DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Emergent and Outpatient Care of a Patient with Alcohol Use Disorder at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana

HEALTHCARE INSPECTION | REPORT #21-03680-80 | MARCH 29, 2023

MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

FOR MORE
VA OIG REPORTS
CLICK HERE

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate allegations that staff at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana, (facility) (1) provided inadequate alcohol withdrawal management in the Emergency Department for a patient who died approximately two days after discharge, (2) inadequately responded to the patient's report of "bad" withdrawal symptoms and lack of transportation to present to the Emergency Department, and (3) failed to provide posttraumatic stress disorder (PTSD) care.[1] Further, the OIG identified concerns related to the Emergency Department staffs' discharge coordination with the patient's family, primary care post-discharge care coordination, leaders' consideration for completing an institutional disclosure, and adequacy of a primary care nurse practitioner's assessment and documentation regarding the patient's alcohol use and safe transport.

Synopsis of the Patient's Care

The patient was in their late thirties at the time of death in summer 2021.[2] The patient's medical history included alcohol abuse, chronic back and neck pain, high blood pressure, PTSD, and recurrent major depressive episodes. Beginning in early 2014, the patient received care intermittently at the facility.

During an early spring 2021 primary care visit, a nurse practitioner assessed the patient "for follow up on chronic conditions of neck/lower back pain" and high blood pressure.[3] The nurse practitioner documented that the patient "drinks a gallon of whiskey every 2 days" and "smells of alcohol." The patient reported three non-VA emergency department visits for alcohol abuse over the prior six months and continued use of alcohol after participating in a 20-day rehabilitation program.[4] The patient also reported "weekly meeting and drug testing" and declined the offer of VA substance use disorder treatment resources. The nurse practitioner ordered x-rays to further evaluate the patient's chronic neck and back pain, planned to "call with treatment plan when I have the x-ray results," and placed the patient on a "Call Back List" for an

[1] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[2] The OIG uses the singular form of they (their) in this instance for privacy purposes.

[3] Facility Bylaws, Rules, and Regulations of the Medical Staff, revised September 2019. The facility community-based outpatient clinic was a contract clinic and facility bylaws require contract nurse practitioners to practice "within a Collaborative Practice Agreement or Scope of Practice with a fully credentialed and clinically privileged medical staff member at this facility."

[4] The patient's electronic health record did not contain documentation of other Veterans Health Administration emergency department or outpatient substance use disorder clinic care, and family members reported the patient obtained non-VA care for alcohol use disorder.

appointment in one year. Following multiple contact attempts, including phone calls and a letter, a clinic clerk was unsuccessful in reaching the patient to schedule the x-rays.

In early summer 2021 (day 1), the patient called the Veterans Crisis Line and reported a history of "military-related chronic pain and use of alcohol to self-medicate" and requested assistance with substance use.[5] The following day, a facility suicide prevention coordinator contacted the patient who reported "a serious alcohol problem," denied current withdrawal symptoms, and requested treatment. The suicide prevention coordinator submitted a Substance Use Disorder Recovery Program (SUDRP) consult for the patient. On day 5, a Friday, the SUDRP medical support assistant (MSA) contacted the patient to schedule an appointment. The patient reported a plan to go to the Emergency Department ". . .tomorrow as the withdrawal symptoms were getting bad" and a lack of transportation to go that day. The MSA documented a plan to call the patient back on the next business day (day 8). The MSA called the patient on day 9 and did not reach the patient. On day 15, the MSA could not reach the patient by phone and mailed the patient a letter.

In summer 2021 (day 23), the patient presented to the Emergency Department, and a triage nurse documented that the patient reported needing alcohol detoxification. A registered nurse (Nurse 1) documented that the patient reported: a history of withdrawal seizures, "shakes and vomiting," last alcohol use was "a couple of shots between 10am" and approximately two hours later when the patient arrived at the Emergency Department, and drinking "a handle of whiskey over 2 days."[6]

Approximately 90 minutes after the patient presented to the Emergency Department, Nurse 1 documented that the patient's Clinical Institute Withdrawal Assessment (CIWA) score was 0 and that the patient reported drinking alcohol "four or more times a week," on a "Daily or almost daily basis" with 10 or more drinks on a typical day during the past year.[7] Four hours later, Nurse 1 documented that the patient's CIWA score was 2 due to tremors that were "not visible but can be felt" and mild anxiety that indicated "absent or minimal withdrawal."

---

[5] Veterans Crisis Line, "About Us," accessed September 8, 2022, https://www.veteranscrisisline.net/about/about-us/. The Veterans Crisis Line is a free and confidential telephone, text, and chat resource for veterans in emotional crisis.

[6] "What is a standard serving size of alcohol?," accessed on February 16, 2022, at https://uwm.edu/basics/wp-content/uploads/sites/192/2020/03/Standard-Drink-Serving-Sizes.pdf. A handle of whiskey is equivalent to 1.75 liters, 59.2 ounces, or approximately 39 shots or standard drinks.

[7] S. Jesse et al., "Alcohol withdrawal syndrome: mechanisms, manifestations, and management," Acta Neurologica Scandinavica 135, (2017): 4-16. The CIWA is the most widely used tool for the evaluation of a patient's alcohol withdrawal symptom severity. For purposes of this report, the OIG will refer to the CIWA Alcohol Scale Revised (CIWA-Ar) as CIWA; Elizabeth C. Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome," CNS Drugs 28, (April 30, 2014): 401-410, accessed on March 2, 2020, https://link.springer.com/content/pdf/10.1007/s40263-014-0163-5.pdf. A score less than 10 indicates mild withdrawal, 10–18 indicates moderate to severe withdrawal, and greater than 18 indicates risk for major complications if left untreated.

An Emergency Department physician (Physician 1) documented the patient's report of past sobriety and inpatient rehabilitation and a history of "visual and auditory hallucinations" and seizures with a plan to monitor the patient until "legally sober" with a five-day gabapentin prescription. Additionally, Physician 1 documented that the patient would be admitted if the "patient begins to go into active withdrawal symptoms with high CIWA scores," and the patient's "alcohol level was 286" when the patient's care was signed over to another Emergency Department physician (Physician 2).[8]

Another nurse (Nurse 2) documented that the patient's CIWA score was 6 due to moderate tremors with arms extended, mild anxiety, and a "very mild" headache and a breathalyzer result was 0.14. Approximately two hours later, Nurse 2 documented that the patient's CIWA score remained 6 due to moderate tremors with arms extended, mild anxiety, and "very mild" headache and noted "Intervention: Monitor every 4 hours."

On day 24 (12 hours after the patient presented to the Emergency Department), Physician 2 completed the patient's Emergency Department discharge plan that advised the patient to take gabapentin as prescribed, present to the SUDRP walk-in clinic the next day for orientation, and "return to ED [Emergency Department] for: seizures, or any other worsening or concerning symptoms."

Approximately 30 minutes later, Physician 2 documented receiving "signout on this patient" and that the patient was "clinically sober," "stable for discharge home," provided with SUDRP resources, and documented that the patient would be given "gabapentin taper for [alcohol] withdrawal [detoxification]."[9]

Two days after the patient's Emergency Department discharge, a coroner documented that the patient had died after being found "draped over a fence line that was among heavy brush." Emergency medical service medics removed the patient from the fence and the patient "began to hemorrhage uncontrollably" from the right thigh and hamstring area. A forensic pathologist concluded that the patient's cause of death was "exsanguinating hemorrhage due to sharp force injury of leg."[10]

[8] Physician 1 documented the patient's alcohol level was "286;" however, the laboratory results, obtained approximately five hours earlier, indicated that the patient's blood alcohol level was 386 milligrams per deciliter and the 5:15 p.m. breathalyzer result was 0.287. "Sobering Facts: Alcohol Impaired Driving, Indiana," Centers for Disease Control and Prevention, accessed November 29, 2021, https://www.cdc.gov/motorvehiclesafety/pdf/impaired-driving-new/CDC-impaired-driving-fact-sheet-Indiana.pdf. Indiana's legal driving limit is a blood alcohol level less than 0.08.

[9] The Chief, Emergency Department told the OIG that clinical sobriety is determined by the provider's clinical impression of the patient's functioning including neurological, communicative, cognitive, and physical status.

[10] Exsanguinating hemorrhage is extreme blood loss from a blood vessel that will lead to death if not contained.

OIG Findings

The OIG substantiated that Emergency Department staff mismanaged the alcohol withdrawal care of the patient who requested alcohol detoxification and died two days later. The OIG found that Emergency Department staff discharged the patient after approximately 12 hours without adequately assessing the patient's risk for complicated alcohol withdrawal. Consistent with subject matter experts' opinions and clinical practice guidelines, the OIG concluded that further monitoring or inpatient admission should have been more strongly considered given the patient's risk of complicated withdrawal.[11] The OIG was unable to determine if severe alcohol withdrawal contributed to the patient's behaviors, and ultimate death, because of the absence of medical assessment during the hours following the Emergency Department discharge.

Upon presentation to the Emergency Department, the patient acknowledged heavy alcohol use, requested alcohol detoxification, and reported a history of withdrawal seizures. The patient reported consuming approximately 39 shots (or standard drinks) every two days; nearly three times the American Society of Addiction Medicine threshold of seven standard drinks daily as advised for inpatient withdrawal management.[12] Based on interviews, the OIG found that Physicians 1 and 2 did not consider the patient's withdrawal seizure history as a risk factor due to their understanding that the seizures occurred in the distant past.

Based on the patient's (1) increasing and then persistent CIWA score of 6 and a positive blood alcohol content over the course of the patient's visit, (2) high level of alcohol consumption, and (3) alcohol withdrawal seizure history, the OIG would have expected Physician 2 to consider additional Emergency Department monitoring of the patient's withdrawal symptoms and inpatient detoxification. Further, based on these same factors, the OIG considers it likely that the patient's alcohol withdrawal symptoms continued to progress after discharge from the Emergency Department. A family member (Family Member 2) told the OIG that on day 25, the day after discharge, the patient became confused and appeared to be hallucinating. If the patient's withdrawal symptoms progressed following discharge from the Emergency Department, they would likely have included disorientation and confusion by day 25.

The OIG was unable to determine the extent of Family Member 1's involvement in the patient's discharge planning because of the absence of electronic health record (EHR) documentation and

[11] ASAM, The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management, January 23, 2020, accessed on October 29, 2021, https://www.asam.org/Quality-Science/quality/guideline-on-alcohol-withdrawal-management; VA and Department of Defense, VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders, December 2015. These guidelines were in place during the time of the events in this report. They were updated in VA and Department of Defense, VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders, August 2021. Both sets of guidelines contain the same or similar language regarding alcohol withdrawal management.

[12] The OIG calculated the patient's drink consumption based on an 80-proof whiskey that contains approximately 40 percent alcohol.

the conflicting reports provided by Family Member 1 and Physician 2. Veterans Health Administration (VHA) and facility policy do not require family participation in planning for a patient's Emergency Department discharge. Physician 2 documented a discharge plan that included the patient's gabapentin prescription, instructions to present to the SUDRP walk-in clinic the next day for orientation, and instructions to "[r]eturn to ED [Emergency Department] for: seizures, or any other worsening or concerning symptoms." Physician 2 noted that Family Member 1 "is driving the patient" home and that the patient and Family Member 1 were "informed;" however, the note did not include the specific information provided.

In an interview with the OIG, Family Member 1 told the OIG that during a telephone call, an Emergency Department physician said that the patient would be discharged if there were no signs of withdrawal and the patient's blood alcohol level decreased.[13] Family Member 1 reported speaking to Emergency Department staff by phone multiple times and pleading with them to not send the patient home because the patient was in too much pain and needed the help. Further, Family Member 1 told the OIG about not receiving any information about the patient's discharge plan and both Family Members 1 and 2 described not knowing about the patient's SUDRP post-discharge appointment until after the patient died. Although a next-day SUDRP follow-up was in the patient's discharge plan, EHR documentation did not indicate that Family Member 1 was informed about the care plan.

Physician 2 alerted the community-based outpatient clinic (CBOC) nurse practitioner and nurse of the patient's discharge from the Emergency Department by including them as additional signers on the patient's Emergency Department visit documentation. The OIG found that facility leaders had not established procedures for care coordination of patients discharged from the Emergency Department. VHA requires that primary care teams ensure adequate processes are in place to coordinate care for patients assigned to their team who are discharged from an emergency department.[14] Although facility leaders established a policy requiring a call to patients discharged from inpatient units within two business days "to identify any issues needing further involvement by inpatient staff or immediate action by primary care staff," there is not a similar requirement for care coordination when patients are discharged from the Emergency Department.[15] The absence of a process may have resulted in inadequate care coordination of issues needing action by primary care staff, including the patient's alcohol withdrawal symptoms, which likely occurred during the two days following discharge.

