefits Management Strategic Healthcare Group and the VA Medical Advisory Panel, "Pharmaceutical Use Outside of Approved Indications, Guidance on 'Off-Label' Prescribing'," May 2004, accessed March 17, 2021, https://www.pbm.va.gov/PBM/vacenterformedicationsafety/directive/GuidanceOffLabelPrescribing.pdf.

[63] In seven of the 150 patients' EHRs reviewed, the BHNP documented only two notes. Given the insufficient information to determine the use of copy and paste, the OIG excluded the seven patients' EHRs from the OIG review of the BHNP's copy and paste use.

occurred since the last visit with a patient. As discussed above, the OIG also found that the BHNP appeared to copy and paste (1) suicide risk assessment information from previous visits without including updated information about relevant behaviors, (2) another provider's assessment of antipsychotic medication side effects for one of the 36 applicable patients, (3) another provider's documentation of a discussion of risks and benefits of taking an off-label medication in one of three applicable patients' EHRs, and (4) rule-out diagnoses without resolution.

For fiscal years 2018 through the first half of 2021, BHNPs' OPPEs included a review of patients' EHRs for "inappropriate use of copy and paste."[64] Beginning in February 2020, facility leaders added a review of a completed safety plan in high risk for suicide patients' EHRs to the BHNPs' OPPEs. Regarding the BHNP reviewed in this report, the Nurse Manager rated the BHNP's use of copy and paste as satisfactory in the six completed OPPEs from November 2018 through May 2021. In fiscal year 2021, the Nurse Manager rated the BHNP satisfactory on the safety plan review element. The Associate Chief of Staff, a psychiatrist, signed the OPPEs to "validate review." However, as discussed above, the OIG determined that the BHNP used copy and paste substantially and failed to document or comment on safety plans for patients who endorsed suicidal ideation.

The OIG concluded that the Nurse Manager evaluated BHNPs as satisfactory in the OPPE elements of copy and paste use for fiscal year 2018 through the first half of fiscal year 2021, and safety plan completion for high risk for suicide patients for February 2020 through the first half of fiscal year 2021, without these elements being evaluated. Behavioral Health managers' failure to ensure evaluation of OPPE elements significantly compromised the oversight and identification of "professional practice trends that impact the quality of care and patient safety," as required by VHA.[65]

[64] A fiscal year is a 12-month cycle that spans October 1 through September 30. Fiscal year 2018 began on October 1, 2017, and ended on September 30, 2018, and fiscal year 2019 began on October 1, 2018, and ended on September 30, 2019. VA/VHA Employee Health Promotion Disease Prevention Guidebook, *VA Finance Terms and Definitions*, July 2011, accessed April 13, 2021, https://www.publichealth.va.gov/docs/employeehealth/14-Finance-Terms.pdf. The Outpatient Nurse Manager, Behavioral Health told the OIG that the Automated Data Processing Application Coordinator randomly selected five patients' EHRs for OPPE review purposes.

[65] VHA Handbook 1100.19.

Recommendations 1–5

1. The VA Pittsburgh Healthcare System Director ensures a comprehensive review of the Behavioral Health Nurse Practitioner's assessment practices related to Patient 8's suicide and homicide risk and Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment status; and consults with the appropriate Human Resources and General Counsel Offices to determine whether personnel action is warranted and takes action, as appropriate.

2. The VA Pittsburgh Healthcare System Director ensures a comprehensive review of the Behavioral Health Nurse Practitioner's assessment and documentation practices including suicide risk assessments, assessment of antipsychotic medication health factors and side effects, informed consent for off-label medication use, resolution of rule-out diagnoses, and use of copy and paste, and provides training as needed.

3. The VA Pittsburgh Healthcare System Director aligns VA Pittsburgh Healthcare System Memorandum TX-154, *Use of Psychopharmacologic Agents*, December 20, 2018, with leaders' expectations for the assessment and documentation of abnormal involuntary movements and metabolic problems for patients prescribed an antipsychotic medication.

4. The VA Pittsburgh Healthcare System Director makes certain that behavioral health managers verify that all elements of the behavioral health nurse practitioner ongoing professional practice evaluation are reviewed.

5. The VA Pittsburgh Healthcare System Director ensures a comprehensive review of managers' oversight of behavioral health nurse practitioners' ongoing professional practice evaluations and consults with the appropriate Human Resources and General Counsel Offices to determine whether personnel action is warranted and takes action, as appropriate.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 24, 2022

From: Director, VA Healthcare-VISN 4 (10N4)

Subj: Healthcare Inspection—Deficiencies in a Behavioral Health Provider's Documentation and Assessments, and Oversight of Nurse Practitioners at the VA Pittsburgh Healthcare System in Pennsylvania

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

1. The recommendations from the draft Healthcare Inspection Report Deficiencies in a Behavioral Health Provider's Documentation and Assessments, and Oversight of Nurse Practitioners at the VA Pittsburgh Healthcare System in Pennsylvania – conducted virtually at VA Pittsburgh Healthcare System on May 3-6, 2021 have been reviewed.
2. Attached are the facility responses addressing each recommendation, including actions that are in progress and those that have already been completed.

