



US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Scheduling Error of the New Electronic Health Record and Inadequate Mental Health Care at the VA Central Ohio Healthcare System in Columbus Contributed to a Patient Death

BE A
VOICE FOR
VETERANS

REPORT WRONGDOING
vaoig.gov/hotline | 800.488.8244

OUR MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

CONNECT WITH US



Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

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.



Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate concerns related to the care of a patient who died due to an accidental inhalant overdose approximately seven weeks after a missed appointment at the VA Central Ohio Healthcare System in Columbus (facility). The concerns were identified during the course of an OIG review of the Veterans Health Administration (VHA) electronic health record (EHR) modernization effort.¹ Specifically, the OIG evaluated facility staff's failure to conduct minimum scheduling efforts due to an error in the functioning of the new EHR following the patient's missed appointment. The OIG also reviewed the adequacy of a primary care advance practice registered nurse's (nurse practitioner) evaluation of the patient, an unlicensed psychologist's (psychologist 1) assessment of the patient's mental health condition, and supervision of psychologist 1. Further, the OIG reviewed the management of caring communications to the patient and the adequacy of leaders' follow-up to an internal review of the patient's care.²

Synopsis of the Patient's Care

In spring 2018, the patient, in their mid-twenties, established care at the VA Cincinnati Healthcare System.³ The patient reported two inpatient mental health admissions due to suicidal ideation, screened positive for alcohol use and depression, and denied current suicidal ideation.

Fall 2018 to Spring 2022

In early fall 2018, the patient was admitted to the VA Cincinnati Healthcare System inpatient mental health unit for six days due to [major depressive disorder](#) with suicidal ideation and [inhalant use disorder](#).⁴ Approximately seven months later, in spring 2019, the patient was readmitted for two days after discontinuing medications and a suicide attempt by suffocation. The patient was assigned a [high risk for suicide patient record flag](#) (high-risk flag).

¹ In 2018, VA awarded Cerner Corporation a contract to replace EHR systems with the system in use by the Department of Defense as part of an initiative to provide VA staff access to patients' EHRs from both military service and non-VA care. "VA Signs Contract with Cerner for an Electronic Health Record System," VA EHR Modernization, accessed March 5, 2024, <https://digital.va.gov/ehr-modernization/news-releases/va-signs-contract-with-cerner-for-an-electronic-health-record-system/>; In June 2022 Oracle acquired Cerner, which is now referred to as Oracle Health. "Oracle Health—Reimagine the Future of Health," Oracle, accessed March 6, 2024, <http://www.oracle.com/health/>.

² VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 1, 2020. The VHA Caring Communications Program includes the mailing of "regular, personalized notes" to patients identified as high risk for suicide.

³ The OIG uses the singular form of they, "their" in this instance, for privacy purposes.

⁴ The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

Approximately a week after the patient's discharge, the patient attempted suicide by overdose and was readmitted for 12 days.

In fall 2019, the patient completed a substance abuse residential rehabilitation treatment program and in spring 2020, was discharged from a Domiciliary Care for Homeless Veterans program due to COVID-19 restrictions.⁵ At the time of this discharge, the patient was diagnosed with alcohol, cannabis, cocaine, and inhalant use disorders.

In late spring 2020, the patient requested to transfer care to the facility due to relocation, and the suicide prevention case manager transferred the patient's high-risk flag and a facility social worker telephoned the patient and completed a [comprehensive suicide risk evaluation](#).⁶ A psychiatrist diagnosed the patient with [posttraumatic stress disorder](#) (PTSD). In late summer 2020, a suicide prevention coordinator inactivated the patient's high-risk flag and noted that the patient "no longer meets criteria."

In late 2020, the patient presented unscheduled to the facility's Mental Health Clinic and reported not sleeping for the previous four days, inhalant use, not taking "medications for 1 month," and suicidal ideation. The patient was admitted to a non-VA inpatient mental health unit and the facility suicide prevention coordinator reactivated the patient's high-risk flag. The patient was discharged from the non-VA inpatient mental health unit three days later with a diagnosis of recurrent and severe major depressive disorder; medications for anxiety, sleep, and depression; and an appointment with a facility psychiatrist six days later.

⁵ "Domiciliary Care for Homeless Veterans Program," VA Homeless Programs, accessed May 15, 2023, <https://www.va.gov/homeless/dchv.asp>; "Definitions of MH RRTPs," VA Homeless Programs, accessed May 15, 2023, https://www.va.gov/HOMELESS/docs/DCHV_Definitions_of_MHRRTPs.pdf. VHA's Domiciliary Care for Homeless Veterans program provides a "24/7 structured and supportive residential environment" as a component of the rehabilitative treatment for homeless veterans. The VA Cincinnati Healthcare System includes a 58-bed domiciliary for homeless veterans; "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19," World Health Organization, accessed May 4, 2023, <https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-COVID-19---11-march-2020>; Merriam-Webster.com Dictionary, "pandemic," accessed May 4, 2023, <https://www.merriam-webster.com/dictionary/pandemic>. A pandemic is "an outbreak of a disease that occurs over a wide geographic area (such as multiple countries or continents) and typically affects a significant proportion of the population"; "Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It," World Health Organization, accessed May 4, 2023, [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

⁶ VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008; VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010; Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Update to High Risk for Suicide Patient Record Flag Changes," January 16, 2020. VHA Directive 1166, *Patient Record Flags*, November 6, 2023; The 2023 directive rescinds and replaces the 2010 directive. Unless otherwise specified, the 2023 directive contains the same or similar language regarding high risk flag transfers as the 2010 directive. When a patient transfers care to another VA site, "the transferring site" suicide prevention coordinator is required to transfer the care and ownership of the patient record flag to the patient's new site and notify the receiving site suicide prevention coordinator about the patient's transfer.

The psychiatry appointment was “cancelled by clinic” and the patient did not attend the rescheduled appointment on the following day.⁷ Four weeks later, the patient called the social worker and reported being employed, denied recent suicidal ideation, “confirmed interest in therapy and expressed desire to be seen in person,” and reported having discontinued medication.

Over the next month, multiple staff attempted to contact the patient by telephone and the social worker also spoke with a family member who reported that the patient was “not doing real well” and “won’t take” medications.

In spring 2021, another social worker attempted a home visit and was unable to gain access to the patient’s residence and could not leave a voice message because the patient’s voicemail “was full.” Through mid to late spring 2021, staff attempted unsuccessfully to contact the patient by telephone and mail.

In late spring 2021, a suicide prevention case manager contacted another family member who agreed to ask the patient to call the suicide prevention case manager. The suicide prevention coordinator documented that the patient “has not been consistent with treatment” and “has not connected with the VA despite frequent outreach attempts” and inactivated the patient’s high-risk flag. Later the same day, the suicide prevention case manager documented that a family member left “a message stating that veteran is doing okay,” and “has a new phone number but did not provide it.”

Spring 2022

Over 10 months later, on a day in mid-spring 2022 (day 1), a behavioral health nurse (nurse) placed an order for an appointment for the patient with psychologist 1 for two days later (day 3).⁸ Later on day 1, during a telephone primary care visit with the nurse practitioner to “re-establish care with the VA and Mental Health,” the patient screened negative for suicide risk and depression.⁹ The patient reported not taking mental health medications since 2020 and “would like to discuss restarting medications.” The nurse practitioner documented that the patient “already has a follow up with [mental health] on [day 3] to discuss.”¹⁰ The nurse practitioner

⁷ Staff document an appointment as ‘cancelled by clinic’ when a clinic or provider is unable to provide care to the patient at the scheduled time.

⁸ The patient’s EHR did not include documentation regarding what prompted the nurse’s scheduling of a mental health appointment for the patient.

⁹ VISN 10 Specialty Care Integrated Clinical Community SharePoint Site, “VHA National EHRM Supplemental Staffing Unit (NESSU),” [https://dvagov.sharepoint.com/sites/VISN10SpecialtyICC/SitePages/VHA-National-EHRM-Supplemental-Staffing-Unit-\(NESSU\).aspx](https://dvagov.sharepoint.com/sites/VISN10SpecialtyICC/SitePages/VHA-National-EHRM-Supplemental-Staffing-Unit-(NESSU).aspx). (This site is not publicly accessible.) The nurse practitioner provided clinical care at the facility through the VHA National EHR Modernization Supplemental Staffing Unit, a temporary resource to support staffing levels during training and implementation of the new EHR. The nurse practitioner reported working for a different VHA healthcare system prior to working for the VHA EHR Modernization Supplemental Staffing Unit.

¹⁰ In spring 2022, providers began entering this patient’s medical information in the new EHR.

ordered laboratory tests and entered a return to clinic order for approximately two weeks later with a primary care physician.¹¹

On day 2, the nurse reported completion of a safety plan with the patient by telephone. At the appointment with psychologist 1 on day 3, the patient reported last using inhalants two years prior and denied “current cravings.” Psychologist 1 documented that the patient “was concerned about it being ‘harder to get out of bed,’ so [the patient] thought” about needing to “‘get back into [therapy].’” The patient “explained that this was a sign prior to [the patient’s] mental health decline and suicidal thoughts in the past,” and reported that “many” suicidal thoughts occurred during inhalant use. The patient screened negative for suicide risk, acknowledged a “wish to be dead/not awake” over the past month, as well as other mental health symptoms, including trouble falling asleep, decreased appetite, and a lack of interest in previously enjoyed activities.

Psychologist 1 assessed the patient as having a “reaction to severe stress, unspecified,” and “suicidal ideations,” with a plan for the patient to “return in two weeks to address [the patient’s] concern regarding [the patient’s] motivation. Veteran is not currently interested in medication management.” Per psychologist 1’s return to clinic order, a medical support assistant scheduled an appointment for the patient 11 days later (day 14). The patient missed the appointment on day 14 and psychologist 1 left a voicemail message for the patient and requested a medical support assistant attempt to contact the patient by telephone and an outreach letter. Later that day, the medical support assistant left a voicemail message and mailed a letter. On day 16, the patient missed a primary care appointment and the physician placed a return to clinic order.

Approximately a month after the missed primary care appointment, on day 45, an advanced medical support assistant called the patient and sent an outreach letter to reschedule.

On day 136, the assistant chief of Health Information Management documented that an individual from a funeral home reported that the patient died on day 56. The death certificate listed the patient’s cause of accidental death as [acute cardiac arrhythmia](#) “due to (or as a consequence of) acute toxic effect of inhalant.” On day 158, the facility Chief of Staff; chief, Behavioral Health; and risk manager completed an institutional disclosure with a family member. The risk manager documented discussing that “we have recently been made aware, that a scheduling error, contributed to a missed opportunity for an appointment in the Behavioral Health department” at the facility and that “leadership of the organization would like to apologize for the missed appointment that created an interruption in [the patient’s] care.”

OIG Findings

The OIG confirmed that a system error in the functioning of the new EHR resulted in staff’s failure to complete required minimum scheduling efforts following the patient’s missed mental

¹¹ VA Manual, *CPRS GUI v31a (PATCH OR*3.0*434)*, *Release Notes*, October 2017. “The Return to Clinic (RTC) feature enables providers to place an order requesting that scheduling set up a return appointment for the patient.”

health appointment with psychologist 1 on day 14.¹² On the day of the patient's missed appointment, psychologist 1 and the advanced medical support assistant each telephoned the patient, and a letter was sent. However, staff did not complete the required three telephone calls on separate days.¹³ The OIG found that the patient's missed appointment, although updated to no-show status, was not routed to a request queue and, as a result, schedulers were not prompted to conduct required rescheduling efforts. The OIG concluded that the lack of contact efforts may have contributed to the patient's disengagement from mental health treatment and ultimately the patient's substance use relapse and death.

On day 64, a facility administrative officer filed an Oracle Health incident ticket to report that canceled and no-show appointments were not routing to the appropriate rescheduling queue.¹⁴ On day 135, Oracle Health staff documented that the issue "has been resolved" and "we did a comprehensive review of all impacted patients and have provided that data" to the EHR Modernization Integration Office.¹⁵ The next day, the assistant chief of Health Information Management documented that an individual from a funeral home reported that the patient died on day 56. On day 141, the risk manager reported to facility leaders that the patient's death was identified during the facility's review of impacted patients. On day 157, VA announced that new EHR deployments would be delayed for approximately eight months because "technical and system issues were identified," including "problems with patient scheduling."¹⁶

On day 158, facility leaders completed an institutional disclosure, and the risk manager noted "that a scheduling error, contributed to a missed opportunity for an appointment in the Behavioral Health department" and that "leadership of the organization would like to apologize

¹² Since 2019, VHA requires staff to document four attempts to reschedule missed mental health appointments, including three telephone calls on separate days and a letter following any of the telephone calls. VHA Notice, *Minimum Scheduling Effort Required for Outpatient Appointments: Updates to VHA Directive 1230 and VHA Directive 1232(1)*, April 24, 2019; *VHA Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure (SOP)*, updated October 26, 2021.

¹³ VHA Notice, *Minimum Scheduling Effort Required for Outpatient Appointments: Updates to VHA Directive 1230 and VHA Directive 1232(1)*, April 24, 2019; *VHA Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure (SOP)*, updated October 26, 2021.

¹⁴ VA OIG, [New Patient Scheduling System Needs Improvement as VA Expands Its Implementation](#), Report No. 21-00434-233, November 10, 2021. Once the facility implemented the new EHR, employees "were able to report system issues and limitations through information technology tickets—electronically or by calling Cerner."

¹⁵ The VA EHR Modernization Integration Office is responsible for new EHR implementation oversight. "Electronic Health Record Modernization," VA EHR Modernization, accessed April 24, 2023, <https://digital.va.gov/ehr-modernization/>.

