US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

System Leaders' Response to Allegations Related to Access to Behavioral Health Care at the El Paso VA Health Care System in Texas

Healthcare Inspection | **23-03167-173** | **May 21, 2024**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review system leaders' actions taken in response to allegations related to access to behavioral health care and patient privacy at the El Paso VA Health Care System (system) in Texas and evaluate whether the system sustained the actions.

The OIG received allegations in August 2022 that patients who present at the system for behavioral health services were denied care, patients who declined virtual care did not receive appointments, and behavioral health clinic staff violated patient privacy.

In November 2022, the OIG requested a written response from system leaders addressing the allegations. The OIG received the system's response on February 16, 2023, indicating the associate chief of staff for Behavioral Health Service (ACOS-BHS) investigated the allegations and took or planned actions to resolve the complaints that the ACOS-BHS substantiated and partially substantiated.[1] Following the system's initial response, the OIG requested additional information in May 2023 related to the system's telemental health and virtual care policy, patient privacy, quality management reviews, and provider re-education. The system responded on July 6, 2023. After reviewing the system's July 2023 response, the OIG initiated an inspection.

The OIG determined the actions taken by system leaders, including those initiated before the OIG inspection and those implemented after OIG inquiries, ensured that the system's behavioral health clinic staff did not deny patients access to care, and that patients were seen in the time frame and at the location that met their preferences and needs. The OIG also determined that actions taken by system leaders ensured patient privacy was maintained during behavioral health services during which patients use tablets.

While conducting the inspection, the OIG identified a potential vulnerability resulting from the varied locations of providers and the settings in which patients receive care. A behavioral health clinic staff member told the OIG that Texas and New Mexico have their own laws addressing emergency detentions and commitments. The Veterans Health Administration (VHA) requires that facility processes for involuntary hospitalizations follow local and state laws.[2] While no cases of concern were identified due to some system providers residing in each of these states, and virtual providers residing in different states altogether, the OIG is concerned with potential issues arising from advice given by providers in emergent and urgent patient situations who may not be versed in Texas and New Mexico state emergency detention order laws.

[1] The ACOS-BHS was on extended leave during the time frame decisions related to changes in the modalities of care were initially made.

[2] VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023.

The OIG made one recommendation to the System Director related to system policies and guidance aligning with federal and state laws.

VA Comments

The Veterans Integrated Service Network and System Directors concurred with the findings and recommendation and provided acceptable action plan (see appendixes A and B). 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

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Abbreviations

ACOS-BHS	associate chief of staff for Behavioral Health Service
EHR	electronic health record
MSA	medical support assistant
NPAT	new patient access team
OIG	Office of Inspector General
PCMHI	primary care mental health integration
RCA	root cause analysis
SAC	safety assessment code
SOP	standard operating procedure
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review system leaders' actions taken in response to allegations related to access to behavioral health care and patient privacy at the El Paso VA Health Care System (system) in El Paso, Texas, and to evaluate whether the system sustained the actions.[1]

System

The system is part of Veterans Integrated Service Network (VISN) 17 and includes the El Paso VA Clinic (facility), which serves as the main location, and six additional clinics: five in El Paso, Texas; and one in Las Cruces, New Mexico.[2] From October 1, 2021, through September 30, 2022, the system served 36,400 patients. The system is designated as Level 2, medium complexity, and provides outpatient care. The facility is located on Fort Bliss and staff work with other VA and community providers for specialty and inpatient medical care needs.

System Responses to Allegations and Related Concerns

The OIG received allegations from a complainant on August 31, 2022, stating that patients who present at the system for behavioral health services are denied care, patients who decline virtual care do not receive an appointment, and facility behavioral health clinic staff violated patient privacy. After reviewing the complaint, the OIG requested a written response from system leaders on November 22, 2022, addressing the allegations. The OIG received the system's response on February 16, 2023, (initial response) indicating the associate chief of staff for Behavioral Health Service (ACOS-BHS) investigated the allegations and took or planned actions to resolve the complaints that the ACOS-BHS substantiated and partially substantiated.

Following the system's initial response, the OIG requested additional information on May 23, 2023, related to the system's telemental health and virtual care policy, patient privacy, quality management reviews, and provider re-education.[3] See figures 1–4, located in each

[1] Evans AC, Bufka LF. "The Critical Need for a Population Health Approach: Addressing the Nation's Behavioral Health During the COVID-19 Pandemic and Beyond," *Preventing Chronic Disease*, August 6, 2020, accessed October 30, 2023, https://www.cdc.gov/pcd/issues/2020/20_0261.htm. In this report, the OIG utilizes the terms *behavioral health* and *mental health* interchangeably. "Behavioral health encompasses traditional mental health and substance use disorders, as well as overall psychological well-being."