[13] Family Member 1 did not recall the name of the Emergency Department physician; however, the OIG concluded that Family Member 1 spoke to Physician 2 based on EHR documentation and Physician 2's report.

[14] VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, amended May 26, 2017.

[15] Facility Policy 11-46, Discharge Planning, August 7, 2019. The quality manager, Utilization Management supervisor informed the OIG that the requirement included patients discharged from the Emergency Department.

VHA requires that staff schedule patients upon their arrival at a walk-in clinic, and that staff call patients who do not present to scheduled appointments.[16] However, because the patient did not present to the SUDRP walk-in clinic, as advised by Emergency Department staff, the patient did not have a scheduled appointment to prompt outreach. Additionally, the OIG found that Emergency Department staff did not add a comment to an existing SUDRP consult in the patient's EHR; therefore, SUDRP staff did not receive notification and follow-up did not occur.

An institutional disclosure is a formal process for facility leaders and clinicians to inform a patient, or a patient's personal representative, of events that occurred during the patient's care and resulted in death or serious injury, and to provide information about rights and recourse. An institutional disclosure must be completed regardless of when the adverse event is discovered.[17] The OIG found that facility leaders including the chief, Quality, Safety, and Value; Associate Director, Patient Care Services; and acting risk manager told the OIG that an institutional disclosure to the patient's family was not considered because the internal reviews did not warrant that action. However, the OIG determined that an institutional disclosure should have been considered given Emergency Department staffs' failure to consider additional Emergency Department monitoring of the patient's withdrawal symptoms and inpatient detoxification as discussed above.

The OIG substantiated that prior to the patient's Emergency Department visit, the SUDRP MSA inadequately responded to the patient's report of "bad" withdrawal symptoms and lack of transportation to present to the Emergency Department. Specifically, the OIG found that the MSA did not seek consultation with a clinician or supervisor when the patient reported potentially serious symptoms and an inability to go for medical help. However, the MSA told the OIG that suicide prevention staff were not contacted because the patient reported planning to present to the Emergency Department the following day. The OIG found that facility leaders had not established policies or procedures for MSAs to address patients' potentially urgent clinical concerns except for reports of suicide-related ideation and behaviors. As a result, the patient did not receive a clinical assessment or treatment scheduling that may have assisted the patient in accessing alcohol use and withdrawal treatment. The OIG determined that the lack of facility guidance for MSAs' response to patients who report potentially urgent clinical concerns during

[16] VHA Directive 1230, Outpatient Scheduling Processes and Procedures, July 15, 2016. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1230, Outpatient Scheduling Management, June 1, 2022. The new directive does not include guidance regarding walk-in clinic scheduling.

[17] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. VHA defines an adverse event as "untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers." For purposes of this report, the OIG defines harm in terms of an adverse clinical outcome such as death within 72 hours of discharge from the Emergency Department.

appointment scheduling calls may contribute to risk of an adverse clinical outcome and delayed patient care.

The OIG did not substantiate that facility staff failed to provide PTSD care to the patient. VHA requires that facility staff screen patients for PTSD using the Primary Care-PTSD screening tool at least once a year for the initial five years after military separation and once every five years subsequently.[18] The OIG concluded that facility staff completed PTSD screens and offered and provided mental health treatment as expected based on VHA requirements.[19]

The OIG found that during the early spring 2021 primary care visit, a nurse practitioner failed to (1) thoroughly assess the patient's substance use, (2) schedule follow-up within a reasonable time frame for the patient's needs, and (3) discuss immediate safety concerns. Facility policy encourages patients to be seen the same day by a primary care-mental health integration staff member when there is a positive screen for PTSD, depression, alcohol, or tobacco use.[20] In an interview with the OIG, when asked about assessing the patient's symptoms further, the nurse practitioner reported that the patient did not want to see the available psychologist and only wanted to address neck and back pain.

The facility's Emergency Department standard operating procedure for management of intoxicated patients includes guidance for evaluating withdrawal risk and the patient's safe transportation.[21] Facility leaders confirmed that similar written guidance had not been established for the primary care setting. The associate chief of staff and medical director for the CBOC told the OIG that they expect providers to involve primary care-mental health integration staff when patients present with substance use disorder concerns or appear intoxicated.

At the patient's primary care visit, a nurse notified the nurse practitioner that the patient had a positive alcohol screen. The OIG found that the nurse practitioner conducted a basic assessment of the patient, provided the patient with substance use disorder treatment information, and reviewed potential medication interactions and alcohol use. However, the nurse practitioner failed to document a final assessment or medical decision-making as to whether the patient was intoxicated at the time of the visit. Given the patient's presentation of tachycardia, anxiety, and anger, which may be indicators of either alcohol intoxication or withdrawal, the OIG would have expected the nurse practitioner's documentation to include a more thorough assessment of the

---

[18] VHA Directive 1160.03(1), Programs for Veterans with Posttraumatic Stress Disorder (PTSD), November 16, 2017, amended April 24, 2019.

[19] VHA Directive 1160.03(1).

[20] VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, February 5, 2014, amended May 26, 2017. Primary care-mental health integration is a mental health team that is integrated into primary care and coordinates with primary care providers to offer mental health services to veterans. Facility Policy, Primary Care Mental Health Integration (PCMHI) Same Day Appointments, March 1, 2021.

[21] Facility Emergency Department, "Management of Alcohol Intoxicated and Alcohol Dependent Patients in the ED," Standard Operating Procedure, May 26, 2021. Facility leaders also established a Domiciliary Residential Rehabilitation Treatment Program nursing standard operating procedure for the management of intoxicated patients.

patient's current condition and risk of alcohol withdrawal such as the date and time of the patient's last drink and withdrawal history including delirium tremens and seizures.

The nurse practitioner planned the patient's next appointment for one year later. CBOC leaders told the OIG the expectation would be for the nurse practitioner to follow up with the patient sooner than one year due to the patient's concurrent medical conditions. In an interview with the OIG, the nurse practitioner reported that the plan was for the patient to complete x-rays to assess chronic neck and back pain and to be in contact with the patient regarding the x-ray results; however, the patient did not complete x-rays.

In an interview with the OIG, the nurse practitioner said that the patient appeared to have been drinking the night before or prior to the appointment. Family Member 2 reported transporting the patient to the appointment, not being allowed to go into the CBOC, and waiting in the vehicle.[22] Although not documented in the patient's EHR, the nurse practitioner reported having assessed whether the patient had been driving and determined that "there was someone" waiting who had driven the patient to the appointment. The OIG would have expected the nurse practitioner to have documented the discussion about safe transportation in the patient's EHR.

Failure to thoroughly assess the patient's substance use, schedule follow-up within a reasonable time frame, and discuss immediate safety concerns may have contributed to diminished access to care and compromised patient safety.

The OIG made seven recommendations to the Facility Director related to a comprehensive review of the patient's care received in the Emergency Department and primary care setting, evaluation of the Emergency Department alcohol withdrawal management protocol and its alignment with evidence-based care guidelines, consideration of written Emergency Department discharge planning procedures, guidance for discharge care coordination, consideration of institutional disclosure, establishment of an administrative staff management protocol for urgent care needs, and development of procedures for the management of intoxicated patients in the primary care setting.

Comments

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

[22] Facility Policy, Veteran Health Indiana Visitation Procedures, August 18, 2020. At the time of this appointment, due to COVID-19, the facility allowed a caregiver to accompany a patient to outpatient appointments only when the patient required assistance or care, such as patients with cognitive impairment or language barriers.

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

Contents

Executive Summary i

Abbreviations xi

Introduction 1

Scope and Methodology 5

Patient Case Summary 6

Inspection Results 9

1. Mismanagement of the Patient's Alcohol Withdrawal Care 9

2. MSA's Inadequate Response to Clinical Concerns 18

3. PTSD Assessment and Care of the Patient 19

4. A Primary Care Nurse Practitioner's Inadequate Substance Use Assessment and Follow-Up for the Patient 20

Conclusion 23

Recommendations 1–7 25

Appendix A: Patient Case Summary 2014–2020 26

Appendix B: VISN Director Memorandum 29

Appendix C: Facility Director Memorandum 30

Glossary 35

OIG Contact and Staff Acknowledgments 37

Report Distribution 38

Abbreviations

ASAM	American Society of Addiction Medicine
CIWA	Clinical Institute Withdrawal Assessment
CBOC	community-based outpatient clinic
EHR	electronic health record
mm HG	millimeters of mercury
MSA	medical support assistant
OIG	Office of Inspector General
PAWSS	Prediction of Alcohol Withdrawal Severity Scale
PTSD	posttraumatic stress disorder
SUDRP	Substance Use Disorder Recovery Program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted an inspection to evaluate the allegations that staff at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana, (facility) (1) provided inadequate alcohol withdrawal management in the Emergency Department for a patient who died approximately two days after discharge, (2) inadequately responded to the patient's report of "bad" withdrawal symptoms and lack of transportation to present to the Emergency Department, and (3) failed to provide posttraumatic stress disorder (PTSD) care.[1] Further, the OIG identified concerns related to the Emergency Department staffs' discharge coordination with the patient's family, primary care post-discharge care coordination, leaders' consideration for completing an institutional disclosure, and adequacy of a primary care nurse practitioner's assessment and documentation regarding the patient's alcohol use and safe transport.

Background

The facility, part of the VA Indiana Healthcare System in Veterans Integrated Service Network (VISN) 10, provides healthcare services to more than 63,000 patients annually and includes 13 community-based outpatient clinics (CBOCs) throughout Indiana.[2] The tertiary care facility provides a range of services including inpatient acute medical, surgical, and psychiatric care, as well as outpatient mental health and primary care.[3] The facility is affiliated with over 59 academic institutions including Indiana University School of Medicine.

Assessment and Treatment of Alcohol Withdrawal

Alcohol withdrawal may occur when a patient's alcohol use "has been heavy and prolonged and is then stopped or greatly reduced."[4] Alcohol withdrawal must include a minimum of two symptoms such as sweating, increased pulse rate, hand tremor, auditory or visual hallucinations,

[1] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[2] "Locations," VA Indiana health care, accessed March 14, 2022, https://www.va.gov/indiana-health-care/locations/. One of the 13 CBOCs was listed as "Closed."

[3] Merriam-Webster Dictionary.com, "tertiary care," accessed February 16, 2022, https://www.merriam-webster.com/dictionary/tertiary%20care. "A highly specialized medical care usually over an extended period time that involves advanced and complex procedures and treatment performed by medical specialists in state-of-the-art facilities;" "Health Services," VA Indiana health care, accessed March 14, 2022, https://www.va.gov/indiana-health-care/health-services/#specialty-care.

[4] Mayo Clinic, "Alcohol use disorder," accessed July 20, 2022, https://www.mayoclinic.org/diseases-conditions/alcohol-use-disorder/symptoms-causes/syc-20369243.

agitation, and seizures. The likelihood of alcohol withdrawal increases with the quantity and frequency of alcohol use.[5]

Alcohol levels can be measured by a breathalyzer or laboratory blood test. A breathalyzer result is typically slightly lower than a laboratory blood test. Blood alcohol content "can range from 0 [percent] (no alcohol) to over 0.4 [percent] (a potentially fatal level)."[6]

Patients with severe alcohol use disorder may develop complications from withdrawal that require immediate treatment. The American Society of Addiction Medicine (ASAM) recommends assessment of a patient's specific risk factors for severe withdrawal, including

- history of delirium tremens or seizures related to withdrawal,
- "[n]umerous prior withdrawal episodes," and
- "[l]ong duration of heavy and regular alcohol consumption."

ASAM advises that a patient's risk for complicated alcohol withdrawal may increase with a "[p]ositive blood alcohol concentration in the presence of signs and symptoms of withdrawal."[7] Inpatient withdrawal management is recommended for patients with a history of withdrawal seizures and "high levels of consumption," which is approximately seven or more standard drinks per day.[8]

Further, patients in alcohol withdrawal should only be referred to outpatient treatment when they

- exhibit mild to moderate symptoms without complications,
- are not currently intoxicated,
- have no history of complicated alcohol withdrawal including seizures, and

---

[5] Diagnostic and Statistical Manual of Mental Disorders, "Substance Related Addictive Disorders," accessed October 5, 2021, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm07#BABJAEHE.