¹⁶ "VA extends delay of upcoming electronic health record deployments to June 2023 to address technical and other system performance issues," VA News, accessed June 6, 2023, <https://news.va.gov/press-room/va-extends-delay-of-upcoming-electronic-health-record-deployments-to-june-2023-to-address-technical-and-other-system-performance-issues/>.

for the missed appointment that created an interruption in [the patient's] care.” Approximately three months later, facility leaders completed a root cause analysis.¹⁷

Standards of practice for nurse practitioners advise that when assessing patients, a “comprehensive relevant health, social, and medical history” is obtained and health risk factors are identified.¹⁸ The OIG found that the nurse practitioner did not evaluate the patient's reasons for wanting to restart mental health medication and did not obtain a comprehensive history of the patient's mental health condition to promote a coordinated approach to address the patient's treatment needs. Although the patient's suicide risk and depression screen scores did not prompt a need for further assessment, the patient acknowledged a history of suicidal behavior and recent symptoms of depression. In an interview with the OIG, the nurse practitioner reported reviewing the patient's EHR and explained not assessing further since the patient was not in distress, denied suicidal ideation, and was scheduled for a mental health appointment.

Although psychologist 1 completed the initial outpatient appointment documentation and screened the patient for suicide risk as required by VHA, the OIG found that psychologist 1 did not thoroughly evaluate or address the patient's severe depression and failed to reconcile critical clinical treatment information.¹⁹ Based on the patient's initial request for medication and history of inpatient mental health unit admissions due to suicidal behaviors following medication discontinuation, the OIG would have expected psychologist 1 to provide [psychoeducation](#) about the benefits of medication to promote the patient's willingness to consult with a mental health medication prescriber. Further, the OIG would have expected the supervisory psychologist to identify concerns about the patient's current level of depression, associated risks for substance use relapse, and suicidal behavior, and ensure follow-up with the patient to resolve the patient's initial medication request.

VHA requires suicide prevention coordinators to send patients at least monthly caring communications for a minimum of one year following high-risk flag inactivation.²⁰ In summer 2021, a suicide prevention coordinator failed to communicate the inactivation to the program support assistant for the patient's inclusion in the Caring Communication Program upon inactivation of the patient's second high-risk flag. The OIG concluded that staff's failure to send the patient caring communications upon high-risk flag inactivation may have contributed to the

¹⁷ VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. A root cause analysis is a “comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls.”

¹⁸ “Standards of Practice for Nurse Practitioners,” American Association of Nurse Practitioners, accessed July 26, 2023, <https://www.aanp.org/advocacy/advocacy-resource/position-statements/standards-of-practice-for-nurse-practitioners>.

¹⁹ VA Memorandum, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy),” November 13, 2020.

²⁰ VHA Notice 2020-13, *Inactivation Process for Category I High Risk for Suicide Patient Record Flags*, 03-27-2020; VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 1, 2020.

patient's lack of treatment engagement until 10 months later when the patient's depression symptoms had worsened, and the patient reached out to reestablish care. The division director, Suicide Prevention, told the OIG that since May 2022, the program support assistant accesses a data dashboard and "that each month we can verify every veteran who appears on the list is receiving caring contacts."

The OIG found that the root cause analysis identified a Lesson Learned regarding suicide prevention, and facility leaders did not communicate the information to staff, as expected. While identified root causes and causal factors are to remain confidential by the root cause analysis team and leaders, Lessons Learned "should always be shared to promote transparency and a learning environment," and may be shared with the facility, Veterans Integrated Services Network, and VHA.²¹ The OIG also found that VHA does not provide written guidance related to the documentation, leaders' review, follow-up actions, and tracking of Lessons Learned.²² The OIG determined that the absence of written VHA guidance regarding the documentation, leaders' review, follow-up actions, and tracking of Lessons Learned likely contributed to facility leaders' failure to consider, address, and communicate the Lesson Learned at the time of the patient's root cause analysis.

The OIG determined that starting in May 2022, VHA implemented new EHR minimum scheduling effort procedures that require fewer contact attempts than VHA's minimal scheduling efforts for missed mental health appointments.²³ In an interview with the OIG, the Director, Optimization of Integrated Access, acknowledged responsibility for the oversight of minimum scheduling requirement policies and procedures for the new EHR and explained that the new EHR software did not readily track contact attempts for specific appointments and the required

²¹ VHA National Center for Patient Safety, *Guide to Performing a Root Cause Analysis*, revised February 5, 2021. This guide was in place during the time of the events discussed in this report. It was updated and replaced with VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis, Version 10*, March 2023. Unless otherwise specified, the 2023 guide contains the same or similar language regarding RCA processes as the 2021 guide.

²² VHA National Center for Patient Safety, *Guide to Performing a Root Cause Analysis*, revised February 5, 2021. This guide was in place during the time of the events discussed in this report. It was updated and replaced with VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis, Version 10*, March 2023. Unless otherwise specified, the 2023 guide contains the same or similar language regarding RCA processes as the 2021 guide.

²³ This standard operating procedure was effective after the patient's missed appointment and the chief, Behavioral Health, told the OIG that facility staff followed VHA policy of three phone contact attempts and a letter for patients who missed mental health appointments. *Cerner Minimum Scheduling Effort SOP*, May 24, 2022. This standard operating procedure was replaced by *Cerner Minimum Scheduling Effort SOP*, July 28, 2022; *Cerner Minimum Scheduling Effort SOP*, September 1, 2022; and *Cerner Minimum Scheduling Effort SOP*, November 1, 2022. Unless otherwise specified, the May 24, 2022, standard operating procedure contains the same or similar language regarding minimum scheduling efforts in the new EHR as the July, September, and November 2022 standard operating procedures. VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016; VHA Notice, *Minimum Scheduling Effort Required for Outpatient Appointments: Update to VHA Directive 1230 and VHA Directive 1232(1)*, April 24, 2019; VHA Notice, *Mandatory Use of the Electronic Health Record and Process to Resolve Identified Concerns*, July 26, 2022.

minimum scheduling efforts were reduced to “make this workable.” The Director, Optimization of Integrated Access, confirmed not meeting with VHA mental health leaders regarding the standard operating procedure.

The minimum scheduling efforts standard operating procedure establishes a different standard of care based on the EHR system used at the site at which a patient seeks mental health services. Different scheduling contact requirements could result in a disparity in access to care. The OIG would expect requirements for minimum scheduling efforts to maximize opportunities to engage patients in care and for VHA leaders to focus on identification of strategies to address administrative barriers such as software capabilities without compromising established VHA patient care standards.

The OIG made one recommendation to the Deputy Secretary related to establishing ongoing monitors to ensure that scheduling procedures in the new EHR are functioning in accordance with VHA requirements.

The OIG made two recommendations to the Under Secretary for Health related to taking action to ensure the implementation of standardized minimum scheduling effort requirements for mental health appointments in the best interest of patient care, and establishing written guidance related to documentation, leaders’ review, follow-up actions, and tracking of Lessons Learned in root cause analyses.

The OIG made two recommendations to the Facility Director related to conducting a full review of the care of the patient and supervisory oversight and ensuring compliance with the Caring Communication Program including the initiation and cessation of caring communications as required.

Comments

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



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

Contents

Executive Summary	i
Abbreviations	xi
Introduction.....	1
Scope and Methodology	3
Patient Case Summary	4
VA Cincinnati Healthcare System Care from Spring 2018–Spring 2020	4
Facility Care from Spring 2020–Spring 2022	5
Inspection Results	9
1. New EHR Missed Appointment Scheduling Error, VA Response to the Scheduling Error, and VHA Scheduling Procedure Inconsistency	9
2. Failure to Effectively Evaluate and Address the Patient’s Treatment Needs	16
3. Failure to Send Caring Communications	23
4. Failure to Communicate a Lesson Learned.....	24
Conclusion	28
Recommendations 1–5.....	30
Appendix A: Deputy Secretary Memorandum	31
Appendix B: Office of the Under Secretary for Health Memorandum	33
Appendix C: VISN Director Memorandum.....	36
Appendix D: Facility Director Memorandum.....	37

Glossary	40
OIG Contact and Staff Acknowledgments	42
Report Distribution	43

Abbreviations

EHR	electronic health record
OIG	Office of Inspector General
PTSD	posttraumatic stress disorder
STORM	Stratification Tool for Opioid Risk Mitigation
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate concerns related to the care of a patient who died due to an accidental inhalant overdose approximately seven weeks after a missed appointment at the VA Central Ohio Healthcare System in Columbus (facility). The concerns were identified during the course of an OIG review of the Veterans Health Administration (VHA) electronic health record (EHR) modernization effort.¹ Specifically, the OIG evaluated facility staff's failure to conduct minimum scheduling efforts due to an error in functioning of the new EHR following the patient's missed appointment. Approximately seven weeks after the missed appointment, the patient died due to an accidental inhalant overdose. The OIG also reviewed the adequacy of a primary care advance practice registered nurse's (nurse practitioner) evaluation of the patient, an unlicensed psychologist's (psychologist 1) assessment of the patient's mental health condition, and supervision of psychologist 1. Further, the OIG reviewed the management of caring communications to the patient and the adequacy of leaders' follow-up to an internal review of the patient's care.²

Background

The facility, part of Veterans Integrated Service Network (VISN) 10, provided healthcare services to over 40,000 patients from October 1, 2020, to September 30, 2021. The facility and its four community-based outpatient clinics provide outpatient services in mental health, primary care, urgent care, specialty medicine, and ambulatory surgery.³

The New EHR

In 2018, VA awarded Cerner Corporation a contract to replace EHR systems with the system in use by the Department of Defense as part of an initiative to provide VA staff access to patients'

¹ In 2018, VA awarded Cerner Corporation a contract to replace EHR systems with the system in use by the Department of Defense as part of an initiative to provide VA staff access to patients' EHRs from both military service and non-VA care. "VA Signs Contract with Cerner for an Electronic Health Record System," VA EHR Modernization, accessed March 5, 2024, <https://digital.va.gov/ehr-modernization/news-releases/va-signs-contract-with-cerner-for-an-electronic-health-record-system/>; In June 2022 Oracle acquired Cerner, which is now referred to as Oracle Health. "Oracle Health—Reimagine the Future of Health," Oracle, accessed March 6, 2024, <http://www.oracle.com/health/>.

² VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 1, 2020. The VHA Caring Communications Program includes the mailing of "regular, personalized notes" to patients identified as high risk for suicide.

³ "Locations," VA Central Ohio Health Care, accessed May 4, 2023, <https://www.va.gov/central-ohio-health-care/locations/>. The facility's four community-based outpatient clinics are located in Grove City, Marion, Newark, and Zanesville, Ohio.

EHRs from both military service and non-VA care.⁴ In August 2020, the facility was the first VHA site to implement the patient scheduling system component of the new EHR. The new EHR was implemented at the facility by May 2022. The following month, Oracle Corporation acquired Cerner Corporation and became Oracle Health.⁵ The VA EHR Modernization Integration Office is responsible for new EHR implementation oversight.⁶

Prior OIG Reports

In November 2021, the OIG reported that VA leaders did not fully resolve known system and process limitations during new EHR implementation at the facility and the Mann-Grandstaff VA Medical Center in Spokane, Washington. In the 2021 report, the OIG reviewed new EHR system vulnerabilities, although the missed appointment routing error discussed in the current inspection was not identified at that time.⁷ As of May 2023, four of eight recommendations were closed.

In March 2022, the OIG evaluated care coordination deficiencies with the new EHR scheduling process at the Mann-Grandstaff VA Medical Center and found that the routing for scheduling requests “caused orders to populate as an ‘unknown’ appointment type with a location that could not be scheduled.”⁸ As of May 2023, the one recommendation to the Deputy Secretary to ensure that substantiated and unresolved allegations were reviewed and addressed remained open.

A July 2022 OIG report evaluated patient safety concerns resulting from a new EHR issue that routed orders to an undetectable location, or unknown queue, rather than to the intended service. The OIG determined that the new EHR routing failure identified in the current inspection was distinct from the unknown queue routing error described in the July 2022 report.⁹ As of February 2023, the OIG had closed the two recommendations to the Deputy Secretary to review the process that led to Oracle Health’s failure to inform VA of the unknown queue and to evaluate the unknown queue technology and mitigation process.

⁴ “About Oracle Cerner,” Oracle Cerner, accessed February 7, 2023, <https://www.cerner.com/oracle>; “Electronic Health Record Modernization,” VA EHR Modernization, accessed April 24, 2023, <https://digital.va.gov/ehr-modernization/>.

⁵ “About Oracle Cerner,” Oracle Cerner, accessed February 7, 2023, <https://www.cerner.com/oracle>.

⁶ “Electronic Health Record Modernization,” VA EHR Modernization, accessed April 24, 2023, <https://digital.va.gov/ehr-modernization/>.

⁷ VA OIG, *New Patient Scheduling System Needs Improvement as VA Expands Its Implementation*, Report No. 21-00434-233, November 10, 2021.

⁸ VA OIG, *Care Coordination Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-00781-109, March 17, 2022.

⁹ VA OIG, *The New Electronic Health Record’s Unknown Queue Caused Multiple Events of Patient Harm*, Report No. 22-01137-204, July 14, 2022.

Concerns

In October 2022, during the course of another OIG review of the VHA EHR modernization effort, the OIG identified concerns at the facility, including that

1. staff did not conduct minimum scheduling efforts due to errors in the new EHR,
2. the nurse practitioner failed to complete an adequate initial assessment of the patient,
3. psychologist 1 failed to adequately evaluate the patient's mental health treatment needs, and
4. the supervisory psychologist failed to ensure an adequate evaluation of the patient's mental health condition.

During the healthcare inspection, the OIG identified additional concerns related to VA minimum scheduling efforts policy discrepancies, facility leaders' failure to communicate Lessons Learned in a root cause analysis for the patient, and failure to send caring communications to the patient.

Scope and Methodology

The OIG initiated the inspection on November 1, 2022, and conducted a virtual site visit January 9–12, 2023.¹⁰

The OIG team interviewed facility staff and leaders familiar with the patient's care and relevant processes and the Director, Optimization of Integrated Access, VHA Office of Integrated Veteran Care.¹¹

The OIG reviewed the patient's EHR; relevant VHA directives, handbooks, and memoranda; facility policies and standard operating procedures; credentialing and privileging committee minutes; facility leaders' reviews and actions related to the patient's care; and state requirements for the supervision of unlicensed psychologists.