(*Original signed by*:)

Timothy W. Liezert
Network Director, VISN 4

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 24, 2022

From: Acting Director, VA Pittsburgh Healthcare System (646/00)

Subj: Healthcare Inspection—Deficiencies in a Behavioral Health Provider's Documentation and Assessments, and Oversight of Nurse Practitioners at the VA Pittsburgh Healthcare System in Pennsylvania

To: Director, VA Healthcare-VISN 4 (10N4)

1. The recommendations from the draft Healthcare Inspection Report Deficiencies in a Behavioral Health Provider's Documentation and Assessments, and Oversight of Nurse Practitioners at the VA Pittsburgh Healthcare System in Pennsylvania – conducted virtually at VA Pittsburgh Healthcare System on May 3-6, 2021, have been reviewed.
2. Attached are the facility responses addressing each recommendation, including actions that are in progress and those that have already been completed.

(*Original signed by*:)

Ali F. Sonel, MD
Acting Executive Director
VA Pittsburgh Healthcare System

Facility Director Response

Recommendation 1

The VA Pittsburgh Healthcare System Director ensures a comprehensive review of the Behavioral Health Nurse Practitioner's assessment practices related to Patient 8's suicide and homicide risk and Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment status; and consults with the appropriate Human Resources and General Counsel Offices to determine whether personnel action is warranted and takes action, as appropriate.

Concur.

Target date for completion: September 2022

Director Comments

The VA Pittsburgh Healthcare System (VAPHS) Director will ensure a comprehensive review of the Behavioral Health Nurse Practitioner's (BHNP) assessment practices related to Patient 8's suicide and homicide risk and Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment status is completed. Human Resources and General Counsel Offices will be consulted to determine whether any personnel action is warranted. Of note, the BHNP retired as of January 2022.

Recommendation 2

The VA Pittsburgh Healthcare System Director ensures a comprehensive review of the Behavioral Health Nurse Practitioner's assessment and documentation practices including suicide risk assessments, assessment of antipsychotic medication health factors and side effects, informed consent for off-label medication use, resolution of rule-out diagnoses, and use of copy and paste; and provides training as needed.

Concur in principle.

Target date for completion: April 2022

Director Comments

The VAPHS Director recognizes that due to the Nurse Practitioner's retirement, staffing changes and time passed since this OIG review, the purpose of record review of the BHNP's patients is to ensure those patients are receiving appropriate care from newly assigned providers. For patients who have not reengaged in care, the VAPHS Director will ensure chart reviews are conducted and, as appropriate, Mental Health Providers reach out to Veterans to discuss their safety and care needs.

OIG Comment

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

Recommendation 3

The VA Pittsburgh Healthcare System Director aligns VA Pittsburgh Healthcare System Memorandum TX-154, *Use of Psychopharmacologic Agents*, December 20, 2018, with leaders' expectations for the assessment and documentation of abnormal involuntary movements and metabolic problems for patients prescribed antipsychotic medication.

Concur.

Target date for completion: August 2022 Computerized Patient Record System

Director Comments

TX-154 is being reviewed and updated in accordance with current guidelines in consultation with BHNPs, Psychiatrists and Clinical Pharmacists. Following approval, the revised version of TX-154 will be distributed to all BHNPs. Explanations will be provided at a Psychiatrist/BHNP meeting.

The VAPHS Director confirms automated reminders have been instituted in CPRS [computerized patient record system] with regard to evaluation of Abnormal Involuntary Movement Scale (AIMS) for Veterans prescribed Antipsychotic drugs, per VAPHS memorandum TX-154, Use of Psychopharmacologic Agents. The reminders for the metabolic variables in CPRS are being reviewed and will be updated in accordance with TX-154.

At least 90% of BH [Behavioral Health] staff will review the revised VAPHS memorandum TX-154, Use of Psychopharmacologic Agents, by August 2022.

Recommendation 4

The VA Pittsburgh Healthcare System Director makes certain that behavioral health managers verify that all elements of the behavioral health nurse practitioner ongoing professional practice evaluation are reviewed.

Concur.

Target date for completion: November 2022

Director Comments

The VAPHS Director will make certain that behavioral health managers are assigned to verify that all elements of the BHNP's ongoing professional practice evaluation are reviewed in

accordance with VHA Central Office guidelines for 2022. Human Resources and General Counsel Offices will be consulted to determine whether any personnel action is warranted.

The BHNP supervisor will randomly audit 10 CPRS charts reviewed by peer nurse practitioners. The audit will verify that all elements of the BHNP's ongoing professional practice evaluation are reviewed in accordance with VHA Central Office guidelines for at least a 90% accuracy rate. The audit will occur monthly until 6 consecutive months of at least a 90% accuracy rate is sustained.

Recommendation 5

The VA Pittsburgh Healthcare System Director ensures a comprehensive review of managers' oversight of behavioral health nurse practitioners' ongoing professional practice evaluations and consults with the appropriate Human Resources and General Counsel Offices to determine whether personnel action is warranted and takes action, as appropriate.

Concur.

Target date for completion: June 2022

Director Comments

The VAPHS Director confirms that a change in supervisory structure is warranted for BHNPs. All BHNPs will be supervised by a psychiatrist or BHNP, who will review OPPEs completed by peer BHNPs. The Psychiatrists or Nurse Practitioners supervising the BHNPs will report directly to the Associate Chief of Staff (ACOS) of Behavioral Health.

The Director confirms the ACOS of BH will review deviations in charts evaluated during OPPEs for BHNPs.

If persistent performance issues are identified, necessary action will be taken in consultation with colleagues in Human Resources (HR) and OGC.

OIG Contact and Staff Acknowledgments

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