[6] Cleveland Clinic, "blood alcohol content," accessed June 7, 2022, https://my.clevelandclinic.org/health/diagnostics/22689-blood-alcohol-content-bac.

[7] ASAM "developed this Guideline on Alcohol Withdrawal Management to provide updated information on evidence-based strategies." ASAM, The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management, January 23, 2020, accessed on October 29, 2021, https://www.asam.org/Quality-Science/quality/guideline-on-alcohol-withdrawal-management.

[8] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*, January 23, 2020; "What is a Standard Drink?" National Institute on Alcohol Abuse and Alcoholism, accessed on November 29, 2021, https://www.niaaa.nih.gov/alcohols-effects-health/overview-alcohol-consumption/what-standard-drink. A standard drink contains approximately 14 grams of alcohol as found in 12 ounces of beer, 5 ounces of wine, or 1.5 ounces (a shot) of distilled spirits (such as gin, vodka, or whiskey). VA and Department of Defense, *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders*, December 2015. These guidelines were in place during the time of the events in this report. They were updated in VA and Department of Defense, *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders*, August 2021. Both sets of guidelines contain the same or similar language regarding alcohol withdrawal management.

- have no history of medical or psychiatric illnesses that would complicate outpatient management.[9]

Clinical Institute Withdrawal Assessment

The Clinical Institute Withdrawal Assessment (CIWA) is the most widely used tool for the evaluation of a patient's alcohol withdrawal symptom severity.[10] The CIWA measures the severity of a patient's alcohol withdrawal symptoms on a scale of 0 to 7 for 10 symptoms, including tremor, headache, and anxiety, with a total CIWA score ranging from 0 to 67.[11]

A CIWA score of less than 10 indicates mild alcohol withdrawal symptoms including anxiety, insomnia, tremor, headache, and heart palpitations.[12] Symptoms can occur in as little as six hours from the time of a person's last drink.[13] Treatment may include intravenous rehydration, electrolyte abnormality correction, and supportive care.

A CIWA score of 10 – 18 indicates moderate to severe alcohol withdrawal symptoms such as seizures, and requires inpatient monitoring, hourly symptom assessment, and medication.[14] Approximately 5 percent of patients hospitalized for alcohol withdrawal symptoms may develop delirium tremens.[15]

Prediction of Alcohol Withdrawal Severity Scale

The Prediction of Alcohol Withdrawal Severity Scale (PAWSS) is a tool used to predict a patient's risk of complicated alcohol withdrawal.[16] PAWSS includes 10 questions, 8 of which are based on information from the patient including if the patient "ever" experienced episodes of

---

[9] ASAM, The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management, January 23, 2020, accessed on October 29, 2021, https://www.asam.org/Quality-Science/quality/guideline-on-alcohol-withdrawal-management.

[10] S. Jesse et al., "Alcohol withdrawal syndrome: mechanisms, manifestations, and management," Acta Neurologica Scandinavica 135, (2017): 4-16. For purposes of this report, the OIG will refer to the CIWA Alcohol Scale Revised (CIWA-Ar) as CIWA.

[11] Elizabeth C. Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome," CNS Drugs 28, (April 30, 2014): 401-410, accessed on March 2, 2020, https://link.springer.com/content/pdf/10.1007/s40263-014-0163-5.pdf. The "Orientation and clouding of sensorium" symptom is scored on a scale of 0 to 4 while the other nine symptoms are scored from 0 to 7; therefore, the maximum total score for the 10 symptoms is 67.

[12] S. Jesse et al., "Alcohol withdrawal syndrome: mechanisms, manifestations, and management."; Elizabeth C. Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome."

[13] Elizabeth C. Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome."

[14] Elizabeth C. Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome."

[15] Elizabeth C. Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome."

[16] A SME noted that PAWSS is well-established as "the best predictor for clinically significant alcohol withdrawal," "helping clinicians identify those at risk for complicated [alcohol withdrawal syndrome] and allowing for prevention and timely treatment," and was "studied as a tool for patients admitted to the hospital because this was actually the only way that this could be studied, otherwise patients would be lost to follow-up." The SME also noted that "Despite the necessity of its design, it has much broader applicability."

alcohol withdrawal, alcohol withdrawal seizures, and alcohol rehabilitation treatment. Scores of 4 to 10 indicate a high risk for moderate to severe alcohol withdrawal.[17]

Prior OIG Reports

Although not related to care at the facility, the OIG published two reports relevant to the management of alcohol withdrawal.

In an August 2021 report, the OIG made two recommendations to the Director, Tomah VA Medical Center, related to providers receiving education regarding management of alcohol withdrawal and delirium tremens, and staff adherence to CIWA protocols.[18] Both recommendations were closed as of January 26, 2022.

In a May 2022 healthcare inspection at the Charlie Norwood VA Medical Center in Augusta, Georgia, the OIG recommended that the "alcohol withdrawal treatment protocol is specific, does not conflict with physicians' orders, and aligns with the probable onset of patients' alcohol withdrawal symptoms."[19] This recommendation remained open as of September 2022.

Allegations and Related Concerns

On August 13, 2021, the OIG received allegations that facility staff

- mismanaged the alcohol withdrawal care of the patient who requested alcohol detoxification and later died,
- inadequately responded to the patient's report of "bad" withdrawal symptoms and lack of transportation to present to the Emergency Department during Substance Use Disorder Recovery Program (SUDRP) scheduling communication,
- failed to provide PTSD care.

During evaluation of the allegations, the OIG identified additional concerns related to the

- Emergency Department staffs' discharge coordination with the patient's family,
- primary care post-discharge care coordination,
- consideration for completing an institutional disclosure, and

[17] J.R. Maldonado et al., "The Prediction of Alcohol Withdrawal Severity (PAWSS): Systematic Literature review and pilot study of a new scale for the prediction of complicated alcohol withdrawal syndrome," Alcohol 48, (2014): 375-390, accessed on June 9, https://www.psychdb.com/_media/addictions/etoh_pawss_score_maldonando_.pdf.

[18] VA OIG, Mismanagement of a Patient at the Tomah VA Medical Center in Wisconsin, Report No. 20-01917-242, August 26, 2021.

[19] VA OIG, Deficiencies in the Care of a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia, Report No. 21-01048-154, May 12, 2022.

- adequacy of a primary care nurse practitioner's assessment and documentation regarding the patient's alcohol use and safe transport.

Scope and Methodology

The OIG initiated the inspection in September 2021 and conducted a virtual site visit from November 15–18, 2021.[20]

The OIG team interviewed facility leaders and staff familiar with the patient's care and relevant processes; the VISN Acting Chief Medical Officer; and the patient's family members.

Additionally, the OIG team consulted with the Director for Clinical Services, National Office of Primary Care and three Veterans Health Administration (VHA) emergency medicine physicians (subject matter experts) with knowledge of emergency department standards of care, policies, and practices.

The OIG team reviewed relevant VHA directives, handbooks, and memoranda; facility policies and standard operating procedures; ASAM and VA clinical practice guidelines; literature related to alcohol withdrawal management; and the patient's electronic health record (EHR) and autopsy report.

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

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, Pub. L. No. 117-286, § 3(b), 136 Stat. 4196, 4206 (2022) (to be codified at 5 U.S.C. §§ 401–24). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and

[20] The site visit was conducted virtually due to the Coronavirus (COVID-19) pandemic. "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19," World Health Organization, 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, "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 most of the population."; "Naming the Coronavirus Disease (COVID-19) and the Virtus that Causes It," World Health Organization, 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).

methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Patient Case Summary

The patient was in their late thirties at the time of death in summer 2021.[21] The patient's medical history included alcohol abuse, chronic back and neck pain, high blood pressure, PTSD, and recurrent major depressive episodes. Beginning in early 2014, the patient received care intermittently at the facility. (See Appendix A for a summary of the patient's care at the facility from 2014 through 2020.)

In early 2021, the patient transferred from a patient aligned care team (primary care) at the facility to one of the facility's CBOCs.[22] During an early spring 2021 primary care visit, a nurse practitioner assessed the patient "for follow up on chronic conditions of neck/lower back pain" and high blood pressure.[23] The patient's blood pressure was 124/94 millimeters of mercury (mm HG) and heart rate was 130. The nurse practitioner documented that the patient "drinks a gallon of whiskey every 2 days" and "smells of alcohol." The patient reported three emergency department visits for alcohol abuse over the prior six months and continued use of alcohol after participating in a 20-day rehabilitation program. The patient also reported "weekly meeting and drug testing" and declined the offer of VA substance use disorder treatment resources.[24] The nurse practitioner advised the patient about the risks of drinking alcohol while taking blood pressure medication and encouraged the patient to discontinue drinking. The nurse practitioner ordered x-rays to further evaluate the patient's chronic neck and back pain, planned to "call with treatment plan when I have the x-ray results," and placed the patient on a "Call Back List" for an appointment in one year. Following multiple contact attempts, including phone calls and a letter, a clinic clerk was unsuccessful in reaching the patient to schedule the x-rays.

---

[21] The OIG uses the singular form of they (their) in this instance for privacy purposes.

[22] VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, amended May 26, 2017. A patient aligned care team (PACT) is a team of healthcare professionals who partner with a patient to provide comprehensive primary care and healthcare coordination.

[23] Facility Bylaws, Rules, and Regulations of the Medical Staff, revised September 2019. The facility CBOC was a contract clinic and facility bylaws require contract nurse practitioners to practice "within a Collaborative Practice Agreement or Scope of Practice with a fully credentialed and clinically privileged medical staff member at this facility."

[24] The patient's EHR did not contain documentation of other VHA emergency department or outpatient substance use disorder clinic care, and family members reported the patient obtained non-VA care for alcohol use disorder.

In early summer 2021 (day 1), the patient called the Veterans Crisis Line and reported a history of "military-related chronic pain and use of alcohol to self-medicate" and requested assistance with substance use.[25] The following day, a facility suicide prevention coordinator contacted the patient who reported "a serious alcohol problem," denied current withdrawal symptoms, and requested treatment. The suicide prevention coordinator submitted a SUDRP consult for the patient. On day 5, a Friday, the SUDRP medical support assistant (MSA) contacted the patient to schedule an appointment. The patient reported a plan to go to the Emergency Department " . . .tomorrow as the withdrawal symptoms were getting bad" and a lack of transportation to go that day. The MSA documented a plan to call the patient back on the next business day (day 8). The MSA called the patient on day 9 and did not reach the patient. On day 15, the MSA could not reach the patient by phone and mailed the patient a letter. On day 23, the patient presented to the Emergency Department. See table 1 for a timeline of the patient's Emergency Department care on days 23 and 24.

Table 1. Timeline of Patient's Emergency Department Care on Days 23 and 24

Day 23 Time Noted in the EHR	Event
12:12 p.m.	Patient presented to the Emergency Department, and a triage nurse documented that the patient reported needing alcohol detoxification and a history of seizures with alcohol withdrawal. The patient's heart rate was 118 and blood pressure was 131/91 mm HG.
1:10 p.m.	A registered nurse (Nurse 1) obtained the patient's blood for laboratory testing.
1:18 p.m.	Nurse 1 documented that the patient reported: • a history of withdrawal seizures, • "shakes and vomiting," • last alcohol use was "a couple of shots between 10am" and the time the patient arrived at the Emergency Department, and • drinking "a handle of whiskey over 2 days."* Nurse 1 also documented that the "Family in at bedside."
1:30 p.m.	Patient received an intravenous infusion of phenobarbital as prescribed by an Emergency Department physician (Physician 1).
1:45 p.m.	Nurse 1 documented that the patient's CIWA score was 0 and that the patient reported drinking alcohol "four or more times a week," "Daily or almost daily," with 10 or more drinks on a typical day during the past year.
1:50 p.m.	Patient received an intravenous infusion of vitamins prescribed by Physician 1.
2:55 p.m.	Patient received an intravenous infusion of magnesium prescribed by Physician 1 after a low magnesium level was noted in the patient's laboratory results.
3:00 p.m.	The patient's heart rate was 96 and blood pressure was 136/106 mm HG.

[25] Veterans Crisis Line, "About Us," accessed September 8, 2022,https://www.veteranscrisisline.net/about/about-us/. The Veterans Crisis Line is a free and confidential telephone, text, and chat resource for veterans in emotional crisis.