¹⁰ 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 May 4, 2023, <https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-COVID-19---11-march-2020>; Merriam-Webster.com Dictionary, "pandemic," accessed May 4, 2023, <https://www.merriam-webster.com/dictionary/pandemic>. A pandemic is "an outbreak of a disease that occurs over a wide geographic area (such as multiple countries or continents) and typically affects a significant proportion of the population"; "Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It," World Health Organization, accessed May 4, 2023, [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

¹¹ The VHA Office of Integrated Veteran Care "is a national program office that manages and advocates for Veterans' and beneficiaries' access to health care in both VA and community facilities." VA, "Community Care," accessed September 28, 2023, <https://www.va.gov/COMMUNITYCARE/about-us/index.asp>.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Patient Case Summary

Starting in 2018, while in their mid-twenties, the patient received care at the VA Cincinnati Healthcare System for over two years before transferring to the facility.¹²

VA Cincinnati Healthcare System Care from Spring 2018–Spring 2020

In spring 2018, the patient presented to a primary care clinic to establish care at the VA Cincinnati Healthcare System. A primary care physician referred the patient for mental health services for follow-up on the patient’s positive screenings for alcohol use and depression. The next day, a mental health provider documented that the patient denied current suicidal ideation and “had two brief back-to-back” inpatient mental health admissions due to suicidal ideation. The patient requested “[medication evaluation] only at this point” and the patient was scheduled for a medication management appointment 12 days later.¹³

From summer 2018 through fall 2019, the patient intermittently engaged in mental health and substance use treatment. In early fall 2018, the patient was admitted to the VA Cincinnati Healthcare System inpatient mental health unit for six days due to [major depressive disorder](#) with suicidal ideation and [inhalant use disorder](#).¹⁴ Following discharge, the patient engaged in outpatient mental health treatment and medication management. Approximately seven months later, in spring 2019, the patient was readmitted for two days after discontinuing medications and a suicide attempt by suffocation. The patient was assigned a [high risk for suicide patient record flag](#) (high-risk flag). Approximately a week after the patient’s discharge, the patient attempted suicide by overdose and was readmitted for 12 days.

¹² The OIG uses the singular form of they, “their” in this instance, for privacy purposes.

¹³ The patient missed the medication management appointment scheduled for 12 days after psychologist 1’s referral.

¹⁴ The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the “alt” and “left arrow” keys together.

In fall 2019, the patient completed a substance abuse residential rehabilitation treatment program and then was admitted to a Domiciliary Care for Homeless Veterans program.¹⁵ In spring 2020, a social worker documented that the Domiciliary Care for Homeless Veterans program “suspended services in support of COVID-19 mitigation efforts. This resulted in the veteran being discharged prior to full completion.” At the time of this discharge, the patient was diagnosed with alcohol, cannabis, cocaine, and inhalant use disorders.

Approximately six weeks later, a suicide prevention case manager documented that the patient had not engaged in mental health follow-up since domiciliary discharge and contacted the patient, who declined virtual treatment options and expressed a preference for face-to-face treatment.

In late spring 2020, the patient requested to transfer care to the facility due to relocation, and the suicide prevention case manager transferred the patient’s high-risk flag that day.¹⁶

Facility Care from Spring 2020–Spring 2022

The same day, in late spring 2020, that the patient’s high-risk flag was transferred to the facility, a facility social worker telephoned the patient and completed a [comprehensive suicide risk evaluation](#). Five days later, a psychiatrist diagnosed the patient with [posttraumatic stress disorder](#) (PTSD) and documented the patient’s history of [military sexual trauma](#) and use of alcohol, cannabis, cocaine, and inhalants.

During an early summer 2020 mental health appointment, a psychologist (psychologist 2) documented that the patient reported cocaine use and requested to resume PTSD treatment. From mid to late summer 2020, the patient participated in outpatient psychotherapy with psychologist 2. In late summer 2020, a suicide prevention coordinator inactivated the patient’s high-risk flag and noted that the patient “no longer meets criteria.” The suicide prevention coordinator cited the comprehensive suicide risk evaluation completed in early summer 2020 that indicated the patient was at “low acute risk” for suicide.

¹⁵ “Domiciliary Care for Homeless Veterans Program,” VA Homeless Programs, accessed May 15, 2023, <https://www.va.gov/homeless/dchv.asp>; “Definitions of MH RRTPs,” VA Homeless Programs, accessed May 15, 2023, https://www.va.gov/HOMELESS/docs/DCHV_Definitions_of_MHRRTPs.pdf. VHA’s Domiciliary Care for Homeless Veterans program provides a “24/7 structured and supportive residential environment” as a component of the rehabilitative treatment for homeless veterans. The VA Cincinnati Healthcare System includes a 58-bed domiciliary for homeless veterans.

¹⁶ VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008; VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010; Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, “Update to High Risk for Suicide Patient Record Flag Changes,” January 16, 2020; VHA Directive 1166, *Patient Record Flags*, November 6, 2023; The 2023 directive rescinds and replaces the 2010 directive. Unless otherwise specified, the 2023 directive contains the same or similar language regarding high risk flag transfers as the 2010 directive. When a patient transfers care to another VA site, “the transferring site” suicide prevention coordinator is required to transfer the care and ownership of the patient record flag to the patient’s new site and notify the receiving site suicide prevention coordinator about the patient’s transfer.

In late summer 2020, psychologist 2 placed a consult for the patient's ongoing care with another psychologist due to psychologist 2's "transferring," and provided the patient with contact information for the other psychologist (psychologist 3). Approximately two weeks later, the patient met with psychologist 3 via video. The patient did not show for the next four scheduled video appointments with psychologist 3 and staff were unable to reach the patient to reschedule.

One day in late 2020, over three months after the patient met with psychologist 3, the patient, accompanied by a family member (family member 1), presented unscheduled to the facility's Mental Health Clinic and was "seeking voluntary hospitalization for suicidal thoughts." The patient reported lack of sleep for the previous four days, inhalant use, and not taking "medications for 1 month." The patient reported suicidal ideation with a plan and was "not willing to discuss the plan." A physician assistant noted that the nearest VA medical center was "closed to acute psychiatric patient care because of COVID" and recommended that the patient go to a non-VA hospital. The physician assistant placed a consult for community care.

Later that same day, the patient was admitted to a non-VA inpatient mental health unit. A non-VA psychiatrist documented that the patient told staff about wanting to try a different antidepressant medication "but told me" about wanting to continue the same medication "at least until [the patient] sees" the "[outpatient] provider at VA." While the patient was admitted to the non-VA hospital, the facility suicide prevention coordinator reactivated the patient's high-risk flag. After three days, a non-VA physician discharged the patient with a diagnosis of recurrent and severe major depressive disorder; medications for anxiety, sleep, and depression; and an appointment with a facility psychiatrist six days later.

On the day of the scheduled psychiatric follow-up appointment, a clerk entered that the appointment was "cancelled by clinic" and the appointment was rescheduled for the following day.¹⁷ The patient did not attend the rescheduled appointment. The psychiatrist, a Behavioral Health nurse (nurse), and the suicide prevention coordinator attempted to reach the patient by phone over the following week.

Almost two weeks after the missed appointment, in early 2021, the social worker unsuccessfully attempted to reach the patient and contacted a family member of the patient (family member 2). Family member 2 reported the patient had been "struggling," and "agreed to give veteran the message to contact" the social worker.

Five days later, the social worker sent the patient a text message requesting a call after reaching the patient's full voicemail box; two days after that, the nurse sent an outreach letter to the patient because the patient's voicemail box was still full.

Over a week after the nurse's contact attempts, the patient called the social worker and reported being employed and "doing ok right now." The patient denied recent suicidal ideation,

¹⁷ Staff document an appointment as 'cancelled by clinic' when a clinic or provider is unable to provide care to the patient at the scheduled time.

“confirmed interest in therapy and expressed desire to be seen in person,” and reported having discontinued taking medication and not being “interested in medication.” The social worker completed a comprehensive suicide risk evaluation and documented that the patient was at “High ACUTE Risk” and “Intermediate CHRONIC Risk” for suicide. The social worker included psychologist 3 as an additional signer on the note to “alert to veteran’s request for in person therapy.” Psychologist 3, who was leaving the facility, telephoned the patient to discuss “options for continuing care, left message requesting return call.”

Approximately two weeks later, the social worker contacted the patient “for follow up and assessment” and the patient “reported that the at home setting wasn’t right for” the patient’s treatment. Over the next month, the social worker, the nurse, and a supervisory psychologist attempted to contact the patient. Due to the patient’s “lack of recent clinical contact,” the social worker contacted family member 2, who reported that the patient was “not doing real well” and “won’t take” medications. The same day, the suicide prevention coordinator documented that the patient’s high risk record flag “will be continued and re-evaluated in 90 days.” Approximately one week later, in early spring 2021, the nurse could not reach the patient by phone and mailed an outreach letter.

Another social worker attempted a home visit with the patient and “was unable to reach the Veteran’s front door due to the layout of the building/locked door into the building” and could not leave a voice message because the patient’s voicemail “was full.” Through mid- to late-spring 2021, staff attempted to contact the patient by telephone and mail.

In late spring 2021, a suicide prevention case manager contacted family member 2, left a voicemail message, and five days later contacted another family member (family member 3) who reported that the patient had changed phone numbers and agreed to ask family member 2 to have the patient call the suicide prevention case manager.

The suicide prevention coordinator documented that the patient “has not been consistent with treatment” and “has not connected with the VA despite frequent outreach attempts” and inactivated the patient’s high-risk flag. Later the same day, the suicide prevention case manager documented that family member 2 left “a message stating that veteran is doing okay,” and that the patient was “working full time night shift and bought a car,” and “has a new phone number but did not provide it.”

Spring to Summer 2022

Over 10 months later, on a day in mid-spring 2022 (day 1), the nurse placed an order for an appointment for the patient with a psychologist two days later (day 3).¹⁸ Later on day 1, during a telephone primary care visit with a nurse practitioner to “re-establish care with the VA and

¹⁸ The patient’s EHR did not include documentation regarding what prompted the nurse’s scheduling of a mental health appointment for the patient.

Mental Health,” the patient screened negative for suicide risk and depression.¹⁹ The patient reported not taking mental health medications since 2020 and “would like to discuss restarting medications.” The nurse practitioner documented that the patient “already has a follow up with [mental health] on [day 3] to discuss.”²⁰ The nurse practitioner ordered laboratory tests and entered a return-to-clinic order for approximately two weeks later with a primary care physician.²¹

On day 2, the nurse completed a safety plan with the patient by telephone.²² At the appointment with psychologist 1 on day 3, the patient reported last using inhalants two years prior and denied “current cravings.” Psychologist 1 documented that the patient “was concerned about it being ‘harder to get out of bed,’ so [the patient] thought” about needing to “‘get back into [therapy].’” The patient “explained that this was a sign prior to [the patient’s] mental health decline and suicidal thoughts in the past,” and reported that “many” suicidal thoughts occurred during inhalant use. The patient screened negative for suicide risk, acknowledged a “wish to be dead/not awake” over the past month, as well as other mental health symptoms including trouble falling asleep, decreased appetite, and a lack of interest in previously enjoyed activities.

Psychologist 1 assessed the patient as having a “reaction to severe stress, unspecified,” and “suicidal ideations,” with a plan for the patient to “return in two weeks to address [the patient’s] concern regarding [the patient’s] motivation. Veteran is not currently interested in medication management.” Per psychologist 1’s return to clinic order, a medical support assistant scheduled an appointment for the patient 11 days later (day 14). The patient missed the appointment on day 14 and psychologist 1 left a voicemail message for the patient and requested a medical support assistant attempt to contact the patient by telephone and an outreach letter. Later that day, the medical support assistant left a voicemail message and mailed a letter. On day 16, a primary care physician documented that the patient missed an appointment and placed a return-to-clinic order. Approximately a month after the missed primary care appointment on day 45, an advanced medical support assistant called the patient and sent an outreach letter to reschedule.

¹⁹ VA/DoD, *Clinical Practice Guideline for the Management of Major Depressive Disorder*, Version 4.0, February 2022; VISN 10 Specialty Care Integrated Clinical Community SharePoint Site, “VHA National EHRM Supplemental Staffing Unit (NESSU),” [https://dvagov.sharepoint.com/sites/VISN10SpecialtyICC/SitePages/VHA-National-EHRM-Supplemental-Staffing-Unit-\(NESSU\).aspx](https://dvagov.sharepoint.com/sites/VISN10SpecialtyICC/SitePages/VHA-National-EHRM-Supplemental-Staffing-Unit-(NESSU).aspx). (This site is not publicly accessible.); The nurse practitioner provided clinical care at the facility through the VHA National EHR Modernization Supplemental Staffing Unit, a temporary resource to support staffing levels during training and implementation of the new EHR. The nurse practitioner reported working for a different VHA healthcare system prior to working for the VHA National EHR Modernization Supplemental Staffing Unit.

²⁰ In spring 2022, providers began entering this patient’s medical information in the new EHR.

²¹ VA Manual, *CPRS GUI v31a (PATCH OR*3.0*434)*, *Release Notes*, October 2017. “The Return to Clinic (RTC) feature enables providers to place an order requesting that scheduling set up a return appointment for the patient.”

²² In an interview, the nurse told the OIG about calling the patient on day 2 to complete the safety plan.

EHR Documentation Following Notification of the Patient's Death

On day 136, the assistant chief of Health Information Management documented that an individual from a funeral home reported that the patient died on day 56. The death certificate listed the patient's cause of accidental death as [acute cardiac arrhythmia](#) "due to (or as a consequence of) acute toxic effect of inhalant." On day 158, the Chief of Staff, chief, Behavioral Health, and risk manager completed an institutional disclosure with family member 2. The risk manager documented discussing that "we have recently been made aware, that a scheduling error, contributed to a missed opportunity for an appointment in the Behavioral Health department" at the facility and that "leadership of the organization would like to apologize for the missed appointment that created an interruption in [the patient's] care."