5:00 p.m.	The patient's heart rate was 115 and blood pressure was 132/84 mm HG.
5:15 p.m.	Nurse 1 notified Physician 1 that the patient's breathalyzer result was 0.287.[†]
5:45 p.m.	Patient's CIWA score was 2 due to tremors that were "not visible but can be felt" and mild anxiety that indicated "absent or minimal withdrawal."
6:22 p.m.	Physician 1 documented: • the patient's report of past sobriety and inpatient rehabilitation and a history of "visual and auditory hallucinations" and seizures. • a plan to monitor the patient until "legally sober" with a five-day gabapentin prescription and that the patient would be admitted if the "patient begins to go into active withdrawal symptoms with high CIWA scores." • that the patient's "alcohol level was 286" when the patient's care was signed over to another Emergency Department physician (Physician 2).[‡]
7:45 p.m.	Another registered nurse (Nurse 2) documented receiving a report on the patient from Nurse 1.
8:30 p.m.	The patient's heart rate was 113 and blood pressure was 138/97 mm Hg.
9:30 p.m.	Nurse 2 documented that the patient's CIWA score was 6 due to moderate tremors with arms extended, mild anxiety, and a "Very mild" headache and breathalyzer result was 0.14.
11:29 p.m.	Nurse 2 documented that the patient's CIWA score remained 6 due to moderate tremors with arms extended, mild anxiety, and "very mild" headache and noted "Intervention: Monitor every 4 hours." The patient's heart rate was 110 and blood pressure was 127/91 mm Hg.
Day 24 **Time Noted in the EHR**	**Event**
12:00 a.m.	Nurse 2 completed the patient's discharge plan that advised the patient to: • take gabapentin as prescribed, • present to the SUDRP walk-in clinic the next day for orientation, and • "return to ED [Emergency Department] for: seizures, or any other worsening or concerning symptoms."
12:10 a.m.	Patient took first gabapentin dosage.
12:34 a.m.	Physician 2 documented receiving "signout on this patient" and that the patient was: • "clinically sober." • "stable for discharge home." • provided with SUDRP resources. • to be given "gabapentin taper for [alcohol] withdrawal [detoxification]." • going to be transported home by a family member (Family Member 1).
12:37 a.m.	A social worker: • documented that the patient reported a desire to participate in inpatient substance use treatment and "was very shaky and tremulous." • requested the patient's nurse "complete a CIWA just to rule out [alcohol] withdrawal." • "followed up with the [physician]."

	• provided the patient with a "connection recovery card" and "SUDRP pamphlet."

Source: OIG review of patient's EHR.
** "What is a standard serving size of alcohol?" accessed on February 16, 2022, at https://uwm.edu/basics/wp-content/uploads/sites/192/2020/03/Standard-Drink-Serving-Sizes.pdf. A handle of whiskey is equivalent to 1.75 liters, 59.2 ounces, or approximately 39 shots or standard drinks.*
† "Sobering Facts: Alcohol Impaired Driving, Indiana," Centers for Disease Control and Prevention, accessed November 29, 2021, https://www.cdc.gov/motorvehiclesafety/pdf/impaired-driving-new/CDC-impaired-driving-fact-sheet-Indiana.pdf*. Indiana's legal driving limit is a blood alcohol level less than 0.08.*
‡Physician 1 documented the patient's alcohol level was 286; however, the laboratory results, obtained approximately five hours earlier, indicated that the patient's blood alcohol level was 386 milligrams per deciliter and the 5:15 p.m. breathalyzer result was 0.287.

On day 26, a coroner documented that the patient had died that day after being found "draped over a fence line that was among heavy brush." Emergency medical service medics removed the patient from the fence and the patient "began to hemorrhage uncontrollably" from the right thigh and hamstring area. A forensic pathologist concluded that the patient's cause of death was "Exsanguinating hemorrhage due to sharp force injury of leg."[26] On day 60, a facility registered nurse documented notification of the patient's death.

Inspection Results

1. Mismanagement of the Patient's Alcohol Withdrawal Care

The OIG substantiated that Emergency Department staff mismanaged the alcohol withdrawal care of the patient who requested alcohol detoxification and died two days later. The OIG found that Emergency Department staff discharged the patient after approximately 12 hours without adequately assessing the patient's risk for complicated alcohol withdrawal. Consistent with the subject matter experts' opinions and clinical practice guidelines, the OIG concluded that further monitoring or inpatient admission should have been more strongly considered given the patient's risk of complicated withdrawal.[27] The OIG was unable to determine if severe alcohol withdrawal contributed to the patient's behaviors and ultimate death because of the absence of medical assessment during the hours following Emergency Department discharge.

---

[26] Exsanguinating hemorrhage is extreme blood loss from a blood vessel that will lead to death if not contained.

[27] ASAM, The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management, January 23, 2020, accessed on October 29, 2021, https://www.asam.org/Quality-Science/quality/guideline-on-alcohol-withdrawal-management; VA and Department of Defense, VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders, December 2015, was in place during the time of the events in this report. It was updated in VA and Department of Defense, VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders, August 2021. Both sets of guidelines contain the same or similar language regarding alcohol withdrawal management.

Inadequate Assessment of Alcohol Withdrawal Risk

According to facility policy, facility nursing staff may initiate assessment, including the CIWA, for patients with alcohol dependence and suspected alcohol withdrawal. Facility nursing staff are also responsible for ongoing monitoring of CIWA scores within specified time frames.[28] Additionally, facility nursing staff may obtain "breath alcohol content and blood alcohol testing" with a patient's verbal consent.[29] CIWA scores

- less than or equal to 7 require staff to complete another CIWA and obtain a patient's vital signs approximately every four hours,
- between 8 and 15 require staff to repeat a CIWA score and obtain vital signs every four hours, and
- over 15 require staff to complete CIWA and obtain vital signs hourly and consider transferring the patient to a higher level of care.[30]

Upon presentation to the Emergency Department, the patient acknowledged heavy alcohol use, requested alcohol detoxification, and reported a history of withdrawal seizures. The patient reported consuming approximately 39 shots (or standard drinks) every two days; nearly three times the ASAM threshold of seven standard drinks daily as advised for inpatient withdrawal management.[31]

The patient received phenobarbital 90 minutes after presenting to the Emergency Department. Despite phenobarbital's expected effect to alleviate alcohol withdrawal symptoms, the patient's CIWA assessment increased from 0 to 2 over four hours and then to 6 over approximately the next four hours. Between 2:00 p.m. and 9:30 p.m., the patient's breathalyzer results decreased from 0.287 to 0.140. (see figure 1.)

---

[28] Facility Standard Operating Procedure Emergency Department-07, "Management of Alcohol Intoxicated and Alcohol Dependent Patients in the ED," May 26, 2021.

[29] Facility Standard Operating Procedure Emergency Department-07.

[30] Facility Standard Operating Procedure Emergency Department-07.

[31] The OIG calculated the patient's drink consumption based on an 80-proof whiskey that contains approximately 40 percent alcohol rather than 100-proof or about 50 percent alcohol.

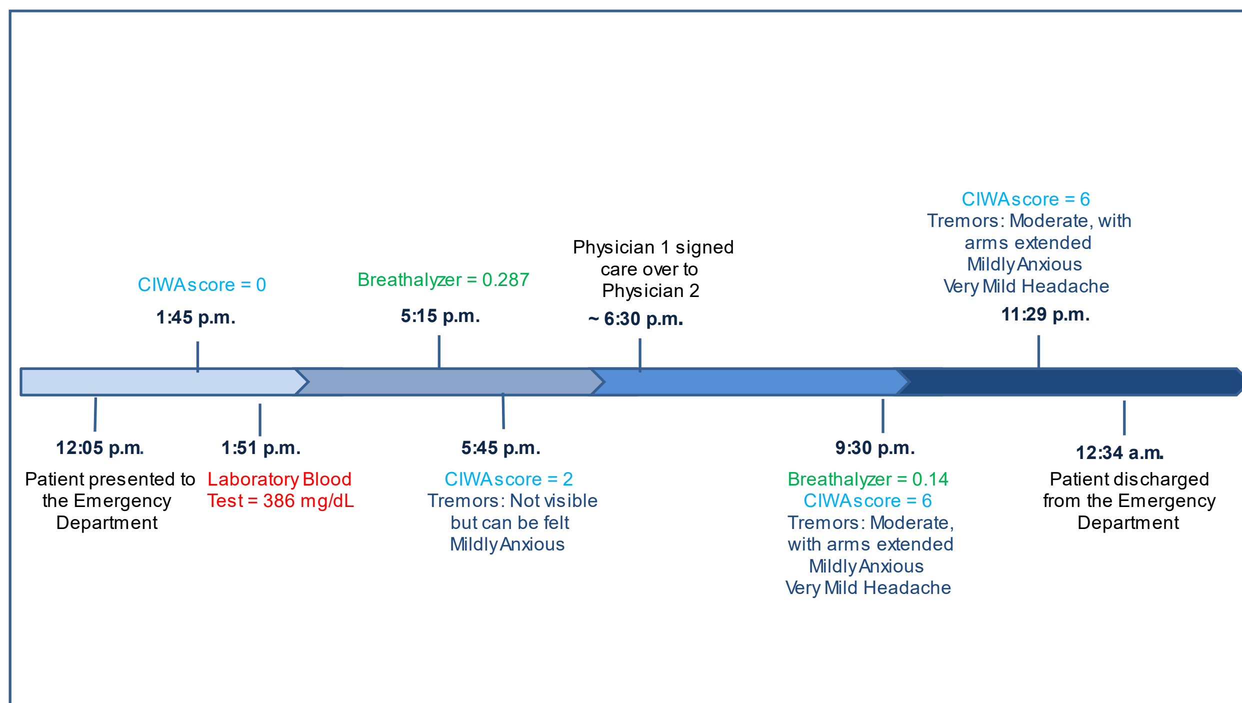

Figure 1. *Timeline of the patient's assessed blood alcohol content and CIWA scores.*
Source: OIG review of the patient's EHR.

Physician 1 planned to monitor the patient until "legally sober," discharge the patient with a gabapentin prescription "[i]f no further evidence of acute withdrawal," or admit if signs of active withdrawal presented or the CIWA score increased.[32] Physician 1 documented that the patient reported past sobriety, and a history of "visual and auditory hallucinations" and seizures that "occurred a long time ago." In an interview with the OIG, Physician 1 reported that the patient was thinking clearly, interacting appropriately, not exhibiting "classic signs of any withdrawal symptoms," and not having seizures or hallucinations. At approximately 6:30 p.m., Physician 1 transferred the patient's care to Physician 2.[33]

Over a period of approximately three and a half hours, Physician 2 documented in an ongoing note that the patient was "clinically sober," "stable for discharge home," and that Family Member 1 would "pick up patient."[34] The OIG was unable to identify when Physician 2 determined that the patient was ready for discharge because Physician 2 did not document the times corresponding to the evaluation. Further, Physician 2 did not document the criteria used to explain and support the decision to discharge the patient home.

[32] Facility Standard Operating Procedure Emergency Department-07.

[33] The Emergency Department unit manager reported that on Day 23, Physician 1 worked from 6:00 a.m.– 6:00 p.m.; on Days 23–24, Physician 2 worked from 2:00 p.m.–2:00 a.m.

[34] The Chief, Emergency Department told the OIG that clinical sobriety is determined by the provider's clinical impression of the patient's functioning including neurological, communicative, cognitive, and physical status.

Physician 2 told the OIG that the patient was discharged based on clinical sobriety, available family support, and a CIWA score that indicated the patient was appropriate for outpatient management of alcohol use disorder. Physician 2 reported an understanding that the patient's described alcohol withdrawal seizures were in the distant past.

Based on interviews, the OIG found that Physicians 1 and 2 did not consider the patient's withdrawal seizure history as a risk factor due to their understanding that the seizures occurred in the distant past. A second family member (Family Member 2) told the OIG that the patient received treatment in non-VA facilities for pancreatitis in summer 2020; alcohol withdrawal seizures in late fall 2020 and early 2021; rehabilitation in early 2021; and an alcohol use disorder-related concern in late spring 2021.

PAWSS and ASAM criteria consider seizures during the lifetime, not just recent seizure activity, to be a risk factor. Further, ASAM recommends that "Patients should be monitored for alcohol withdrawal seizures even in the absence of other clinically prominent alcohol withdrawal signs or symptoms."[35] The OIG did not find evidence in interviews or the patient's EHR that staff attempted to obtain additional information about the patient's seizure history from the patient or family members, as recommended by ASAM.[36] Family Member 1 told the OIG that staff did not ask for any information about seizure history. Additionally, the patient's risk of severe alcohol withdrawal was increased by the patient's reported history of "shaking" (tremors); auditory and visual hallucinations; and multiple alcohol use related emergency department visits over the prior six months.[37]

The OIG determined that the patient's PAWSS score upon presentation to the Emergency Department would have been 6 and, starting at approximately 5:45 p.m., would have increased to 7 due to onset of mild tremors, suggesting that the patient was at moderate to high risk for alcohol withdrawal. In addition, the patient met 5 of the 11 ASAM risk factors for severe or complicated withdrawal, including history of alcohol withdrawal seizure, numerous prior withdrawal episodes, and long duration of heavy and regular alcohol use.

Approximately three hours prior to the patient's discharge, the patient's blood alcohol content was 0.14 and CIWA score of 6 that indicated the patient was experiencing withdrawal symptoms while intoxicated and was therefore at increased risk for severe withdrawal. One hour before discharge, the patient's CIWA score was still 6 and staff did not obtain another blood alcohol content prior to the patient's discharge. However, given the rate that alcohol leaves the body, the patient's alcohol level at the time of discharge was likely 0.095. Physician 1 told the OIG that

---

[35] ASAM, The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management, January 23, 2020, accessed on October 29, 2021, https://www.asam.org/Quality-Science/quality/guideline-on-alcohol-withdrawal-management.

[36] ASAM, The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management, January 23, 2020, accessed on October 29, 2021, https://www.asam.org/Quality-Science/quality/guideline-on-alcohol-withdrawal-management.

[37] ASAM, The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management, January 23, 2020, accessed on October 29, 2021, https://www.asam.org/Quality-Science/quality/guideline-on-alcohol-withdrawal-management.

although 0.08 is the legal limit, they consider 0.10 on a breathalyzer as legally sober due to the "margin of error."

Two of the three subject matter experts who reviewed the patient's EHR told the OIG that they would have likely admitted the patient for alcohol withdrawal management given the patient's reported history of withdrawal seizures. The third subject matter expert reported to the OIG that a history of withdrawal seizures is "not sufficient to establish a need to admit or further observe a patient if other clinical parameters indicate a milder withdrawal course ([that is] low CIWA score)." However, although the facility standard operating procedure advises consideration of inpatient admission for patients with CIWA scores over 15, ASAM recommends monitoring of patients for seizures even in the absence of other withdrawal symptoms.[38]

Based on the patient's (1) increasing and then persistent CIWA score of 6 and a positive blood alcohol content over the course of the patient's visit, (2) high level of alcohol consumption, and (3) alcohol withdrawal seizure history, the OIG would have expected Physician 2 to consider additional Emergency Department monitoring of the patient's withdrawal symptoms and inpatient detoxification. Further, based on these same factors, the OIG considers it likely that the patient's alcohol withdrawal symptoms continued to progress after discharge from the Emergency Department. Family Member 2 told the OIG that on day 25, the patient became confused and appeared to be hallucinating. If the patient's withdrawal symptoms progressed following discharge from the Emergency Department, they would likely have included disorientation and confusion by day 25.

Inadequate Discharge Coordination with the Patient's Family

The OIG was unable to determine the extent of Family Member 1's involvement in the patient's discharge planning because of the absence of EHR documentation and the conflicting reports provided by Family Member 1 and Physician 2. The chief, Emergency Department, told the OIG that having family involved is beneficial to the patient and that the involvement of family would depend on (1) the patient wanting their involvement, (2) the willingness of the family, and (3) the condition being treated.

However, VHA and facility policy do not require family participation in planning for a patient's Emergency Department discharge. Although the facility policy outlines discharge planning from inpatient units, including communication of the plan to the patient and the patient's family, facility leaders had not established protocols or procedures for Emergency Department discharge planning that included family involvement.[39]

---

[38] ASAM, The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management, January 23, 2020, accessed on October 29, 2021, https://www.asam.org/Quality-Science/quality/guideline-on-alcohol-withdrawal-management. Facility Standard Operating Procedure Emergency Department-07.

[39] Facility Memorandum 11-46, Discharge Planning, August 7, 2019.

At approximately midnight on day 24, Physician 2 documented a discharge plan that included the patient's gabapentin prescription, instructions to present to the SUDRP walk-in clinic the next day for orientation, and instructions to "return to ED [Emergency Department] for: seizures, or any other worsening or concerning symptoms." Physician 2 noted that Family Member 1 "is driving the patient" home and that the patient and Family Member 1 were "informed;" however, the note did not include the specific information provided.

In an interview with the OIG, Family Member 1 told the OIG that during a telephone call, an Emergency Department physician said that the patient would be discharged if there were no signs of withdrawal and the patient's blood alcohol level decreased.[40] Family Member 1 reported speaking to Emergency Department staff by phone multiple times and pleading with them to not send the patient home because the patient was in too much pain and needed the help. Further, Family Member 1 told the OIG about not receiving any information about the patient's discharge plan and both Family Member 1 and 2 described not knowing about the patient's SUDRP post-discharge appointment until after the patient died. Although a next-day SUDRP follow-up was in the patient's discharge plan, EHR documentation did not indicate that Family Member 1 was informed about the care plan.

Physician 2 told the OIG that "I think I talked to [Family Member 1] on the phone initially." Physician 2 told the OIG that Family Member 1

> physically did come and pick up the patient, and [what] we do with every patient that we discharge is review that discharge plan and a part of that discharge plan, and a part of that discharge plan is the discussion of return criteria, the newly prescribed medications, how to take them, etcetera, so that's a part of the discussion plan and that would have been conducted once [the patient] had [Family Member 1] present in the room upon discharge.

However, Family Member 1 told the OIG that the patient was discharged prior to Family Member 1's arrival at the facility and was waiting outside the facility when Family Member 1 arrived.

Deficient Post-Discharge Care Coordination

VHA requires that primary care teams ensure adequate processes are in place to coordinate care for patients assigned to their team who are discharged from an emergency department.[41] Although VHA requires primary care staff contact patients within two days of discharge from inpatient settings, there is not a similar requirement for care coordination when patients are discharged from the Emergency Department. The OIG found that facility leaders had not

---

[40] Family Member 1 did not recall the name of the Emergency Department physician; however, the OIG concluded that Family Member 1 spoke to Physician 2 based on EHR documentation and Physician 2's report.

[41] VHA Handbook 1101.10(1).

established procedures for care coordination of patients discharged from the Emergency Department.

Emergency Department Discharge Follow-Up

VHA requires that primary care staff ensure adequate processes to coordinate care for assigned patients who are discharged from an emergency department.[42] The Director for Clinical Services, National Office of Primary Care told the OIG that primary care teams should

> coordinate care for patients during all transitions of care (includes discharge from the emergency department) in the manner most convenient and preferred by the Veteran and their caregiver. This can occur either in person or virtually (includes but not limited to telephone or Video or secure messaging).

The Director for Clinical Services, National Office of Primary Care clarified that "[t]he VISNs and medical centers are responsible for establishing processes to monitor all clinical transitions of care." The chief nurse, Primary Care told the OIG that a standardized process had not been established at the facility to address when patients are discharged from the Emergency Department.

The clinic manager, Primary Care, Ambulatory Care (CBOC manager) told the OIG that primary care nurses conduct Emergency Department post-discharge calls daily for up to four calls over a period of seven days until the patient is reached. The CBOC manager further explained that an EHR templated note is completed by the primary care nurse upon successful contact with a patient, or the completion of four outreach attempts. However, in this case the primary care nurses did not document each of the first three unsuccessful contact attempts.

Physician 2 alerted the CBOC nurse practitioner and nurse of the patient's discharge from the Emergency Department by including them as additional signers on the patient's Emergency Department visit documentation.[43] The CBOC Manager told the OIG that the nurse may have attempted to call the patient without success but that calls were not documented because of the limitations of the EHR template. However, in an interview with the OIG, the chief nurse, Primary Care explained that nurses "should be documenting what attempts they've made and by what avenue." The OIG found that the patient's EHR did not include documentation of staff's outreach following the patient's Emergency Department visit. Failure to document outreach attempts may contribute to inadequate follow-up with patients transitioning to different levels of care. Further, given that the patient's next scheduled appointment was over six months later, the OIG would have expected additional outreach to the patient.

[42] VHA Handbook 1101.10(1).

[43] The CBOC manager told the OIG that the nurse is no longer employed at the CBOC.

VHA requires that staff schedule patients upon their arrival at a walk-in clinic, and that staff call patients who do not present to scheduled appointments.[44] However, because the patient did not present to the SUDRP walk-in clinic as advised by Emergency Department staff, the patient did not have a scheduled appointment to prompt outreach. The SUDRP Manager told the OIG that Emergency Department staff can place a consult, or add a comment to an existing consult, for patients advised to present to the walk-in clinic. Further, the SUDRP Manager explained that consult submission would notify SUDRP staff who may follow up with the patient. In an interview with the OIG, Physician 2 shared the understanding that SUDRP staff reach out to patients to ensure that follow-up is scheduled. The OIG found that Emergency Department staff did not add a comment to an existing SUDRP consult in the patient's EHR; therefore, SUDRP staff did not receive notification and follow-up did not occur. Although the OIG is unable to determine if contact with the patient or the patient's family following discharge from the Emergency Department would have prevented the patient's death, outreach might have provided an opportunity for the patient to access care.

The OIG found that facility leaders had not established processes to coordinate care for patients discharged from the Emergency Department. The absence of a process may have resulted in inadequate care coordination of issues needing action by primary care staff, including the patient's alcohol withdrawal symptoms, which likely occurred during the two days following discharge.

In August 2022, the chief nurse, Primary Care reported to the OIG that facility leaders were establishing procedures and oversight responsibilities for contacting patients within two business days of discharge from the Emergency Department.

Post-Discharge Contact

Since 2010, VHA has required that primary care teams contact patients within two business days of discharge from an inpatient setting. The Director for Clinical Services, National Office of Primary Care provided information that verified that this requirement was not applicable to emergency department discharges. Facility leaders established a policy requiring a call to patients discharged from inpatient units within two business days "to identify any issues needing further involvement by inpatient staff or immediate action by primary care staff."[45] The Chief of Staff reported to the OIG that completion of the two-day post-discharge follow-up call was monitored by facility leaders.

---

[44] VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022. The new directive does not include guidance regarding walk-in clinic scheduling.

[45] Facility Policy 11-46, Discharge Planning, August 7, 2019. The quality manager, Utilization Management supervisor informed the OIG that the requirement included patients discharged from the Emergency Department.

When interviewed by the OIG, the Chief of Staff and the CBOC Manager mistakenly told the OIG that primary care nurses are required to call patients who have been seen in the Emergency Department within two days of discharge.[46] However, the chief nurse, Primary Care clarified that the requirement applied only to inpatient setting discharges and did not include patients discharged from the Emergency Department.

In fiscal year 2021, facility staff's monthly completion rate for two-day inpatient post-discharge follow-up calls ranged from approximately 31 to 47 percent.[47] The Chief of Staff explained to the OIG that the completion rate was low due to short staffing. In December 2021, the chief nurse, Primary Care confirmed that the facility has "historically been low with this performance" and that a workgroup was being established. The Director for Clinical Services, National Office of Primary Care confirmed that a national workgroup was established in January 2022 "To improve the compliance and quality of the team two-day post-discharge contact after 'VHA inpatient' hospitalization." The Director for Clinical Services, National Office of Primary Care reported that the workgroup recommended development, training, and the creation of a "national two-day post discharge [EHR] standardized template."

Institutional Disclosure Considerations

An institutional disclosure is a formal process for facility leaders and clinicians to inform a patient, or a patient's personal representative, of events that occurred during the patient's care and resulted in death or serious injury, and to provide information about rights and recourse. An institutional disclosure must be completed regardless of when the adverse event is discovered.[48] VHA requires an institutional disclosure of adverse events that cause death or disability, regardless of whether they resulted from an error.[49]

Facility leaders including the chief, Quality, Safety, and Value; Associate Director, Patient Care Services; and acting risk manager told the OIG that an institutional disclosure to the patient's family was not considered because the internal reviews did not warrant that action. However, the OIG determined that an institutional disclosure should have been considered given Emergency Department staffs' failure to consider additional Emergency Department monitoring of the patient's withdrawal symptoms and inpatient detoxification as discussed above.