Inspection Results

1. New EHR Missed Appointment Scheduling Error, VA Response to the Scheduling Error, and VHA Scheduling Procedure Inconsistency

The OIG confirmed that a system error in the functioning of the new EHR resulted in staff's failure to complete required minimum scheduling efforts following the patient's missed appointment with psychologist 1 on day 14. Over the next seven to eight months, Oracle Health staff, and facility and VA leaders addressed this system error and other new EHR problems. In addition, in May 2022, the VHA Office of Integrated Veteran Care implemented new EHR minimum scheduling effort procedures that require fewer contact attempts than VHA minimal scheduling efforts for missed mental health appointments.²³

New EHR Missed Appointment Scheduling Error

Since 2019, VHA requires staff to document four attempts to reschedule missed mental health appointments, including three telephone calls on separate days and a letter following any of the telephone calls.²⁴ In the new EHR, when a patient does not present for a scheduled appointment, schedulers are required to update the appointment status to "no show." The updated "no show"

²³ *Cerner Minimum Scheduling Effort SOP*, May 24, 2022. This standard operating procedure was replaced by *Cerner Minimum Scheduling Effort SOP*, July 28, 2022; *Cerner Minimum Scheduling Effort SOP*, September 1, 2022; and *Cerner Minimum Scheduling Effort SOP*, November 1, 2022. Unless otherwise specified, the May 24, 2022, standard operating procedure contains the same or similar language regarding minimum scheduling efforts in the new EHR as the July, September, and November 2022 standard operating procedures; VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016; VHA Notice, *Minimum Scheduling Effort Required for Outpatient Appointments: Update to VHA Directive 1230 and VHA Directive 1232(1)*, April 24, 2019; VHA Notice, *Mandatory Use of the Electronic Health Record and Process to Resolve Identified Concerns*, July 26, 2022.

²⁴ VHA Notice, "Minimum Scheduling Effort Required for Outpatient Appointments: Updates to VHA Directive 1230 and VHA Directive 1232(1)," April 24, 2019; *VHA Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure (SOP)*, updated October 26, 2021.

appointment status routes the patient's information to a request queue that alerts schedulers to the need to initiate rescheduling efforts.²⁵

On day 14, psychologist 1 alerted an advanced medical support assistant and the supervisory psychologist to the patient's missed appointment. Psychologist 1 left the patient a voicemail message and requested that the advanced medical support assistant "make a second contact attempt and send a scheduling letter as needed." That same day, the advanced medical support assistant updated the patient's appointment status to "no show," left the patient a voicemail message, and sent a letter.

On the day of the patient's missed appointment, psychologist 1 and the advanced medical support assistant each telephoned the patient, and a letter was sent. However, staff did not complete the required three telephone calls on separate days.²⁶ The OIG found that the implementation of the new EHR scheduling application resulted in a rescheduling error that contributed to staff's failure to adhere to minimum scheduling requirements for the patient's missed mental health appointment. Specifically, the OIG found that the patient's missed appointment, although updated to no-show status, was not routed to a request queue and, as a result, schedulers were not prompted to conduct required rescheduling efforts. The OIG concluded that the lack of contact efforts may have contributed to the patient's disengagement from mental health treatment and, ultimately, the patient's substance use relapse and death.

VA Response to the Scheduling Error

In November 2021, the OIG reported that once the facility implemented the new EHR, employees "were able to report system issues and limitations through information technology tickets—electronically or by calling Cerner."²⁷

A facility administrative officer identified that patient orders were not routing to the appropriate queue and, on day 64, filed an Oracle Health incident ticket to report "Cancelled/No Showed veterans not falling into any cancel/no show queue." The administrative officer told the OIG that "We try to ticket pretty quickly," and estimated the ticket was entered on the same day or "within a couple of days" of the identification of the error. On day 100, the facility administrative officer informed Oracle Health staff that

"The veterans that cancel, no show, or that are displaced now populate into the appropriate queues. That being said I believe our facility is still awaiting a final

²⁵ VA Office of EHR Modernization, REG 200, *Registration and Scheduling Foundations*, March 2, 2023.

²⁶ VHA Notice, "Minimum Scheduling Effort Required for Outpatient Appointments: Updates to VHA Directive 1230 and VHA Directive 1232(1)," April 24, 2019; VHA *Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure (SOP)*, updated October 26, 2021.

²⁷ VA OIG, [New Patient Scheduling System Needs Improvement as VA Expands Its Implementation](#), Report No. 21-00434-233, November 10, 2021.

audit of the veterans effected [*sic*] . . . Those veterans will need to be reviewed to ensure that no one has fallen through the cracks.”

The facility acting patient safety manager reported that three weeks later, on day 121, facility leaders received a list of impacted patients and initiated a clinical review.

On day 135, Oracle Health staff documented that the issue “has been resolved” and “we did a comprehensive review of all impacted patients and have provided that data” to the EHR Modernization Integration Office. The next day, the assistant chief of Health Information Management documented that an individual from a funeral home reported that the patient died on day 56. On day 141, the risk manager reported to facility leaders that the patient’s death was identified during the facility’s review of impacted patients.

On day 157, VA announced that new EHR deployments would be delayed for approximately eight months because “technical and system issues were identified,” including “problems with patient scheduling.”²⁸ VA and VHA leaders established the EHR Modernization Sprint Team to develop solutions for concerns with the new EHR implementation, including no show and cancelled appointment orders failing to route to scheduling queues.²⁹

Facility leaders completed an institutional disclosure with family member 2 on day 158. In the applicable EHR documentation, the risk manager noted “that a scheduling error, contributed to a missed opportunity for an appointment in the Behavioral Health department” and that “Leadership of the organization would like to apologize for the missed appointment that created an interruption in [the patient’s] care.” Approximately three months later, on day 255, facility leaders completed a root cause analysis.³⁰

Around day 296, VA reported implementing five of six EHR Modernization Sprint Team’s solutions for the scheduling queue errors with plans to implement the sixth within six months.³¹ Approximately seven weeks later, on day 347, VA reported pausing additional EHR

²⁸ “VA extends delay of upcoming electronic health record deployments to June 2023 to address technical and other system performance issues,” VA News, accessed June 6, 2023, <https://news.va.gov/press-room/va-extends-delay-of-upcoming-electronic-health-record-deployments-to-june-2023-to-address-technical-and-other-system-performance-issues/>.

²⁹ VA/VHA, *Electronic Health Record Modernization (EHRM) Sprint Report*, March 2023. The EHR Modernization Sprint Team was established following the day 157 announcement. Within EHR systems, queues capture orders that may not route to the proper location within the system and serve as a safety net for monitoring and resolution to ensure “prompt patient care and integrity of the system.”

³⁰ VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. A root cause analysis is a “comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls.”

³¹ VA/VHA, *Electronic Health Record Modernization (EHRM) Sprint Report*, March 2023.

implementation “until it is confident that the system is highly functioning at current sites and ready to deliver for Veterans and VA clinicians at future sites.”³² (See figure 1.)

³² "EHR Deployment Schedule," VA EHR Modernization, accessed April 24, 2023, <https://digital.va.gov/ehr-modernization/resources/ehr-deployment-schedule/>.

Scheduling Error of the New Electronic Health Record and Inadequate Mental Health Care at the VA Central Ohio Healthcare System in Columbus Contributed to a Patient Death

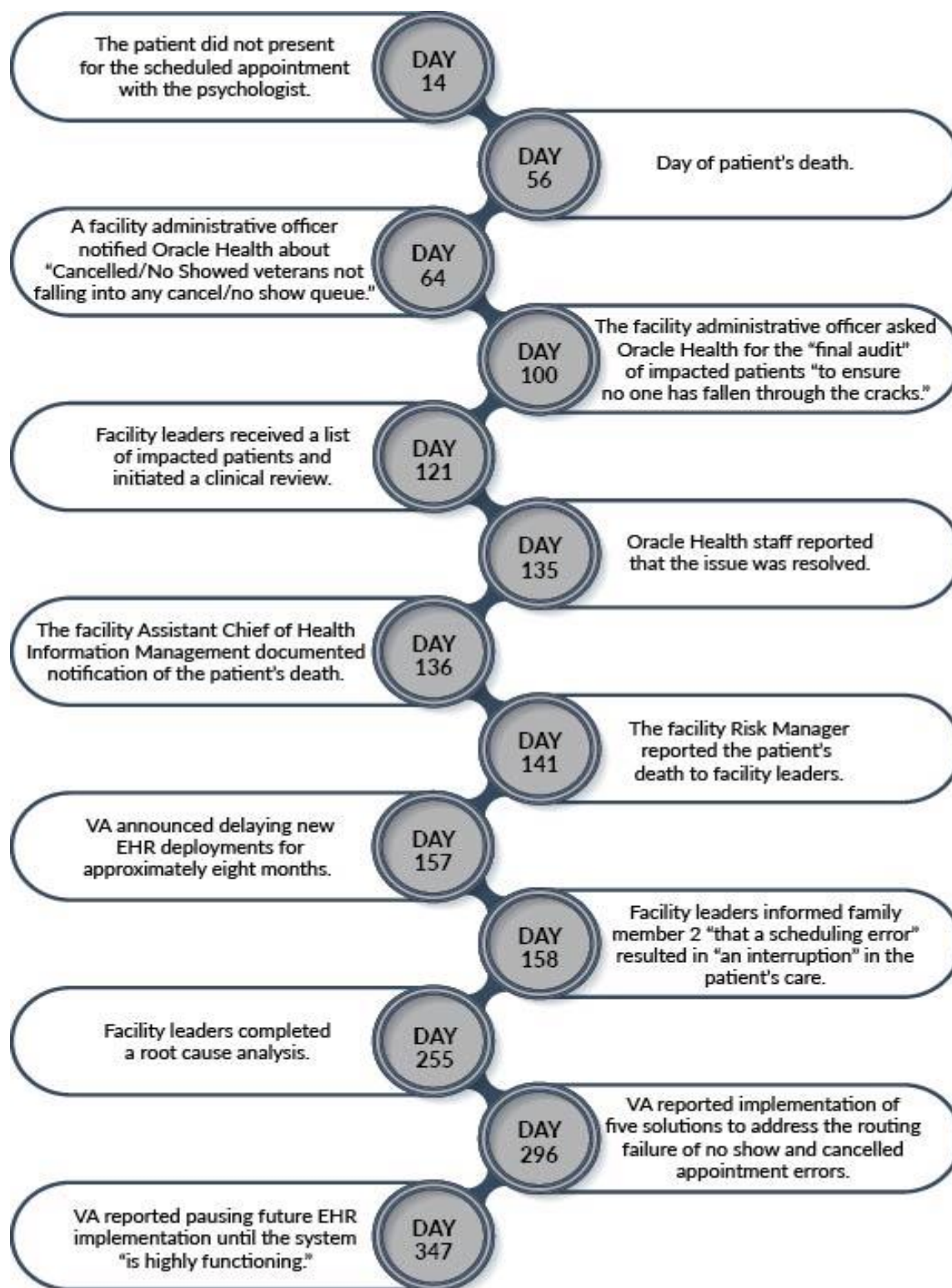


Figure 1. VA actions in response to the new EHR scheduling error.
Source: OIG review of the patient's EHR and VA documentation.

VHA Scheduling Procedure Inconsistency

In 2019, VHA confirmed that staff were required to document four attempts to reschedule missed mental health appointments, including three telephone calls on separate days and a letter following any of the telephone calls.³³ The Director of Analytics, Innovations and Collaborations explained that “three [telephone calls] was settled on as a means of showing kind of going above and beyond. We didn’t just call once; we didn’t just call twice. We made multiple attempts to try to engage,” and that this was an arbitrary decision.³⁴

In May 2021, VHA required staff to use the new EHR “as the official system for health care records immediately upon deployment at their VA medical facility.”³⁵ VHA acknowledged “expected conflicts” between the new EHR “applications and workflows” and “existing policies and other documents, such as standard operating procedures and clinical guidelines.”³⁶ VHA instructed that the new EHR workflows “supersede any conflicting national or local policy or other national or local issuance.”³⁷

In May 2022, the VHA Office of Integrated Veteran Care implemented a standard operating procedure “to establish procedures on Minimum Scheduling Effort for scheduling and rescheduling appointments” in the new EHR.³⁸ The standard operating procedure requires staff to complete two documented contact attempts following a patient’s missed mental health

³³ VHA Notice, *Minimum Scheduling Effort Required for Outpatient Appointments: Updates to VHA Directive 1230 and VHA Directive 1232(1)*, April 24, 2019.

³⁴ VHA Notice, *Minimum Scheduling Effort Required for Outpatient Appointments: Updates to VHA Directive 1230 and VHA Directive 1232(1)*, April 24, 2019. The Director of Analytics, Innovations and Collaborations is the listed point of contact from the Office of Mental Health and Suicide Prevention in the notice.

³⁵ VHA Notice 2021-07, *Mandatory Use of the Electronic Health Record and Process to Resolve Identified Concerns*, May 3, 2021; VHA Notice 2022-08, *Mandatory Use of the Electronic Health Record and Process to Resolve Identified Concerns*, July 26, 2022. Unless otherwise specified, the 2022 notice contains the same or similar language regarding use of the new EHR and identified concerns as 2021 notice.

³⁶ VHA Notice 2021-07, *Mandatory Use of the Electronic Health Record and Process to Resolve Identified Concerns*, May 3, 2021; VHA Notice 2022-08, *Mandatory Use of the Electronic Health Record and Process to Resolve Identified Concerns*, July 26, 2022. Unless otherwise specified, the 2022 notice contains the same or similar language regarding use of the new EHR and identified concerns as 2021 notice.