---

[46] The clinic manager was in the role at the time of the patient's visit and OIG site visit. The chief nurse, Primary Care told the OIG that the clinic manager is no longer in that role.

[47] A fiscal year is a 12-month cycle that spans October 1 through September 30. Fiscal year 2021 began on October 1, 2020, and ended on September 30, 2021.

[48] VHA Directive 1004.08. VHA defines an adverse event as "untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers." For purposes of this report, the OIG defines harm in terms of an adverse clinical outcome such as death within 72 hours of discharge from the Emergency Department.

[49] VHA Directive 1004.08

2. MSA's Inadequate Response to Clinical Concerns

The OIG substantiated that a SUDRP MSA inadequately responded to the patient's report of "bad" withdrawal symptoms and lack of transportation to present to the Emergency Department. Specifically, the OIG found that the MSA did not seek consultation with a clinician or supervisor when the patient reported potentially serious symptoms and an inability to go for medical help. However, the OIG found that facility leaders had not established policies or procedures for MSAs to address patients' potentially urgent clinical concerns except for reports of suicide-related ideation and behaviors.

VHA requires that staff responsible for scheduling patient consults follow facility standard operating procedures when "further contact attempts or actions are required based on clinical needs."[50] Facility policy specifies the requirements for a non-licensed independent professional, such as a MSA, to access immediate Veterans Crisis Line assistance for patients who report suicidal ideation, self-harm, and emotional crisis; however, other potential urgent patient safety concerns, such as alcohol withdrawal, are not addressed.[51]

On a Friday in early July 2021, an MSA telephoned the patient in response to the SUDRP consult placed by the suicide prevention coordinator, following the patient's report of "a serious alcohol problem" and request for treatment. The patient reported planning to go to the Emergency Department ". . .tomorrow as the withdrawal symptoms were getting bad" and the patient "didn't have a ride until tomorrow." The MSA documented a plan to call the patient back on Monday. The MSA attempted to call the patient on Tuesday and left a voicemail. In an interview with the OIG, the MSA reported likely not calling the patient as planned on Monday due to the SUDRP being busy. The following Monday, the MSA attempted another call and mailed the patient a letter. Approximately five weeks later, in early August, the MSA discontinued the consult due to inability to reach the patient.

When interviewed by the OIG, the MSA stated that when patients report urgent clinical concerns during consult scheduling calls, such as withdrawal symptoms, the typical process is to contact a suicide prevention staff member. However, the MSA said that suicide prevention staff were not contacted because the patient reported planning to present to the Emergency Department the following day. Given that the patient reported that "withdrawal symptoms were getting bad," the OIG would have expected the MSA to contact a clinician to determine the appropriate intervention for the patient.

In interviews with the OIG, the Chief of Staff, and the chief, Psychiatry and Mental Health Services reported different expectations regarding who MSAs should follow up with when a

[50] VHA Directive 1232(3), Consult Processes and Procedures, August 24, 2016, amended April 5, 2021.

[51] Facility Policy 116-05, "Suicide and Suicide-Related Behavior," June 14, 2021; VHA Handbook 1100.19, Credentialing and Privileging, October 15, 2012. A licensed independent practitioner is an individual permitted by law and the facility to provide independent patient care.

patient expresses potentially urgent clinical concerns during scheduling calls. The Chief of Staff said that the MSA could contact the patient's primary care team or the service involved. The chief, Psychiatry and Mental Health Services told the OIG that the MSA should consult with suicide prevention staff who can then involve a provider as needed. Additionally, the chief, Psychiatry and Mental Health Services noted that MSAs receive training on how to manage suicidal ideation or safety threats, and that the MSA may not have recognized the patient's report as a potentially emergent situation. The SUDRP program manager told the OIG that a procedure had not been established for MSAs to address when a patient reports withdrawal symptoms during a call.

When interviewed by the OIG, the supervisory management analyst (MSA supervisor) reported the expectation that an MSA would contact SUDRP providers or suicide prevention staff for consultation when a patient reported withdrawal symptoms.[52] The MSA supervisor acknowledged that the facility policy only addresses MSA procedures for patients reporting suicidal behavior concerns and not withdrawal symptoms.[53]

The OIG found that the facility policy was limited to MSAs' management of patients' reported suicide-related ideation and behavior, and did not include other potentially urgent clinical issues such as alcohol withdrawal symptoms. As a result, the patient did not receive a clinical assessment or treatment scheduling that may have assisted the patient in accessing alcohol use and withdrawal treatment. The OIG determined that the lack of facility guidance for MSAs' response to patients who report potentially urgent clinical concerns during appointment scheduling calls may contribute to risk of an adverse clinical outcome and delayed patient care.

3. PTSD Assessment and Care of the Patient

The OIG did not substantiate that facility staff failed to provide PTSD care to the patient. Beginning in early 2016, the patient received mental health treatment including medication and counseling until April 2016 when the patient discontinued and declined treatment. The OIG determined that facility staff conducted PTSD screening and follow-up per VHA requirements.[54]

VHA requires that facility staff screen patients for PTSD using the Primary Care-PTSD screening tool at least once a year for the initial five years after military separation and once every five years subsequently.[55] Patients who screen positive for PTSD should receive a suicide risk evaluation by a "mental health clinician or another acceptable provider" by the close of the

[52] The supervisory management analyst oversees the Mental Health Services MSAs.

[53] Facility Policy 116-05, "Suicide and Suicide-Related Behavior," June 14, 2021.

[54] VHA Directive 1160.03(1).

[55] VHA Directive 1160.03(1).

following business day.[56] Facility staff should provide PTSD services based on the patient's clinical preferences and needs.

In summer 2015, the patient screened positive for PTSD at a VA medical center in Alabama, was diagnosed with "anxiety disorder, [not otherwise specified] (subthreshold PTSD)" and attended two mental health visits. (See Appendix A.) In a 2015 visit to the facility, the patient reported mental health diagnoses and a social worker placed an outpatient mental health consult for "Anxiety, PTSD, [Attention Deficit Hyperactivity Disorder]."

In early 2016, a primary care provider documented that the patient screened positive for PTSD and that same day, a social worker documented that the patient was "seeking treatment for depressed mood, poor sleep, and for what [the patient] was told was PTSD previously." In early 2016 and spring 2016, a clinical nurse specialist provided the patient with medication management for depression and anxiety. During that time, the patient continued to see the social worker for individual therapy and in late spring 2016, the social worker documented the patient's plan to relocate to another state. In late fall 2016, another primary care physician documented a positive PTSD screen and the patient declined PTSD treatment. In fall 2017, a primary care nurse documented the patient's negative PTSD screen. Based on VHA requirements, the patient would have been due for the next PTSD screen in fall 2022.

The OIG concluded that facility staff completed PTSD screens and offered and provided mental health treatment as expected based on VHA requirements.[57]

4. A Primary Care Nurse Practitioner's Inadequate Substance Use Assessment and Follow-Up for the Patient

The OIG found that at the early spring 2021 CBOC visit, a nurse practitioner failed to (1) thoroughly assess the patient's substance use, (2) schedule follow-up within a reasonable time frame for the patient's needs, and (3) discuss immediate safety concerns.

VHA requires patients in primary care to be screened for alcohol misuse at least annually.[58] Assessment and management of substance use disorders in the primary care setting typically includes reviewing the patient's reported substance use, providing education about substance use disorder consequences and treatments, and encouraging supports for recovery and lifestyle changes.[59] Facility policy encourages patients to be seen the same day by a primary care-mental

[56] VHA Directive 1160.03(1).

[57] VHA Directive 1160.03(1).

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

[59] VA and Department of Defense, VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders, December 2015, was in effect during the OIG's inspection period. It was replaced in August 2021. Unless otherwise specified, the requirements in the 2021 Clinical Practice Guideline contain the same or similar language as the replaced December 2015 document.

health integration staff member when there is a positive screen for PTSD, depression, alcohol, or tobacco use.[60]

A patient is considered intoxicated after "recent ingestion of alcohol with a breath or blood alcohol level greater than [0.08] and/or the presence of signs or symptoms indicating clinically significant intoxication" to include "alcohol on the breath," slow or slurred speech, aggressive behavior, or mood instability.[61] Evaluating alcohol withdrawal is critical for patient safety and signs and symptoms include "diaphoresis, tremulousness and gait instability, tachycardia and severe hypertension, visual and/or tactile hallucinations or other alterations in consciousness and cognition, seizure."[62] The medical risks of chronic alcohol abuse include cardiomyopathy, high blood pressure, pancreatitis, a weakened immune system, and mood disorders.[63]

An Emergency Department standard operating procedure for management of intoxicated patients includes guidance for evaluating withdrawal risk and the patient's safe transportation.[64] Facility leaders confirmed that similar written guidance had not been established for the primary care setting. The associate chief of staff and medical director for the CBOC told the OIG that they expect providers to involve primary care-mental health integration staff when patients present with substance use disorder concerns or appear intoxicated.

At the patient's early morning primary care visit, a nurse notified the nurse practitioner that the patient had a positive alcohol screen. The patient reported three emergency department visits related to alcohol use over the prior six months, and continued use of alcohol after participating in a 20-day rehabilitation program. The patient reported "drinking to treat the pain," and being "discharged from [rehabilitation] with some medication for [the patient's] blood pressure but is not sure the dose or the exact name." The nurse practitioner documented that the patient "will call with the spelling and the dose" so the "medication can be adjusted."

The nurse practitioner documented that the patient had a steady gait, was alert and oriented, and responded appropriately during the exam, which may indicate that the patient was not impaired

---

[60] VHA Handbook 1101.10(1); Primary care-mental health integration is a mental health team that is integrated into primary care and coordinates with primary care providers to offer mental health services to veterans. Facility Policy, "Primary Care Mental Health Integration (PCMHI) Same Day Appointments," March 1, 2021.

[61] Facility Emergency Department, "Management of Alcohol Intoxicated and Alcohol Dependent Patients in the ED," Standard Operating Procedure, May 26, 2021. While this facility standard operating procedure is intended to guide Emergency Department staff, it provides information that is relevant to general patient care and gives an indication of what the facility expects of providers discharging patients from an outpatient setting.

[62] Facility Emergency Department, "Management of Alcohol Intoxicated and Alcohol Dependent Patients in the ED," Standard Operating Procedure, May 26, 2021.

[63] National Institute on Alcohol Abuse and Alcoholism, Alcohol's Effects on the Body, accessed July 12, 2022, https://www.niaaa.nih.gov/alcohols-effects-health/alcohols-effects-body.

[64] Facility Emergency Department, "Management of Alcohol Intoxicated and Alcohol Dependent Patients in the ED," Standard Operating Procedure, May 26, 2021; Facility leaders also established a Domiciliary Residential Rehabilitation Treatment Program nursing standard operating procedure for the management of intoxicated patients.

from alcohol use. However, the nurse practitioner also documented potential signs of intoxication including that the patient “drinks a gallon of whiskey every 2 days,” “smells of alcohol,” “got angry,” was “agitated and unable to sit still,” and reported hearing “voices that other people don’t hear or music.” The nurse practitioner did not document further assessment of the patient’s symptoms. The OIG would expect additional documented clinical assessment to determine if the patient was intoxicated at the time of the visit and if the patient’s hallucinations were related to intoxication or mental illness. In an interview with the OIG, when asked about assessing the patient’s symptoms further, the nurse practitioner reported that the patient did not want to see the available psychologist and only wanted to address neck and back pain. Given the absence of further clinical assessment of the patient’s intoxication, the OIG was unable to determine if the patient should have been encouraged to go to the Emergency Department for additional evaluation.

The nurse practitioner planned the patient’s next appointment for one year later. The nurse practitioner also ordered testing and x-rays to further evaluate the patient’s chronic neck and back pain; however, the patient did not schedule or complete the ordered tests. An administrative staff member could not reach the patient during follow-up calls to schedule the testing and x-rays. CBOC leaders told the OIG the expectation would be for the nurse practitioner to follow up with the patient sooner than one year due to the patient’s concurrent medical conditions. In an interview with the OIG, the nurse practitioner reported that the plan was for the patient to complete x-rays “so I knew that I would be talking to [the patient]” and would request the patient be scheduled if there was a need to see the patient.

At the time of the examination, the patient had tachycardia and “some swelling” in feet and ankles. While these findings could be explained by less serious conditions, they could also be signs of cardiomyopathy, and justification to recommend this patient follow up more frequently in the primary care clinic. In addition to monitoring the patient’s pain condition, the OIG would have expected a one-to-three-month follow-up appointment to evaluate medication effectiveness given the patient’s report of recently being prescribed blood pressure medication. Additionally, the OIG would expect a primary care follow-up be scheduled sooner to plan for additional assessment and counseling of the patient regarding the risks of chronic alcohol use, screen and monitor potential alcohol-related health conditions and substance use disorder treatment engagement, and offer substance use disorder treatment, as warranted.

The nurse practitioner advised the patient about the risks of drinking alcohol while taking a prescribed blood pressure medication and encouraged the patient to discontinue drinking. The patient reported attending weekly meetings outside of the VA and “declined need for further treatment through the VA.” The nurse practitioner did not clarify where the patient was receiving substance use disorder treatment and discussed self-help options such as Alcoholics Anonymous.

The OIG found that the nurse practitioner conducted a basic assessment of the patient, provided the patient with substance use disorder treatment information, and reviewed potential medication

interactions and alcohol use. However, the nurse practitioner failed to document a final assessment or medical decision-making as to whether the patient was intoxicated at the time of the visit. Given the patient's presentation of tachycardia, anxiety, and anger, which may be indicators of either alcohol intoxication or withdrawal, the OIG would have expected the nurse practitioner's documentation to include a more thorough assessment of the patient's current condition and risk of alcohol withdrawal, such as the date and time of the patient's last drink and withdrawal history including delirium tremens and seizures. The nurse practitioner's collaborative agreement guides the nurse practitioner to "seek consultation from physicians and other health care providers for more complex diagnostic or therapeutic problems." Although the nurse practitioner had an assigned collaborating physician, the OIG would expect the nurse practitioner to have sufficient education to address the patient's clinical needs that day without consultation.

In an interview with the OIG, the nurse practitioner said that the patient appeared to have been drinking the night before or prior to the appointment. Family Member 2 reported transporting the patient to the appointment, not being allowed to go into the CBOC, and waiting in the vehicle.[65] Although not documented in the patient's EHR, the nurse practitioner reported having assessed whether the patient had been driving and determined that "there was someone" waiting who had driven the patient to the appointment. The OIG would expect the nurse practitioner to have documented the discussion about safe transportation in the patient's EHR.

Failure to thoroughly assess the patient's substance use, schedule follow-up within a reasonable time frame, and discuss immediate safety concerns may have contributed to diminished access to care and compromised patient safety.

Conclusion

The OIG substantiated that Emergency Department staff mismanaged the alcohol withdrawal care of the patient who requested alcohol detoxification and died two days later. Further monitoring or inpatient admission should have been more strongly considered given the patient's risk of complicated withdrawal. Additionally, based on these factors, the OIG considers it likely that the patient's alcohol withdrawal symptoms continued to progress after discharge from the Emergency Department.

The OIG was unable to determine the extent of Family Member 1's involvement in the patient's discharge planning because of the absence of EHR documentation and the conflicting reports provided by Family Member 1 and Physician 2. VHA and facility policy do not require family participation in planning for a patient's Emergency Department discharge. Although a next-day

[65] Facility Policy, "Veteran Health Indiana Visitation Procedures," August 18, 2020. At the time of this appointment, due to COVID-19, the facility allowed a caregiver to accompany a patient to outpatient appointments only when the patient required assistance or care, such as patients with cognitive impairment or language barriers.

SUDRP follow-up was in the patient's discharge plan, EHR documentation did not indicate that Family Member 1 was informed about the care plan.

Facility leaders had not established processes to coordinate care for patients discharged from the Emergency Department. The absence of a process may have resulted in inadequate care coordination of issues needing action by primary care staff, including the patient's alcohol withdrawal symptoms, which likely occurred during the two days following discharge. VHA requires that staff schedule patients upon their arrival at a walk-in clinic, and that staff call patients who do not present to scheduled appointments. However, because the patient did not present to the SUDRP walk-in clinic as advised by Emergency Department staff, the patient did not have a scheduled appointment to prompt outreach.

Emergency Department staff did not add a comment to an existing SUDRP consult in the patient's EHR; therefore, SUDRP staff did not receive notification and follow-up did not occur. Although the OIG is unable to determine if contact with the patient or the patient's family following discharge from the Emergency Department would have prevented the patient's death, outreach might have provided an opportunity for the patient to access care.

VHA requires that primary care teams ensure adequate processes are in place to coordinate care for patients assigned to their team who are discharged from an emergency department. Although VHA requires primary care staff contact patients within two days of discharge from inpatient settings, there is not a similar requirement for care coordination when patients are discharged from the Emergency Department. Facility leaders did not establish procedures for care coordination of patients discharged from the Emergency Department.

The OIG determined that an institutional disclosure should have been considered given Emergency Department staffs' failure to consider additional Emergency Department monitoring of the patient's withdrawal symptoms and inpatient detoxification.

The OIG substantiated that a SUDRP MSA inadequately responded to the patient's report of "bad" withdrawal symptoms and lack of transportation to present to the Emergency Department. Facility leaders had not established policies or procedures for MSAs to address patients' potentially urgent clinical concerns except for reports of suicide-related ideation and behaviors. As a result, the patient did not receive a clinical assessment or treatment scheduling that may have assisted the patient in accessing alcohol use and withdrawal treatment. Lack of facility guidance for MSAs' response to patients who report potentially urgent clinical concerns during appointment scheduling calls may contribute to risk of an adverse clinical outcome and delayed patient care.

The OIG did not substantiate that facility staff failed to provide PTSD care to the patient. Facility staff completed PTSD screens and offered and provided mental health treatment as expected based on VHA requirements.

The OIG found that during one of the patient's CBOC visits, a nurse practitioner failed to thoroughly assess the patient's substance use, schedule follow-up within a reasonable time frame, and discuss immediate safety concerns. These may have contributed to diminished access to care and compromised patient safety.

Recommendations 1–7

1. The Richard L. Roudebush VA Medical Center Director conducts a comprehensive review of the patient's care received in the Emergency Department and primary care setting, consults with the appropriate Human Resources and General Counsel Offices to determine whether any personnel action is warranted, and takes action.

2. The Richard L. Roudebush VA Medical Center Director evaluates the Emergency Department alcohol withdrawal treatment protocol and ensures policy aligns with evidence-based care guidelines.

3. The Richard L. Roudebush VA Medical Center Director considers establishing written procedures for discharge planning in the Emergency Department, including documentation of contact with family members regarding notification of discharge, and follow-up when applicable.

4. The Richard L. Roudebush VA Medical Center Director expedites written guidance for primary care staff's care coordination of patients discharged from the Emergency Department including documentation expectations and oversight responsibilities, and monitors compliance.

5. The Richard L. Roudebush VA Medical Center Director conducts a full review of the patient's care, determines if an institutional disclosure is warranted, and takes action as indicated.

6. The Richard L Roudebush VA Medical Center Director establishes a protocol for the administrative staff management of potentially urgent patient care needs, ensures training, and monitors compliance.

7. The Richard L. Roudebush VA Medical Center Director develops procedures for the management of intoxicated patients in the primary care setting to include documentation of safe transport considerations.

Appendix A: Patient Case Summary 2014–2020

2014

In early 2014, the patient presented to the facility's homeless services program after relocating to the area. That same day, the patient met with a social worker and reported seeking care for back pain that resulted from disc dislocation during military service. The patient reported living in a vehicle, declined emergency housing resources, and reported a plan to travel to Florida. After missing appointments, a social worker documented that the patient had established care in Florida.

2015

In summer 2015, the patient screened positive for PTSD at a VA medical center in Alabama; a psychologist diagnosed the patient with an anxiety disorder, not otherwise specified; and planned treatment for insomnia per the patient's preference. The patient discontinued treatment at the VA medical center in Alabama after two visits with the psychologist.

In late 2015, the patient presented to the facility to transfer care from the VA medical center in Alabama and requested pain medication refills. The patient told a social worker about being diagnosed with PTSD, depression, and attention deficit hyperactivity disorder, and discontinuing medications prescribed during military service. The patient agreed to a mental health counseling appointment and reported interest in medication management for the "diagnosed conditions."

2016

In early 2016, the patient returned as scheduled "to establish primary care." The primary care physician documented that the patient "notes hardware left in cervical spine" from cervical fusion procedure approximately four years earlier. The patient reported "cutting back from heavier drinking in 2012." The patient screened positive for PTSD and negative for suicide risk. The patient told another social worker about being prescribed psychiatric medication while in the military and being diagnosed with "PTSD by the VA in the past." Later that month, in a scheduled psychiatric visit, the patient reported low motivation, nightmares, anxiety triggered by crowds and loud noises, and a PTSD diagnosis. The clinical nurse specialist prescribed an antidepressant that the patient reported taking in the past.

The following week, a chiropractor evaluated the patient for "treatment of chronic back pain" and documented a plan for the patient to follow up weekly for four weeks. Additionally, the patient completed a diagnostic scan and a neurosurgery nurse practitioner recommended physical therapy, chiropractic care, and interventional pain management prior to additional surgery. Approximately a month later, the patient returned for chiropractic care and the chiropractor documented a plan for follow-up; the patient reported not previously continuing care due to being out of state.

In a late winter 2016 appointment, the clinical nurse specialist decreased the antidepressant dose in response to the patient's report of feeling "fidgety/foggy/off" when taking the initial dosage. That same day, the patient attended individual psychotherapy with the social worker and reported "significant pain."

In early spring 2016, a neurosurgery resident documented a plan for additional diagnostic scans, injections, and "depending on cervical films, patient may need posterior fusion" with a plan to follow up in one month. The social worker met with the patient who reported frustration with providers and the treatment of the patient's chronic pain and a plan to relocate to Texas "to get better care." The social worker notified the patient's clinical nurse specialist, primary care physician, and a patient advocate of the patient's concerns. The patient did not present for two scheduled neurosurgery appointments and did not respond to an administrative staff member's phone calls. In fall 2016, the social worker discharged the patient from therapy due to non-attendance since the spring.

At a late fall 2016 primary care appointment, the patient had a positive PTSD screen and reported no use of alcohol in the past year. The primary care physician noted that the "[p]atient declined further assistance for PTSD." The primary care physician documented that the patient had been "out of state," had canceled appointments during that time, and was "not happy" that the appointments were listed as "no-shows." The primary care physician noted a plan for the patient to reschedule missed appointments and provide previous diagnostic scans from a VA medical center in Florida for the next primary care appointment. The patient did not present for the next scheduled primary care appointment and the primary care physician documented a plan to "wait for the [patient] to reschedule." The next day, during a visit with a social worker, the patient requested to enroll in an "anger management class for legal reasons."

2017

The social worker scheduled the patient for an early 2017 appointment with the patient's former social worker for anger management. Staff canceled the appointment due to "provider illness."[66] In fall 2017, the primary care physician requested that the patient be scheduled for pain medication consent and notification of random urine drug screens to continue the prescribed pain medication. The patient did not respond to the outreach calls and did not present to a scheduled primary care appointment." A week later, after the missed appointment, the patient presented to primary care, had negative PTSD and alcohol screens, and reported having one to two alcoholic drinks two to four times per month. The primary care physician documented that the patient "really gets benefit" from the pain medication and the patient signed required consent forms. The primary care physician referred the patient for a clinical pharmacy pain evaluation and the clinical pharmacy specialist documented a plan for continued pain medications and physical

[66] The patient's EHR did not include provision of VA services from early January 2017 until early October 2017.

therapy. In late fall 2017, the patient attended a scheduled physical therapy appointment and requested to be discharged from physical therapy with a home exercise plan.

2018

In spring 2018, the patient did not present to a scheduled primary care appointment and the primary care physician documented a plan to "wait for [the patient] to reschedule."

2019

At a visit in early 2019, the patient reported one or two alcoholic drinks "[m]onthly or less." The patient told the primary care physician about recently returning from out of state and ongoing chronic pain. The patient reported being unable to obtain diagnostic scans from the other VA medical facility and the primary care physician re-prescribed the pain medications. The patient did not present to the next scheduled primary care appointment and the primary care physician again documented a plan to "wait for [the patient] to reschedule." In summer 2019, the primary care physician renewed the patient's pain medication after the patient called the pharmacy contact center for refills.