³⁷ VHA Notice 2021-07, *Mandatory Use of the Electronic Health Record and Process to Resolve Identified Concerns*, May 3, 2021; VHA Notice 2022-08, *Mandatory Use of the Electronic Health Record and Process to Resolve Identified Concerns*, July 26, 2022. Unless otherwise specified, the 2022 notice contains the same or similar language regarding use of the new EHR and identified concerns as 2021 notice.

³⁸ This standard operating procedure was effective after the patient’s missed appointment and the chief, Behavioral Health, told the OIG that facility staff followed VHA policy of three phone contact attempts and a letter for patients who missed mental health appointments. *Cerner Minimum Scheduling Effort SOP*, May 24, 2022. This standard operating procedure was replaced by *Cerner Minimum Scheduling Effort SOP*, July 28, 2022; *Cerner Minimum Scheduling Effort SOP*, September 1, 2022; and *Cerner Minimum Scheduling Effort SOP*, November 1, 2022. Unless otherwise specified, the May 24, 2022, standard operating procedure contains the same or similar language regarding minimum scheduling efforts in the new EHR as the July, September, and November 2022 standard operating procedures.

appointment.³⁹ Staff must note a need for additional contact attempts in the scheduling instructions of the order “if it is clinically indicated.”⁴⁰

In an interview with the OIG, the Director, Optimization of Integrated Access acknowledged responsibility for the oversight of minimum scheduling requirement policies and procedures for the new EHR and explained that the new EHR software did not readily track contact attempts for specific appointments and the required minimum scheduling efforts were reduced to “make this workable.” The Director, Optimization of Integrated Access confirmed that “my team did not meet with Mental Health at the time to discuss the [minimum scheduling effort standard operating procedure].” Following the OIG interview, the Director, Optimization of Integrated Access contacted the Director of Analytics, Innovations and Collaborations within the Office of Mental Health and Suicide Prevention.

In July 2023, the Director of Analytics, Innovations and Collaborations told the OIG that “I was focused on COMPACT [Act] implementation and this fell off my radar.”⁴¹ When asked thoughts about the two contact attempts standard operating procedure for new EHR sites, the Director of Analytics, Innovations and Collaborations said, “I’d be happier if it said two attempts and then a letter so we’re still at three,” which was the “original [Deputy Under Secretary for Health for Operations and Management’s] intent” for mental health scheduling. The Director of Analytics, Innovations and Collaborations reported initiating a plan to establish a “field-based work group” the day after speaking with the OIG and that the work group will develop recommendations for the Office of Mental Health and Suicide Prevention leadership within 60 days.

The minimum scheduling efforts standard operating procedure establishes a different standard of care based on the EHR system used at the site at which a patient seeks mental health services. Different scheduling contact requirements could result in a disparity in access to care. The OIG would expect requirements for minimum scheduling efforts to maximize opportunities to engage patients in care. Further, the OIG would expect VHA leaders to focus on identification of

³⁹ *Cerner Minimum Scheduling Effort SOP*, May 24, 2022. This standard operating procedure was replaced by *Cerner Minimum Scheduling Effort SOP*, July 28, 2022; *Cerner Minimum Scheduling Effort SOP*, September 1, 2022; and *Cerner Minimum Scheduling Effort SOP*, November 1, 2022. The first contact attempt should be via the patient’s “preferred contact modality” by “telephone, secure message, or email.” The September 1, 2022, standard operating procedure specified that if the second contact was a letter it could be sent the same day as the first contact. The following standard operating procedures note that the second contact attempt “is required to be a different modality than the first contact attempt and should not be made on the same day as first contact attempt.”

⁴⁰ *Cerner Minimum Scheduling Effort SOP*, May 24, 2022. This standard operating procedure was replaced by *Cerner Minimum Scheduling Effort SOP*, July 28, 2022; *Cerner Minimum Scheduling Effort SOP*, September 1, 2022; and *Cerner Minimum Scheduling Effort SOP*, November 1, 2022. Unless otherwise specified, the May 24, 2022, standard operating procedure contains the same or similar language regarding additional contact attempts. If additional contact attempts are indicated, attempts must be made using a different modality.

⁴¹ Veterans COMPACT Act of 2020, Pub. L. No. 116-214, accessed July 19, 2023, <https://www.congress.gov/bill/116th-congress/house-bill/8247>. The Veterans Comprehensive Prevention, Access to Care, and Treatment Act of 2020 or the Veterans COMPACT Act of 2020 “implements programs, policies, and reports related to Department of Veterans Affairs (VA) transition assistance, suicide care, mental health education and treatment, health care, and women veteran care.”

strategies to address administrative barriers such as software capabilities without compromising established VHA patient care standards.

2. Failure to Effectively Evaluate and Address the Patient's Treatment Needs

The OIG found that the nurse practitioner did not evaluate the patient's reasons for wanting to restart mental health medication and did not obtain a comprehensive history of the patient's mental health condition to promote a coordinated approach to address the patient's treatment needs. Although psychologist 1 completed the initial outpatient appointment documentation and screened the patient for suicide risk, as required by VHA, the OIG found that psychologist 1 did not thoroughly evaluate or address the patient's severe depression and failed to reconcile critical clinical treatment information.⁴² Based on the patient's initial request for medication and history of inpatient mental health unit admissions due to suicidal behaviors following medication discontinuation, the OIG would have expected psychologist 1 to provide [psychoeducation](#) about the benefits of medication to promote the patient's willingness to consult with a mental health medication prescriber. Further, the OIG would have expected the supervisory psychologist to identify concerns about the patient's current level of depression, associated risks for substance use relapse and suicidal behavior, and ensure follow-up with the patient to resolve the patient's initial medication request.

Inadequate Primary Care Assessment

The OIG found that the nurse practitioner's failure to obtain a comprehensive history and identify health risk factors contributed to an insufficient patient-centered and coordinated approach to the patient's treatment needs.

Throughout VHA, "Primary Care promotes team based, patient-centered care focusing on a personalized, integrated, comprehensive, and coordinated approach to health care."⁴³ Primary care providers include physicians, nurse practitioners, and physician assistants.⁴⁴ Primary care providers document patients' stated reason for the appointment as the chief complaint. Standards of practice for nurse practitioners advise that when assessing patients a "comprehensive relevant health, social, and medical history" is obtained and health risk factors are identified.⁴⁵

⁴² VA Memorandum, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020.

⁴³ "VA Primary Care," Patient Care Services, accessed July 26, 2023, <https://www.patientcare.va.gov/primarycare/index.asp>.

⁴⁴ "Primary Care," Centers for Medicare & Medicaid Services, accessed July 26, 2023, <https://innovation.cms.gov/key-concept/primary-care>.

⁴⁵ "Standards of Practice for Nurse Practitioners," American Association of Nurse Practitioners, accessed July 26, 2023, <https://www.aanp.org/advocacy/advocacy-resource/position-statements/standards-of-practice-for-nurse-practitioners>.

At the primary care appointment on day 1, the patient's chief complaint was to reestablish mental health care and obtain medications. The patient reported discontinuing three mental health medications two years prior and wanting "to discuss restarting medications." The nurse practitioner documented that the patient "already has a follow up with [mental health] on [day 3] to discuss." The nurse practitioner also documented the patient's history of "depression, anxiety and PTSD," monthly alcohol use in the last year, and use of other substances over a year ago. The patient denied "any" suicidal ideation and "other health concerns," and screened negative for depression and suicide risk.⁴⁶

On the suicide risk screen, the patient acknowledged a history of suicidal behavior and wishing to be dead or not wake up from sleep over the past month, and on the depression screen reported several days of "feeling down, depressed, or hopeless" during the prior two weeks.⁴⁷ However, the patient's suicide risk and depression screens scores did not prompt a need for further assessment. In an interview with the OIG, the nurse practitioner reported reviewing the patient's EHR and explained not assessing further since the patient was not in distress, denied suicidal ideation, and "already had an appointment set up on" day 3 with "mental health."

However, given that this was the patient's initial primary care appointment at the facility with a chief complaint of wanting to restart medication after two years, and the patient's history of depression and PTSD diagnoses, the OIG would have expected the nurse practitioner to

- document the patient's history of inpatient mental health unit admissions and suicidal behaviors,
- assess the patient's depression symptoms beyond the depression screen,
- evaluate the patient's substance use urges and abstinence plan, and
- inquire about the patient's reasons for requesting medication at that time.

The deputy chief of Behavioral Health told the OIG that a [handoff](#) between the nurse practitioner and the nurse "was a really well-done piece" that allowed the nurse to complete a safety plan prior to the patient's appointment with psychologist 1.⁴⁸ However, the nurse practitioner did not document a handoff communication and confirmed to the OIG not having done a handoff because the patient was scheduled for a mental health appointment.

In an interview with the OIG, the nurse explained completing the safety plan with the patient on day 2 because of awareness of the patient's scheduled visit with psychologist 1 on day 3, the

⁴⁶ VA/DoD, *Clinical Practice Guideline for the Management of Major Depressive Disorder*, Version 4.0, February 2022.

⁴⁷ VA/DoD, *Clinical Practice Guideline for the Management of Major Depressive Disorder*, Version 4.0, February 2022.

⁴⁸ Given that the patient was not presenting with urgent treatment needs, and was scheduled to establish mental health treatment, the OIG would not expect handoff communication from the nurse practitioner to mental health staff member.

patient having been on the high risk for suicide list in the past, and having completed prior safety plans with the patient. When asked about being contacted by or provided information from the nurse practitioner, the nurse reported not finding “anything” and not remembering contact from the nurse practitioner. When questioned by the OIG about the patient’s initial request to restart medication, the supervisory psychologist stated that “we didn’t really get a great picture from primary care.” The deputy chief of Behavioral Health’s erroneous understanding of handoff communication between the nurse practitioner and the nurse may have contributed to insufficient review of the nurse practitioner’s care of the patient and failure to identify performance or systemic deficiencies.

The nurse practitioner’s lack of a comprehensive assessment likely contributed to an incomplete understanding of the patient’s current concerns, condition, and risk factors, and a subsequent failure to promote a coordinated approach to address the patient’s treatment needs given the absence of valuable clinical information for the patient’s scheduled mental health appointment.

Inadequate Mental Health Evaluation and Supervisory Oversight

Although psychologist 1 completed the initial outpatient appointment documentation and screened the patient for suicide risk as required by VHA, the OIG found that psychologist 1 did not thoroughly evaluate or address the patient’s severe depression and failed to reconcile critical clinical treatment information.⁴⁹ The OIG found that the supervisory psychologist provided clinical supervision to psychologist 1 consistent with VHA policy and Ohio State law, although did not identify concerns about the patient’s current level of depression, associated risks for substance use relapse and suicidal behavior, and ensure follow-up with the patient.⁵⁰

Clinical practice guidelines advise completion of a risk assessment and diagnostic work-up when a patient presents with “suspected depression or is positive on a depression screen.” For patients who meet diagnostic criteria for major depressive disorder, guidelines recommend the provider develop and initiate a treatment plan using shared decision-making and “considering patient preference,” including medication management.⁵¹ Mental health conditions such as depression and PTSD may contribute to an individual’s use of alcohol or other drugs to self-medicate.⁵²

⁴⁹ VA Memorandum, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy),” November 13, 2020.

⁵⁰ VHA Directive 1027, *Supervision of Psychologists, Social Workers, Professional Mental Health Counselors, and Marriage and Family Therapists Preparing for Licensure*, October 23, 2019; VHA Directive 1027 (1), *Supervision of Psychologists, Social Workers, Professional Mental Health Counselors, and Marriage and Family Therapists Preparing for Licensure*, October 23, 2019, amended March 8, 2023. Unless otherwise specified, the amended directive contains the same or similar language regarding supervision requirements as 2019 directive; Ohio Admin. Code 4732-13-04, Requirements pertaining to supervision (2018).

⁵¹ VA/DoD, *Clinical Practice Guideline for the Management of Major Depressive Disorder*, Version 4.0, February 2022.

⁵² National Institute of Mental Health, *Substance Use and Co-Occurring Mental Disorders*, accessed July 31, 2023, <https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health>.

In addition, VHA requires psychologists to hold a current state license to practice psychology.⁵³ Unlicensed psychologists may provide patient care for up to two years with supervision provided by a licensed psychologist. The supervisor must follow state regulations and address deficiencies in supervisees' provision of care.⁵⁴ Ohio State law requires a supervisor to retain records for five years, including notes regarding reviewed patient care.⁵⁵

Psychologist 1 was unlicensed and hired in late summer 2021, and the supervisory psychologist initiated supervision 10 days later.⁵⁶ The supervisory psychologist provided the OIG with one year of supervisory notes ending on day 141 that reflected regular supervisory contact and included two notes about the patient, the day before and the day after the patient's appointment with psychologist 1 on day 3.

On day 2, the supervisory psychologist documented that the patient was previously identified as high risk for suicide. At the visit on day 3, the patient "was concerned about it being 'harder to get out of bed,'" and that "this was a sign prior to" the patient's "mental health decline and suicidal thoughts in the past." The patient presented with [flat affect](#) and reported not going to work due to this concern and described "issues falling asleep," decreased appetite, and loss of interest in activities. Psychologist 1 documented that the patient "noted that some of these changes started to occur about two months ago."

The patient "reported recently having passive suicidal thoughts," denied a recent suicide plan, intent, or attempts, and screened negative on a suicide risk screen.⁵⁷ The patient also reported suicidal thoughts in the past while using inhalants, two years of abstinence, and denied "current cravings" or access to firearms or medications that could be used to overdose.

Psychologist 1 assessed the patient as having "reaction to severe stress, unspecified" and "suicidal ideations," and did not document an assessment of the patient's depression beyond completion of the depression screen. Based on psychologist 1's documentation of the patient's reported symptoms, the OIG concluded that the patient met the diagnostic criteria for major depressive disorder. (See table 1.) The OIG determined that psychologist 1 did not complete a thorough assessment of the patient's mood disorder as expected given the patient's history and

⁵³ VHA Directive 1027, *Supervision of Psychologists, Social Workers, Professional Mental Health Counselors, and Marriage and Family Therapists Preparing for Licensure*, October 23, 2019; VHA Directive 1027 (1), *Supervision of Psychologists, Social Workers, Professional Mental Health Counselors, and Marriage and Family Therapists Preparing for Licensure*, October 23, 2019, amended March 8, 2023. Unless otherwise specified, the amended directive contains the same or similar language regarding supervision requirements as the 2019 directive.