2020

In late winter 2020, the primary care physician renewed the patient's pain medication after the patient called the pharmacy contact center for refills. In fall 2020, the patient called the pharmacy contact center for a pain medication refill and another primary care physician noted the need for the patient to complete a drug screen before a medication refill was ordered. The patient's primary care physician requested a nurse schedule the patient for laboratory tests and a primary care phone appointment "ASAP" to avoid having the pain medication "cut off." The patient scheduled the appointments and did not present. The primary care physician and licensed practical nurse unsuccessfully attempted to call the patient. The primary care physician left the patient a voicemail message that the pain medication would be discontinued.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 23, 2022

From: Director, VISN 10 VA Healthcare System (10N10)

Subj: Healthcare Inspection—Deficiencies in Emergent and Outpatient Care of a Patient with Alcohol Use Disorder at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana

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

1. I have reviewed the draft report of the Healthcare Inspection - Deficiencies in Emergent and Outpatient Care of a Patient with Alcohol Use Disorder at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana. The unfortunate events provide insight into areas for improvement.

2. I concur with the responses and action plans submitted by the Richard L. Roudebush VA Medical Center Director. We will continue to partner with the Office of Inspector General and leadership at the Richard L. Roudebush VA Medical Center to implement corrective actions to prevent similar situations from occurring in the future. The VISN 10 VA Healthcare System is committed to ensuring Veterans we serve receive exceptional service at our medical centers.

3. Thank you for the opportunity to respond to this report.

(*Original signed by*:)

Laura E. Ruzick, FACHE
Director, VISN 10 VA Healthcare System (10N10)

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 27, 2022

From: Director, Richard L. Roudebush VA Medical Center (583/00)

Subj: Healthcare Inspection—Deficiencies in Emergent and Outpatient Care of a Patient with Alcohol Use Disorder at the Richard L. Roudebush VA Medical Center in Indianapolis, IN

To: Director, VISN 10 VA Healthcare System (10N10)

1. I reviewed the draft report, Deficiencies in Emergent and Outpatient Care of a Patient with Alcohol Use Disorder at the Richard L. Roudebush VA Medical Center and concur with the action plan as submitted.

The Richard L. Roudebush VA Medical Center is committed to honoring our Veterans by ensuring they receive high-quality healthcare services. We deeply regret the circumstances that impacted the quality of care delivered to one of our Veterans. I would like to thank the Office of Inspector General for their thorough review of this case.

2. If you have any additional questions, please contact the Chief, Quality, Safety, and Value (QSV).

(*Original signed by*:)

Michael E. Hershman, MHA, FACHE
Medical Center Director

Facility Director Response

Recommendation 1

The Richard L. Roudebush VA Medical Center Director conducts a comprehensive review of the patient's care received in the Emergency Department and primary care setting, consults with the appropriate Human Resources and General Counsel Offices to determine whether any personnel action is warranted, and takes action.

Concur.

Target date for completion: February 2023

Director Comments

The Richard L. Roudebush VA Medical Center utilizes VA National Center for Patient Safety Just Culture Decision Support Tool in the evaluation of all incidents. Comprehensive clinical reviews and discussions with staff were conducted. The Medical Center Director is consulting with Human Resources and General Counsel to determine if personnel action is warranted.

OIG Comment

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

Recommendation 2

The Richard L. Roudebush VA Medical Center Director evaluates the Emergency Department alcohol withdrawal treatment protocol and ensures policy aligns with evidence-based care guidelines.

Concur.

Target date for completion: April 2023

Director Comments

The American Society of Addiction Medicine (ASAM) guidelines were reviewed both retrospectively in this case and prospectively for application in the facility population. In this case, the ASAM guidelines quote utilization of Prediction of Alcohol Withdrawal Severity Scale (medically ill) or Lubeck Alcohol Withdrawal Risk Scale (> age 55 and medically well) as being potentially predictive of severe alcohol withdrawal. A lack of consensus exists between professional medical organizations regarding the treatment of alcohol withdrawal. Given these differences as well as the lack of applicability of specific guidelines to the Veteran population,

the facility has adopted the VA/Department of Defense (DoD) Clinical Practice Guideline for the Management of Substance Use Disorders, August 2021.

The Office of Mental Health and Suicide Prevention Substance Use Disorder Program office will be consulted to help ensure that the choice of alcohol withdrawal treatment protocol aligns with the evidence-based VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders.

The Quality, Safety, and Value (QSV) Committee will perform chart audits, consistent with The Joint Commission's sample size guidelines, of patients diagnosed with alcohol use disorder discharged from the Emergency Department to monitor compliance with adopted guidelines. Facility will request closure when compliance has been achieved for 6 consecutive months.

Recommendation 3

The Richard L. Roudebush VA Medical Center Director considers establishing written procedures for discharge planning in the Emergency Department, including documentation of contact with family members regarding notification of discharge and follow-up when applicable.

Concur.

Target date for completion: April 2023

Director Comments

The facility adheres to Joint Commission Standards related to Information Management, specifically IM.02.01.01 EP 4, which states the hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation.

The CPRS [Computerized Patient Record System] template for Emergency Department Discharge Plan will be modified to allow for documentation of family communication and potential transportation when authorized by the patient. Follow-up instructions are already present in the current template.

Recommendation 4

The Richard L. Roudebush VA Medical Center Director expedites written guidance for primary care staff's care coordination of patients discharged from the Emergency Department including documentation expectations and oversight responsibilities, and monitors compliance.

Concur.

Target date for completion: April 2023

Director Comments

Written guidance for Primary Care follow-up of Veterans discharged from the Emergency Department will be created and implemented. This guidance will mirror inpatient follow-up guidelines. Applicable National Program Offices will be engaged as an advisory body as these guidelines are developed. The Quality, Safety, and Value Committee will perform chart audits, consistent with The Joint Commission's sample size guidelines, of patients diagnosed with alcohol use disorder discharged from the Emergency Department to monitor compliance with implementation of the guidelines developed in conjunction with the National Program Office. Facility will request closure when compliance has been achieved for 6 consecutive months.

Recommendation 5

The Richard L. Roudebush VA Medical Center Director conducts a full review of the patient's care, determines if an institutional disclosure is warranted, and takes action as indicated.

Concur.

Target date for completion: February 2023

Director Comments

A non-protected clinical review will be performed and institutional disclosure performed as indicated by the results of the review.

OIG Comment

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

Recommendation 6

The Richard L Roudebush VA Medical Center Director establishes a protocol for the administrative staff management of potentially urgent patient care needs, ensures training, and monitors compliance.

Concur.

Target date for completion: February 2023

Director Comments

Administrative staff scripting will be reviewed and updated for urgent patient care needs, including transportation. All Medical Support Assistants interfacing with patients diagnosed with substance abuse disorders will be educated on the updated guidance. The Quality, Safety, and Value Committee will conduct quarterly competency audits with staff to verify compliance with

implementation of updated guidelines. The facility will request closure when compliance has been achieved for 2 consecutive quarters.

OIG Comment

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

Recommendation 7

The Richard L. Roudebush VA Medical Center Director develops procedures for the management of intoxicated patients in the primary care setting to include documentation of safe transport considerations.

Concur.

Target date for completion: February 2023

Director Comments

A CPRS template will be modified to document the clinical assessment of intoxicated patients presenting to Primary Care. Specifically, additional language will be added to formalize the documentation of the counseling and safe transport considerations.

OIG Comment

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

Glossary

To go back, press "alt" and "left arrow" keys.

alcohol use disorder. A pattern of alcohol use within the previous year that leads to significant impairment or distress characterized by drinking larger quantities or for longer periods of time than intended, craving for alcohol, ongoing alcohol use despite recurring problems at home, socially or at work, needing increasing amounts of alcohol to be intoxicated, or experiencing symptoms of alcohol withdrawal.[1]

blood pressure. Blood pressure readings of 120/80 mm HG and below are considered normal and readings above 130/80 mm HG indicate high blood pressure.[2]

breathalyzer. "A device that is used to determine the alcohol content of a breath sample."[3]

cardiomyopathy. "A disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body."[4]

delirium tremens. The most severe form of alcohol withdrawal and a medical emergency that should be managed in an inpatient or intensive care unit setting. Delirium tremens is characterized by fluctuating levels of consciousness, cognition, abnormal vital signs, hallucinations, seizures, and agitation.[5]

gabapentin. An anticonvulsant medication that may be used to treat patients with "moderate to severe alcohol use disorder."[6]

heart rate. "A normal resting heart rate for adults ranges from 60 to 100 beats per minute." A heart rate over 100 beats a minute is considered tachycardia and may indicate an underlying problem.[7]

---

[1] Diagnostic and Statistical Manual of Mental Disorders. "Substance Related and Addictive Disorders," assessed September 8, 2022, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x16_Substance_Related_Disorders#CHDIBCJD.

[2] Mayo Clinic, "Blood pressure chart: What your reading means," accessed February 16, 2022, https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/in-depth/blood-pressure/art-20050982.

[3] Merriam-Webster.com Dictionary, "breathalyzer," accessed March 15, 2022, https://www.merriam-webster.com/dictionary/Breathalyzer#medicalDictionary.

[4] Mayo Clinic, "Cardiomyopathy," accessed July 14, 2022, Cardiomyopathy - Symptoms and causes - Mayo Clinic.

[5] Sandeep Grover and Abhishek Ghosh, "Delirium Tremens: Assessment and Management," Journal of Clinical and Experimental Hepatology 8, (December 2018): 460-470.

[6] "Gabapentin – Drug Summary," Prescribers' Digital Reference, accessed March 15, 2022, https://www.pdr.net/drug-summary/Neurontin-gabapentin-2477.

[7] Mayo Clinic, "What's a normal resting heart rate?," accessed February 16, 2022, https://www.mayoclinic.org/healthy-lifestyle/fitness/expert-answers/heart-rate/faq-20057979.

pancreatitis. Inflammation that occurs when digestive enzymes become activated in the pancreas; the condition can range from a mild case that improves with treatment to a severe case with life threatening complications, and can be caused by alcohol use disorder.[8]

phenobarbital. A sedating medication for the treatment of seizures.[9]

posttraumatic stress disorder. A disorder that may affect people after exposure to a potentially life threatening event or serious injury. Symptoms last longer than one month and must be severe enough to interfere with interpersonal relationships and or work, including re-experiencing symptoms, avoidance symptoms, arousal symptoms, and changes in thoughts or mood.[10]

tachycardia. A heart rate over 100 beats a minute that may be caused by irregular heart rhythms, heavy alcohol use or withdrawal, and high blood pressure; can lead to serious health conditions such as heart failure or stroke.[11]

walk-in. “a person who walks in without an appointment.”[12]

[8] Mayo Clinic, “Pancreatitis,” accessed July 25, 2022, https://www.mayoclinic.org/diseases-conditions/pancreatitis/symptoms-causes/syc-20360227.

[9] “Phenobarbital – Drug Summary,” Prescribers’ Digital Reference, accessed March 15, 2022, https://www.pdr.net/drug-summary/Phenobarbital-Elixir-phenobarbital-2669.3876.

[10] Diagnostic and Statistical Manual of Mental Disorders, “Post-traumatic Stress Disorder,” accessed February 17, 2022, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm07#BABJAEHE.

[11] Mayo Clinic, "tachycardia," accessed June 16, 2022, https://www.mayoclinic.org/diseases-conditions/tachycardia/symptoms-causes/syc-20355127.

[12] Merriam-Webster.com Dictionary, “walk-in,” accessed August 4, 2022, https://www.merriam-webster.com/dictionary/walk-in.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Terri Julian, PhD, Director Stephanie Beres, MSN, MHA Jennifer Caldwell, PhD Dannette Johnson, DO Meggan MacFarlane, LCSW Kelli Toure, LCSW Andrew Waghorn, JD
Other Contributors	Jennifer Baptiste, MD Tabitha Eden, MSN, MSA John Johnson, MD Sarah Mainzer, JD, BSN Erin Mangano, LCSW Natalie Sadow, MBA Elizabeth Winter, MD

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VISN 10: VA Healthcare System (10N10)
Director, Richard L. Roudebush VA Medical Center (583/000)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate:
Mike Braun, Todd Young
U.S. House of Representatives:
James Baird, Jim Banks, Larry Bucshon, Andre Carson, Erin Houchin, Frank J. Mrvan, Greg Pence, Victoria Spartz, Rudy Yakym

OIG reports are available at www.va.gov/oig.