⁵⁴ VHA Directive 1027.

⁵⁵ Ohio Admin. Code 4732-13-04, Requirements pertaining to supervision (2018).

⁵⁶ Psychologist 1 obtained licensure in July 2022 and received facility leaders' approval for independent practice on September 8, 2022.

⁵⁷ "The Columbia Protocol (C-SSRS), "About the Protocol," The Columbia Lighthouse Project, accessed March 1, 2023, <https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/>. Psychologist 1 administered the Columbia-Suicide Severity Rating Scale (C-SSRS), an evidence-based suicide risk assessment tool that uses a "series of simple, plain language questions that anyone can ask."

presentation at the visit. When the OIG asked why a depressive disorder was not documented, psychologist 1 described considering a “trauma diagnosis” and being “very cautious to diagnose certain things from one interaction.” Psychologist 1 further explained, “I felt like I didn’t have enough to say for sure one versus the other, or are both there? I would have wanted to get more information on the symptoms and timeline of things myself.”

Table 1. Major Depressive Disorder Diagnostic Criteria and Patient’s Symptoms

Major Depressive Disorder Diagnostic Criteria	EHR Documentation of the Patient’s Reported Symptoms
Five (or more) symptoms present during the same two-week period	“some of these changes started to occur about two months ago”
Change from previous functioning	“was concerned about it being ‘harder to get out of bed’”
	“this was a sign prior to [the patient’s] mental health decline and suicidal thoughts in the past”
Depressed mood most of the day, nearly every day (feels sad, empty, hopeless, or tearful)	Not evaluated; however, on day 1, the nurse practitioner documented that the patient reported <ul style="list-style-type: none"> wishing to be dead or not wake up from sleep over the past month, and several days of “feeling down, depressed, or hopeless” during the prior two weeks.
Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day	“endorsed a lack of interest in previously enjoyed activities”
Significant weight loss or weight gain, or decrease or increase in appetite nearly every day	“denied having an appetite”
	“not eating as much”
	“Have you been eating 1/2 of what you normally eat because of a decreased appetite?: Yes”
Insomnia or hypersomnia nearly every day	“issues falling asleep”
Psychomotor agitation or retardation nearly every day (observable by others)	“Psychomotor Activity: Within Normal Limits”
Fatigue or loss of energy nearly every day	Not evaluated.
Feelings of worthlessness or excessive or inappropriate guilt nearly every day	Not evaluated.
Diminished ability to think or concentrate, or indecisiveness, nearly every day	Not evaluated.
Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, a specific suicide plan, or a suicide attempt	“having dreams about death”
	“Passive [suicidal ideation]”

Scheduling Error of the New Electronic Health Record and Inadequate Mental Health Care at the VA Central Ohio Healthcare System in Columbus Contributed to a Patient Death

	"Over the past month, have you wished you were dead or wished you could go to sleep and not wake up?: Yes"
The symptoms cause clinically significant distress or impairment in social, occupational, or other areas of functioning	"previously went to the gym and was more social"
	"Barriers to Activities: Mental health"
	"Significant change in typical activities: Yes"
	"skipp[ing] work' due to" the patient's concern about mental health
The episode is not attributable to the physiological effects of a substance or other medical condition	use of inhalants, with patient report of "last using two years ago"
	"Current Physical Conditions Impacting MH Treatment: No"

Source: *Diagnostic and Statistical Manual of Mental Disorders*; *OIG review of patient's EHR*.

Note: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition – Text Revision (DSM-5-TR)*, "Depressive Disorders," accessed May 10, 2023, https://dsm.psychiatryonline.org/doi/10.1176/appi.books.9780890425787.x04_Depressive_Disorders.

The patient's chief complaint at the day 1 primary care visit was to restart mental health medication. On day 3, psychologist 1 documented that the patient "is not currently interested in medication management."

From 2017 through late 2020, the patient was admitted to inpatient mental health treatment six times with four of the admissions occurring after the patient's 2018 engagement with VHA care.⁵⁸ The patient discontinued antidepressant medication prior to the latter three inpatient mental health unit admissions in 2019 and 2020. The supervisory psychologist acknowledged not discussing the patient's history of admissions and medication discontinuation in supervision.

Psychologist 1 reported to the OIG not knowing why the patient was not scheduled with a mental health prescriber given the patient's initial request for medication and speculated that "perhaps I was the quickest available."⁵⁹ Psychologist 1 reported a standard practice of informing the patient about the treatment team members and roles and that if the patient was interested in medication, psychologist 1 could "connect them with the prescriber."

The nurse explained that patients were at times seen by the first available provider, usually a psychologist, with the option to be referred to psychiatry after the initial mental health appointment, as clinically indicated. In an interview with the OIG, the supervisory psychologist stated it is psychologist 1's standard practice to ask about medications during an initial assessment, and noted the ability for psychologist 1 to provide a direct referral to the team

⁵⁸ The patient's EHR included documentation related to six inpatient mental health unit admissions with two in 2017, one in 2018, two in 2019, and one in late 2020.

⁵⁹ Prescribers, professionals with license and authority to prescribe medication, include physicians, advance practice registered nurses, and physician assistants.

psychiatrist as needed. The supervisory psychologist further noted that discussion about medication management is typically ongoing but could not be readdressed with the patient because the patient did not return for the follow-up appointment.

On day 4, the supervisory psychologist signed psychologist 1's new EHR documentation, as required.⁶⁰ Psychologist 1 also received supervision on day 4 and the supervisory psychologist documented that the patient was "not talkative" with "flat affect" and scored negative on a suicide risk screen.⁶¹ In an interview with the OIG, the supervisory psychologist reported discussing the patient not being "talkative" or engaged during the visit with psychologist 1, and that psychologist 1 did not think the patient presented with an elevated suicide risk and the safety plan was sufficient.

The chief, Behavioral Health reported to the OIG having reviewed the patient's care and concluding that "we had done everything according to policy that clinically could be done for [the patient] or was done for" the patient. The OIG determined that psychologist 1 completed the initial outpatient appointment documentation and screened the patient for suicide risk, as required by VHA; however, psychologist 1 did not thoroughly evaluate or address the patient's severe depression.⁶² Additionally, the OIG concluded that psychologist 1 failed to reconcile critical clinical treatment information, including the patient's initial request for medication, history of inpatient mental health unit admissions due to suicidal behaviors following medication discontinuation, and the patient's report that the current symptoms occurred prior to the patient's "mental health decline and suicidal thoughts in the past." The OIG would have expected psychologist 1 to provide psychoeducation about the benefits of medication for the patient to promote the patient's willingness to consult with a mental health medication prescriber.

The OIG found that the supervisory psychologist provided clinical supervision to psychologist 1 consistent with VHA policy and Ohio State law.⁶³ However, the OIG would have expected the supervisory psychologist to identify concerns about the patient's current level of depression and

⁶⁰ VHA Directive 1027, *Supervision of Psychologists, Social Workers, Professional Mental Health Counselors, and Marriage and Family Therapists Preparing for Licensure*, October 23, 2019; VHA Directive 1027 (1), *Supervision of Psychologists, Social Workers, Professional Mental Health Counselors, and Marriage and Family Therapists Preparing for Licensure*, October 23, 2019, amended March 8, 2023. Unless otherwise specified, the amended directive contains the same or similar language regarding supervision requirements as 2019 directive.

⁶¹ "Columbia Suicide Severity Rating Scale (C-SSRS)," *Substance Abuse and Mental Health Services Administration*, accessed June 7, 2023, <https://www.samhsa.gov/resource/dbhis/columbia-suicide-severity-rating-scale-c-ssrs>.

⁶² VA Memorandum, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020.

⁶³ VHA Directive 1027, *Supervision of Psychologists, Social Workers, Professional Mental Health Counselors, and Marriage and Family Therapists Preparing for Licensure*, October 23, 2019; VHA Directive 1027 (1), *Supervision of Psychologists, Social Workers, Professional Mental Health Counselors, and Marriage and Family Therapists Preparing for Licensure*, October 23, 2019, amended March 8, 2023. Unless otherwise specified, the amended directive contains the same or similar language regarding supervision requirements as 2019 directive; Ohio Admin. Code 4732-13-04, Requirements pertaining to supervision (2018).

associated risks for substance use relapse and suicidal behavior, and direct follow-up with the patient to resolve the patient's initial medication request. In an interview with the OIG, the supervisory psychologist noted awareness of the patient's request for medication management on day 1. The supervisory psychologist told the OIG that the patient's declination of medication management was discussed with psychologist 1 during supervision, although it was not documented in supervisory notes.

The OIG concluded that the primary care and mental health clinicians' inadequate assessments of the patient's condition contributed to an underestimation of the patient's worsening depression and risk of substance use disorder relapse and subsequent failure to offer effective treatment timely.

3. Failure to Send Caring Communications

The OIG found that in summer 2021, staff failed to send the patient caring communications upon high-risk flag inactivation because of a failure to communicate the information to the responsible program support assistant.

Clinical practice guidelines recommend sending patients "periodic caring communications" such as postcards "in addition to usual care" following inpatient mental health unit admissions for suicidal ideation or a suicide attempt.⁶⁴ VHA's Caring Communication Program is "designed to strengthen" patients' "sense of social connectedness," reduce the reoccurrence of suicidal behaviors, and enhance treatment engagement.⁶⁵ As of March 2020, VHA requires suicide prevention coordinators to send patients at least monthly caring communications for a minimum of one year following high-risk flag inactivation.⁶⁶

In late summer 2020, the patient's high-risk flag was inactivated, and facility staff mailed the first "caring contact card" to the patient 20 days later.⁶⁷ Consistent with VHA policy, staff mailed the patient caring communications in the following two months, and then discontinued the mailings when the patient's high-risk flag was reactivated.⁶⁸

However, the division director, Suicide Prevention, reported to the OIG that in summer 2021, a suicide prevention coordinator inactivated the patient's second high-risk flag and failed to communicate the inactivation to the program support assistant for the patient's inclusion in the

⁶⁴ VA/DoD, *Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*, May 2019.

⁶⁵ VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 1, 2020.

⁶⁶ VHA Notice 2020-13, *Inactivation Process for Category I High Risk for Suicide Patient Record Flags*, 03-27-2020. VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 1, 2020.

⁶⁷ VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 1, 2020. Approximately six weeks after the patient's high-risk flag inactivation, VHA specified that the caring contacts must be initiated within two weeks of the inactivation of a patient's high-risk flag.

⁶⁸ VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 1, 2020.

Caring Communication Program. The division director, Suicide Prevention, told the OIG about becoming aware of the failure to send the patient caring communications while preparing for a February 2023 OIG interview and acknowledged that the patient should have been added to the Caring Communication Program at that time.

The division director, Suicide Prevention, explained to the OIG that in summer 2021, a suicide prevention coordinator emailed the program support assistant the names of patients whose high-risk flags were inactivated the prior month and the program support assistant then added those patients to the Caring Communication Program. The division director, Suicide Prevention, told the OIG that the patient “was not identified in the email and, as a result, [the patient] was not added to the caring contacts list.” The OIG verified that the list of patients provided to the program support assistant for the month of the patient’s high-risk flag inactivation did not include the patient’s name. In an interview with the OIG, the suicide prevention coordinator was unable to explain why the patient was not included in the email and acknowledged that it may have been an oversight.

The OIG concluded that staff’s failure to send the patient caring communications upon high-risk flag inactivation may have contributed to the patient’s lack of treatment engagement until 10 months later when the patient’s depression symptoms had worsened and the patient reached out to reestablish care. The division director, Suicide Prevention, told the OIG that since “team process improvements” in May 2022, the program support assistant accesses a data dashboard that the suicide prevention team uses “on a daily basis and all veterans who receive high risk flags appear on it for the duration of their flag and then move and remain on the list of inactivated flags for the next 12 months. This helps ensure that each month we can verify every veteran who appears on the list is receiving caring contacts.”⁶⁹

4. Failure to Communicate a Lesson Learned

The OIG found that the root cause analysis identified a Lesson Learned regarding suicide prevention and facility leaders did not communicate the information to staff, as expected. The OIG also found that VHA does not provide written guidance related to the documentation, leaders’ review, follow-up actions, and tracking of Lessons Learned.⁷⁰

Lessons Learned “may be system level topics” identified during the root cause analysis that are not root causes or causal factors of the events under review and “that do not directly influence

⁶⁹ A data dashboard is a tool used “to track, analyze, and display data.” Microsoft, “What is a data dashboard,” accessed June 14, 2023, <https://powerbi.microsoft.com/en-us/data-dashboards/>.

⁷⁰ VHA National Center for Patient Safety, *Guide to Performing a Root Cause Analysis*, revised February 5, 2021. This guide was in place during the time of the events discussed in this report. It was updated and replaced with VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis, Version 10*, March 2023. Unless otherwise specified, the 2023 guide contains the same or similar language regarding RCA processes as the 2021 guide.

the outcome of the event under analysis.”⁷¹ While identified root causes and causal factors are to remain confidential by the root cause analysis team and leaders, Lessons Learned “should always be shared to promote transparency and a learning environment,” and may be shared with the facility, VISN, and VHA.⁷²

The root cause analysis template includes “Who Needs to Know?” and “How to Share Information?” columns to be completed for each Lesson Learned. VHA does not provide written guidance regarding the information to include in the completion of these columns or expectations regarding leaders’ review, follow-up actions, and tracking. At the time the root cause analysis related to the patient’s care was conducted, VHA did not identify responsibilities related to communicating Lessons Learned. In March 2023, VHA assigned patient safety managers the responsibility to share Lessons Learned “with appropriate committees, teams and/or other staff venues for use in system improvement.”⁷³

One Lesson Learned that the root cause analysis team identified was that the suicide prevention team should

“re-evaluate facility process and protocols for removal of high risk flags and the required documentation that is necessary to provide reasoning for the removal to ensure best outcomes,” including consideration of “a delay” in removal of a high risk flag “when there has been an interruption in care.”

The root cause analysis team identified the Suicide Prevention Team; chief, Behavioral Health; and “Storm [Stratification Tool for Opioid Risk Mitigation] Team” in the “Who Needs to Know?” report section.⁷⁴ However, in a February 2023 OIG interview, the division director, Suicide Prevention, reported “This is the first time I even am hearing that there was a [root cause

⁷¹ VHA National Center for Patient Safety, *Guide to Performing a Root Cause Analysis*, revised February 5, 2021. This guide was in place during the time of the events discussed in this report. It was updated and replaced with VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis, Version 10*, March 2023. Unless otherwise specified, the 2023 guide contains the same or similar language regarding RCA processes as the 2021 guide.

⁷² VHA National Center for Patient Safety, *Guide to Performing a Root Cause Analysis*, revised February 5, 2021. This guide was in place during the time of the events discussed in this report. It was updated and replaced with VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis, Version 10*, March 2023. Unless otherwise specified, the 2023 guide contains the same or similar language regarding root cause analysis processes as the 2021 guide.

⁷³ VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023.

⁷⁴ Partnered Evidence-based Policy Resource Center, Policy Brief, *Stratification Tool for Opioid Risk Mitigation (STORM)*, accessed July 6, 2023, https://www.peprec.research.va.gov/PEPRECRESEARCH/docs/Policy_Brief_16_STORM.pdf. The STORM is a “web-based population management dashboard” that identifies “the risk for opioid-related serious adverse events” for each patient prescribed an opioid medication. VHA mandated “Case reviews were to be conducted by an interdisciplinary team of providers” who “were encouraged to use the STORM dashboard to evaluate each patient’s risk factors” and treatment needs.

analysis].” The chief of Quality, Safety and Innovation confirmed that Lessons Learned “need to be specifically communicated to whomever needs to conduct that action.”

Upon completion of a root cause analysis, the root cause analysis team conducts a final presentation (final presentation meeting) for “the Director and leadership team” that “facilitates action plan concurrence.”⁷⁵ The chief of Quality, Safety and Innovation told the OIG that the expectation is for the service chief to communicate the relevant information. The Chief of Staff reported that a leader of services who might benefit from the information is typically invited to the final presentation meeting and that someone from Behavioral Health leadership is often invited.

The chief, Quality, Safety, and Innovation provided rosters for the final presentation meeting related to the patient’s care that indicated that leaders and staff relevant to this Lesson Learned, including the chief, Behavioral Health; division director, Suicide Prevention; and STORM team members were not invited and did not attend the final presentation meeting. The chief of Quality, Safety and Innovation told the OIG that the leaders invited to the final presentation meeting are assigned actions related to root causes and actions are not assigned to Lessons Learned. A VHA patient safety analyst told the OIG that the expectation would be that the person responsible to communicate the information to whomever needs to know would be identified in the “How to Share Information?” column.⁷⁶

The risk manager told the OIG about communicating about the Lesson Learned to the chief, Behavioral Health, in a call a week after the final presentation meeting. However, in an interview with the OIG, the chief, Behavioral Health, denied knowledge about the Lesson Learned and noted that the call with the risk manager focused on the patient’s “case” and the EHR.

The associate director of Patient Safety Analysis and High Reliability Programs, National Center for Patient Safety, told the OIG that sharing of Lessons Learned is accomplished at VHA sites through a discussion between the director and a patient safety manager or another quality and patient safety professional. Eight days after the final presentation meeting, the Patient Safety manager sent individual emails to the Facility Director, Assistant Director, and the acting chief

⁷⁵ VHA National Center for Patient Safety, *Guide to Performing a Root Cause Analysis*, revised February 5, 2021. This guide was in place during the time of the events discussed in this report. It was updated and replaced with VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis, Version 10*, March 2023. Unless otherwise specified, the 2023 guide contains the same or similar language regarding the final presentation meeting as the 2021 guide.

⁷⁶ “VHA National Center for Patient Safety,” accessed July 18, 2023, <https://www.patientsafety.va.gov/>. The Patient Safety Analyst was employed with the National Center for Patient Safety. “The National Center for Patient Safety (NCPS) promotes best practices for safe patient care and optimal patient care utilization throughout the organization,” and develops patient safety policy.

and acting deputy chief, Patient Business Services, that listed all identified Lessons Learned with a heading “Please share with staff the Lessons Learned.”⁷⁷

The Facility Director told the OIG about discussing the Lesson Learned with the division director, Suicide Prevention, and the chief, Behavioral Health, “within 24 hours prior” to meeting with the OIG, almost five months after the final presentation meeting, and concluded “I see no issues with the process with the suicide prevention team.” When the OIG asked how Behavioral Health leaders would find out about relevant Lessons Learned, the Facility Director reported making “the assumption that these would have been communicated by” Quality, Safety and Innovation Department staff.

In an interview with the OIG, the Assistant Director confirmed attending the final presentation meeting and reported sharing Lessons Learned information with the chiefs whose Service the Assistant Director oversees. The acting chief and acting deputy chief, Patient Business Services, reported meeting with the Assistant Director approximately two weeks after the final presentation meeting and discussing the Lessons Learned relevant to administrative documentation processes.

In the “How to Share Information?” column, “[Root cause analysis] and organization facing lessons learned” was listed, which the chief of Quality, Safety and Innovation, told the OIG referred to sharing the Lessons Learned with staff that are “assigned actions.” However, in an interview with the OIG, a patient safety analyst, National Center for Patient Safety, confirmed that the person responsible for the communication to applicable staff should be listed in the “Who Needs to Know?” column.

The associate director of Patient Safety Analysis and High Reliability Programs, National Center for Patient Safety, reported not being aware of tracking or monitoring requirements for Lessons Learned. In an interview with the OIG, the chief of Quality, Safety and Innovation confirmed that actions related to Lessons Learned were not monitored at the facility.

The absence of written VHA guidance regarding the documentation, leaders’ review, follow-up actions, and tracking of Lessons Learned likely contributed to facility leaders’ failure to consider, address, and communicate the Lesson Learned at the time of the patient’s root cause analysis. While VHA recently assigned the patient safety managers’ responsibility to share Lessons Learned with relevant leaders and staff, the absence of clear expectations regarding documentation, leaders’ review, follow-up actions, and tracking may contribute to communication gaps and ultimately a failure to address identified system level patient safety topics.

⁷⁷ The acting chief and acting deputy chief, Patient Business Services, reported being in the acting positions since October 2022.

Conclusion

The OIG found that the implementation of the new EHR scheduling application resulted in a rescheduling error that contributed to staff's failure to adhere to minimum scheduling requirements for the patient's missed mental health appointment. The patient's missed appointment was not routed to a request queue and, as a result, schedulers were not prompted to conduct required rescheduling efforts. Lack of contact efforts may have contributed to the patient's disengagement from mental health treatment and ultimately the patient's substance use, relapse, and death. Oracle Health staff, and facility and VA leaders addressed this system error and other new EHR problems.

The VHA Office of Integrated Veteran Care implemented new EHR minimum scheduling effort procedures that require fewer contact attempts than VHA minimal scheduling efforts for missed mental health appointments.⁷⁸ The minimum scheduling efforts standard operating procedure establishes a different standard of care based on the EHR system used at the site at which a patient seeks mental health services. Different scheduling contact requirements could result in a disparity in access to care.

The nurse practitioner's lack of a comprehensive assessment likely contributed to an incomplete understanding of the patient's current concerns, condition, and risk factors; and a subsequent failure to promote a coordinated approach to address the patient's treatment needs given the absence of valuable clinical information for the patient's scheduled mental health appointment. The OIG also found that psychologist 1 did not thoroughly evaluate or address the patient's severe depression; failed to reconcile critical clinical treatment information, including the patient's initial request for medication, history of inpatient mental health unit admissions due to suicidal behaviors following medication discontinuation, and the patient's report that the current symptoms occurred prior to the patient's "mental health decline and suicidal thoughts in the past;" and did not complete a thorough assessment of the patient's mood disorder.⁷⁹

⁷⁸ *Cerner Minimum Scheduling Effort SOP*, May 24, 2022. This standard operating procedure was replaced by *Cerner Minimum Scheduling Effort SOP*, July 28, 2022; *Cerner Minimum Scheduling Effort SOP*, September 1, 2022; and *Cerner Minimum Scheduling Effort SOP*, November 1, 2022. Unless otherwise specified, the May 24, 2022, standard operating procedure contains the same or similar language regarding minimum scheduling efforts in the new EHR as the July, September, and November 2022 standard operating procedures; VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016; VHA Notice, *Minimum Scheduling Effort Required for Outpatient Appointments: Update to VHA Directive 1230 and VHA Directive 1232(1)*, April 24, 2019; VHA Notice, *Mandatory Use of the Electronic Health Record and Process to Resolve Identified Concerns*, July 26, 2022.

⁷⁹ VA Memorandum, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020.

The supervisory psychologist provided supervision to psychologist 1 as required by VHA.⁸⁰ However, the supervisory psychologist failed to identify concerns about the patient's current level of depression and associated risks for substance use relapse and suicidal behavior, and direct follow-up with the patient to resolve the patient's initial medication request. The OIG determined that the primary care and mental health clinicians' inadequate assessments of the patient's condition contributed to an underestimation of the patient's worsening depression and risk of substance use disorder relapse and subsequent failure to offer effective treatment timely.

The OIG found that in summer 2021, staff did not send the patient caring communications upon high-risk flag inactivation because of a failure to communicate the information to the responsible program support assistant. The OIG concluded that failure to send caring communications may have contributed to the patient's lack of treatment engagement until 10 months later, when the patient's depression symptoms had worsened and the patient reached out to reestablish care.

The OIG found that a Lesson Learned regarding suicide prevention procedures was not shared with the suicide prevention team.⁸¹ The OIG determined that the absence of written VHA guidance regarding the documentation, leaders' review, follow-up actions, and tracking of Lessons Learned likely contributed to facility leaders' failure to consider, address, and communicate the information.

⁸⁰ VHA Directive 1027, *Supervision of Psychologists, Social Workers, Professional Mental Health Counselors, and Marriage and Family Therapists Preparing for Licensure*, October 23, 2019; VHA Directive 1027 (1), *Supervision of Psychologists, Social Workers, Professional Mental Health Counselors, and Marriage and Family Therapists Preparing for Licensure*, October 23, 2019, amended March 8, 2023. Unless otherwise specified, the amended directive contains the same or similar language regarding supervision requirements as 2019 directive.

⁸¹ Partnered Evidence-based Policy Resource Center, Policy Brief, *Stratification Tool for Opioid Risk Mitigation (STORM)*, accessed July 6, 2023, https://www.peprec.research.va.gov/PEPRECRESEARCH/docs/Policy_Brief_16_STORM.pdf. STORM is a "web-based population management dashboard" that identifies "the risk for opioid-related serious adverse events" for each patient prescribed an opioid medication. VHA mandated "Case reviews were to be conducted by an interdisciplinary team of providers" who "were encouraged to use the STORM dashboard to evaluate each patient's risk factors" and treatment needs.

Recommendations 1–5

1. The Deputy Secretary establishes ongoing monitors to ensure that scheduling procedures in the new electronic health record are functioning in accordance with Veterans Health Administration requirements.
2. The Under Secretary for Health evaluates minimum scheduling effort requirements for mental health appointments and takes action to ensure the implementation of standardized policy and procedures in the best interest of patient care.
3. The VA Central Ohio Healthcare System Medical Center Director conducts a full review of the care of the patient provided by the nurse practitioner and psychologist 1, and the supervisory psychologist's oversight, consults with Human Resources and General Counsel Offices, and takes actions as warranted.
4. The VA Central Ohio Healthcare System Medical Center Director ensures compliance with the Caring Communication Program including the initiation and cessation of caring communications as required.
5. The Under Secretary for Health considers establishing written guidance related to documentation, leaders' review, follow-up actions, and tracking of Lessons Learned in root cause analyses.

Appendix A: Deputy Secretary Memorandum

Department of Veterans Affairs Memorandum

Date: February 9, 2024

From: Deputy Secretary (001)

Subj: Healthcare Inspection—Scheduling Error of the New Electronic Health Record and Inadequate Mental Health Care at the VA Central Ohio Healthcare System in Columbus Contributed to a Patient Death

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the Department of Veterans Affairs (VA) Office of Inspector General (OIG) draft hotline report “Scheduling Error of the New Electronic Health Record and Inadequate Mental Health Care at the VA Central Ohio Healthcare System in Columbus Contributed to a Patient Death.” The report contains several conclusions and five recommendations.

2. I concur with the recommendations in this report. I have included as attachments to this memorandum additional acknowledgement memoranda from the Under Secretary of Health, The Veterans Integrated Service Network 10 director, and the Columbus facility director, as well as initial responses to each recommendation from the appropriate program offices.

(Original signed by:)

Tanya J. Bradsher
VA Deputy Secretary

Deputy Secretary Response

Recommendation 1

The Deputy Secretary establishes ongoing monitors to ensure that scheduling procedures in the new electronic health record are functioning in accordance with Veterans Health Administration requirements.

☒ Concur

☐ Nonconcur

Target date for completion: September 2024

Deputy Secretary Comments

The new electronic health record (EHR) has a processing option that creates a reschedule request in the event of canceled or no-show appointments. This request is automatically sent to the appropriate facility location queue; from there, scheduling staff can perform the appropriate workflow for rescheduling the patient per the Veterans Health Administration (VHA) Cerner Minimum Scheduling Effort Standard Operating Procedure (SOP). The processing options are set as appropriate for each nationally approved appointment type. Relevant stakeholder offices, to include the VHA Office of Health Informatics and the Electronic Health Record Modernization Integration Office (EHRM-IO), will collaborate to determine how VA will conduct regular monitoring of these processing options to ensure all new nationally approved appointment types are functioning in accordance with VHA requirements.

Appendix B: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: January 29, 2024

From: Office of the Under Secretary for Health (10)

Subj: Healthcare Inspection—Scheduling Error of the New Electronic Health Record and Inadequate Mental Health Care at the VA Central Ohio Healthcare System in Columbus Contributed to a Patient Death

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on the new electronic health record (EHR) and mental health care at the VA Ohio Healthcare System (HCS) in Columbus. The Veterans Health Administration (VHA) concurs with all of the recommendations and provides action plans for the recommendations made to the Under Secretary for Health (2 and 5). The response to recommendation 1 is provided by the Deputy Secretary and responses to recommendations 3 and 4 are provided by the Veterans Integrated Service Network (VISN) Director.

2. VHA first learned of this tragic Veteran death from the patient safety reporting and tracking systems in place at sites that have implemented the new Oracle EHR, such as VA Central Ohio HCS. Nearly a year ago, in February 2023, the National Center for Patient Safety became aware of this event and reported it to VHA leadership. Within a month (March 2023) VHA briefed House and Senate Congressional staff and separately briefed Senator Brown's and Senator Murray's staff.

3. At the facility, leadership directed and completed a root cause analysis and took corrective actions to prevent similar events from occurring. Additionally, in collaboration with VHA's national Clinical Episode Review Team (CERT), facility and VISN staff conducted a clinical review of 21,658 appointments that occurred between the period of September 2022 to March 2023. The CERT provided direction and guidance for conducting the clinical review according to national VHA practices and prioritized mental health appointments as the first to be reviewed.

4. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Shereef Elnahal M.D., MBA
Under Secretary for Health, VHA

Office of the Under Secretary for Health Response

Recommendation 2

The Under Secretary for Health evaluates minimum scheduling effort requirements for mental health appointments and takes action to ensure the implementation of standardized policy and procedures in the best interest of patient care.

☒ Concur

☐ Nonconcur

Target date for completion: July 2024

Under Secretary for Health Comments

VHA will carry out the following action plan:

1. The VHA Office of Mental Health and Suicide Prevention (OMHSP) will evaluate the clinical adequacy and appropriateness of current VHA policies and procedures for minimum scheduling effort requirements for mental health appointments. This evaluation may incorporate the work of the field-based workgroup initiated by OMHSP's Director of Analytics, Innovations and Collaborations.
2. Based on the results of this evaluation, OMHSP will collaborate with VHA Office of Integrated Veteran Care (IVC) to develop a policy update, reiterating minimum rescheduling requirements for missed mental health appointments.
3. Once the policy update has been prepared, but before it has been published and disseminated, EHRM-IO, VHA electronic health record modernization (EHRM) leaders, and the impacted EHRM Councils will prepare a report on how the Oracle Health EHR can support implementation of the updated policy. This report will outline, at minimum:
 - a. Functions within the EHR that will support VHA-wide implementation of the policy.
 - b. Limitations to the EHR with regard to implementation of the policy, such that manual processes or technical solutions outside the EHR may be required for VHA-wide implementation of the policy.
 - c. An updated documentation workflow outlining the flow of data in the Oracle Health platform regarding missed appointments/no-shows, actions triggered or queued in the EHR, rescheduling efforts taken by VA staff and communication of actions taken.
 - d. Backup capabilities or redundancies in the EHR that can enable VA staff to comply with the scheduling policy in the event of EHR system disruptions.
 - e. Any EHR configuration changes needed to support implementation of the policy update and steps taken to initiate these changes.

4. Upon receipt of the joint report, but before dissemination of the updated policy, OMHSP will work with IVC and EHRM leadership (EHRM-IO, VHA EHRM leaders, and the impacted EHRM Councils) to develop a standard operational workflow outlining the steps VA staff are to take in carrying out scheduling efforts and in documenting these efforts in the EHR.
5. Once this work is complete, the policy update will be disseminated. The update will provide facilities with the updated policy as well as both the informatics-facing documentation workflow and the staff-facing operational workflow outlined above.
6. OMHSP will collaborate with the Office of the Assistant Under Secretary for Health for Operations regarding confirmation that facilities have implemented the standard operational workflow.

Recommendation 5

The Under Secretary for Health considers establishing written guidance related to documentation, leaders' review, follow-up actions, and tracking of Lessons Learned in root cause analyses.

☒ Concur

☐ Nonconcur

Target date for completion: January 4, 2024

Under Secretary for Health Comments

In October 2023, VHA established written guidance in the VHA National Center for Patient Safety Guide to Performing Root Cause Analysis, Version 11.1, under titles "Monitor Completion and Sustainment of Actions and Outcomes" and "Communicate Improvements to Staff". Executive Leaders and Patient Safety Managers are empowered to develop a local template and cadence for summarizing lessons learned for dissemination electronically and in venues such as Safety Forums, town hall meetings, and visual information boards.

OIG Comments

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

Appendix C: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: January 4, 2024

From: Network Director, Veterans Integrated Service Network 10 (10N10)

Subj: Healthcare Inspection—Scheduling Error of the New Electronic Health Record and Inadequate
Mental Health Care at the VA Central Ohio Healthcare System in Columbus Contributed to a
Patient Death

To: Office of the Under Secretary for Health (10)

Director, Mental Health Hotlines, Office of Healthcare Inspections (54MHP1)

Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I have reviewed and concur with the response for the draft report of our Healthcare Inspection – Scheduling Error of the New Electronic Health Record and Inadequate Mental Health Care of the VA Central Ohio Healthcare System in Columbus Contributed to a Patient Death.
2. I concur with the responses and action plans submitted by the Columbus VA Medical Center Director.
3. Thank you for the opportunity to respond to this report.

(Original signed by:)

Laura E. Ruzick, FACHE
Network Director, VISN 10

Appendix D: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 28, 2023

From: Director, VA Central Ohio Healthcare System (757/00)

Subj: Healthcare Inspection—Scheduling Error of the New Electronic Health Record and Inadequate Mental Health Care at the VA Central Ohio Healthcare System in Columbus Contributed to a Patient Death

To: Director, VA Healthcare System Serving Ohio, Indiana, and Michigan (10N10)

1. Thank you for the opportunity to review the draft report of the Healthcare Inspection of the Scheduling Error of the New Electronic Health Record and Inadequate Mental Health Care at the VA Central Ohio Healthcare System in Columbus Contributed to a Patient Death.
2. I have listed our action plans to address the recommendations listed within the report received on December 19, 2023.
3. I appreciate the opportunity for this review to allow our organization to address and ensure that safe, quality patient care is continually reviewed and maintained.

(Original signed by:)

Marc Cooperman, MD
Medical Center Director

Facility Director Response

Recommendation 3

The VA Central Ohio Healthcare System Medical Center Director conducts a full review of the care of the patient provided by the nurse practitioner and psychologist 1, and the supervisory psychologist's oversight, consults with Human Resources and General Counsel Offices, and takes actions as warranted.

☒ Concur

☐ Nonconcur

Target date for completion: April 2024

Director Comments

A management review will be conducted by an outside Supervisory Psychologist to review and address OIG's recommendation(s) and concerns related to "the standard of care specifically to address whether the primary care and mental health clinicians' inadequate assessments of the patient's condition contributed to an underestimation of the patient's worsening depression and risk of substance use disorder relapse and subsequent failure to offer effective treatment timely". All conclusions will be considered by the Medical Center Director and will be delegated to the Medical Center Chief of Staff to consult with Human Resources and the Office of General Counsel for any necessary administrative actions as warranted to be administered and/or implemented immediately following receipt of the Management Review report.

Recommendation 4

The VA Central Ohio Healthcare System Medical Center Director ensures compliance with the Caring Communication Program including the initiation and cessation of caring communications as required.

☒ Concur

☐ Nonconcur

Target date for completion: April 2024

Director Comments

A formal management review will be coordinated by the Columbus VA Office of Risk Management and will be conducted by the local Behavioral Health Social Work Manager to review the status of the program and assess compliance with the initiation and cessation of Caring Communication Program mandates as required.

The VA Central Ohio Healthcare System Medical Center Director will review the findings of fact following the review and will delegate any necessary actions to be immediately implemented to ensure continued compliance with the Caring Communications Program mandates.

Glossary

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

acute cardiac arrhythmia. Sudden onset of “an abnormal rate and/or rhythm of a heart due to its abnormal electrical impulse.”¹

comprehensive suicide risk evaluation. A required evaluation following a patient’s positive suicide risk screening that includes documentation of the patient’s suicidal behavior history, preparatory behavior, warning signs, risk and protective factors, and risk mitigation strategies.²

flat affect. The “absence of appropriate emotional responses to situations and events,” a common symptom of depression.³

handoff. The transfer of information, authority, and responsibility from one health care provider to another during a patient’s care transition.⁴

high risk for suicide patient record flag. An alert in a patient’s EHR to “communicate to VA staff that a veteran is at high risk for suicide” that must be used “only for the duration of the increased risk for suicide.”⁵

inhalant use disorder. A pattern of hydrocarbon-based inhalant use within the previous year that leads to significant impairment or distress characterized by taking larger amounts of the inhalant substance for longer periods of time than intended, craving the inhalant substance, continued inhalant substance use despite having recurrent social or interpersonal problems

¹ Merriam-Webster.com Dictionary, “acute,” accessed June 5, 2023, <https://www.merriam-webster.com/dictionary/acute>; Xiao, Yong-Fu. “Cardiac arrhythmia and heart failure: From bench to bedside.” *Journal of geriatric cardiology: JGC* vol. 8,3 (2011): 131-2. doi:10.3724/SP.J.1263.2011.00131, accessed June 5, 2023, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3390068/?report=reader#_ffn_sectitle.

² Deputy Under Secretary for Health for Operations and Management memorandum, “Suicide Risk Screening and Assessment Requirements,” May 23, 2018; Deputy Under Secretary for Health for Operations and Management memorandum, “Eliminating Veteran Suicide: Implementation of Suicide Risk Screening and Evaluation,” November 2, 2018. In May 2018, VHA established a phased, standardized suicide risk screening and assessment, and requires the completion of a comprehensive suicide risk assessment following a positive initial screening. The May 23, 2018, memorandum refers to a comprehensive suicide risk assessment; however, the November 2, 2018, memorandum establishes the term comprehensive suicide risk evaluation.

³ American Psychological Association Dictionary of Psychology, “flat affect,” accessed June 7, 2023, <https://dictionary.apa.org/flat-affect>.

⁴ Mary Ann Friesen, Susan V. White, and Jacqueline F. Byers, “Handoffs: Implications for Nurses,” *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. Rockville (MD): Agency for Healthcare Research and Quality (US), Chapter 34, (April 2008), <https://www.ncbi.nlm.nih.gov/books/NBK2649/>.

⁵ VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008; VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010; Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, “Update to High Risk for Suicide Patient Record Flag Changes,” January 16, 2020; VHA Directive 1166, *Patient Record Flags*, November 6, 2023; The 2023 directive rescinds and replaces the 2010 directive. Unless otherwise specified, the 2023 directive contains the same or similar language regarding high risk flags as the 2010 directive.

caused by the effects of its use, a need for increased amounts of the inhalant substance to achieve intoxication, or symptoms of withdrawal.⁶

major depressive disorder. An episode of at least two weeks during which the person experiences depressed mood or loss of interest or pleasure in usual activities, and other symptoms such as changes in appetite, sleep disturbance, loss of energy, feelings of worthlessness or guilt, thoughts of death, and suicidal ideation.⁷

military sexual trauma. Any sexual activity during military service “where a Veteran was involved against their will.”⁸

posttraumatic stress disorder. A mental health condition triggered by experiencing or witnessing a terrifying event and characterized by flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event.⁹

psychoeducation. The “process of teaching clients with mental illness and their family members about the nature of the illness, including its etiology, progression, consequences, prognosis, treatment, and alternatives.”¹⁰

⁶ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition – Text Revision* (DSM-5-TR), “Substance Related and Addictive Disorders,” accessed February 27, 2023, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x16_Substance_Related_Disorders#C_HDIBCJD.

⁷ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition – Text Revision* (DSM-5-TR), “Depressive Disorders,” accessed May 10, 2023, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x04_Depressive_Disorders.

⁸ “Military Sexual Trauma,” VA National Center for PTSD, accessed February 27, 2023, https://www.ptsd.va.gov/understand/types/sexual_trauma_military.asp.

⁹ Mayo Clinic, “Post-traumatic stress disorder,” accessed February 27, 2023, <https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967>.

¹⁰ Sarkhel, S., Singh, O.P., and Arora, M, “Clinical Practice Guidelines for Psychoeducation in Psychiatric Disorders General Principles of Psychoeducation,” *Indian Journal of Psychiatry* 62, (January 17, 2020): 319-323.

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 Rachelle Biddles, PhD Alan Mallinger, MD Erin Mangano, LCSW Amber Singh, PhD Kelli Toure, LCSW Andrew Waghorn, JD
------------------------	---

Other Contributors	Sarah Mainzer, JD, BSN Natalie Sadow, MBA April Terenzi, BA, BS Dawn M. Woltemath, MSN, RN Thomas Wong, DO
---------------------------	--

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Healthcare System Serving Ohio, Indiana, and Michigan (10N10)
Director, VA Central Ohio Healthcare System (757/00)

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
US Senate: Sherrod Brown, J.D. Vance
US House of Representatives: Troy Balderson, Joyce Beatty, Shontel Brown, Mike Carey,
Warren Davidson, Jim Jordan, David Joyce, Marcy Kaptur, Greg Landsman, Robert
Latta, Max Miller, Emilia Sykes, Michael Turner, Brad Wenstrup

OIG reports are available at www.vaoig.gov.