[2] Of the six clinics, four are community-based outpatient clinics and two are outpatient clinics.

[3] VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023. Virtual care includes "telephone, text, or app." Telemental health includes clinical video telehealth to clinics and patients' homes or other locations, including VA Video Connect; "VA Video Connect Fundamentals," VHA Telehealth Services, https://vaww.telehealth.va.gov/pgm/vvc/index.asp. (This website is not publicly accessible.) VA Video Connect enables patients to meet virtually with a healthcare provider, in a session that is secure and private.

Inspection Results section, for a detailed list of the allegations and the system's disposition, associated actions, and responses.

After reviewing the system's July 6, 2023, response (subsequent response), the OIG initiated an inspection to review whether facility behavioral health clinic processes ensured that patients had timely access to the care of their choice and whether patient privacy was maintained during care.[4] The OIG evaluated the planned actions, including those initiated before the OIG inspection and those implemented after OIG inquiries, to assess whether system leaders had fully implemented corrective actions that resolved allegations in the complaint, and whether those corrective actions were monitored and sustained over time.

During the inspection, the OIG also identified concerns with system staff's responses to patients experiencing behavioral health emergencies.

Scope and Methodology

The OIG initiated the inspection on August 3, 2023. The OIG conducted virtual interviews August 24 through September 28, 2023, and an unannounced on-site inspection October 3 and 4, 2023, during which the OIG visited three clinic locations: the facility and El Paso South Central VA Clinic (South Central Clinic) in Texas, also called the South Central Wellness Center, offering primarily behavioral health care; and the Las Cruces VA Clinic (Las Cruces Clinic) in New Mexico. The OIG conducted follow-up virtual interviews on October 16 and 31, 2023.

The OIG interviewed the complainant, system and facility leaders, and facility staff. The OIG observed clinic scheduling practices at the three sites of care and interviewed a patient and a patient's family member at the South Central Clinic.

The OIG reviewed relevant Veterans Health Administration (VHA) and system policies and procedures in effect at the time of the review, committee meeting minutes, scheduling audit data, and quality and patient safety documents. The OIG reviewed the electronic health record (EHR) of patients whose names were provided in the complaint or during interviews.

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

[4] *Wait Times for Veterans Scheduling Health Care Appointments: Challenges with Available Data on the Timeliness and Quality of VA Community Care*, *Before the Committee on Veteran' Affairs United States Senate*, (2022) (statement of Carrie Farmer, The RAND Corporation). Timeliness is measured from the time a patient requests an appointment and the date of the appointment. There is no single measure or national standard of timeliness and incorporates time allowances based on clinical appropriateness of the appointment requested.

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.

Inspection Results

1. Leaders' Response to Access to Care and Patient Privacy Issues

The OIG determined the actions taken by the system, including those initiated before the OIG inspection and those implemented after OIG inquiries, ensured that the system's behavioral health clinics did not refuse access to care for patients, and that patient privacy was maintained.

VHA prioritizes "providing and enhancing patient-centered, recovery-oriented mental health" services as part of the continuum of care and "an essential component of overall health care."[5] Important aspects of behavioral health care include providing the type and availability of services requested including patient-centered scheduling and privacy, timely access to care, and oversight to ensure these requirements are being met. VA facility directors are responsible for "verifying [mental health] staffing meets minimum standards for access, quality and satisfaction."[6]

Timely Access and Point-of-Contact Care

The OIG determined that, after receiving access to care allegations, the system took actions to ensure patients were seen in the time frame and at the location that met their preferences and needs.

VHA requires that behavioral health services are accessible when clinically needed for patients, are provided by the appropriate health care professional, and include varied modalities of care. VHA requires outpatient appointment requests to be managed timely and scheduled based on clinical need and patient preference.[7] For example, as outlined in current policy, a patient who presents to a facility with an elevated risk for suicide requires immediate, same-day attention; a patient with an urgent need must have same-day access; and a new patient with a non-urgent

[5] VHA Directive 1160.01(1), *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. This directive was in place at the time the allegations were received. The directive was rescinded and replaced by VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language regarding VHA's mental health services as the rescinded 2015 directive.

[6] VHA Directive 1161, *Productivity and Staffing in Clinical Encounters for Mental Health Providers*, April 28, 2020.

[7] VHA Directive 1160.01(1); VHA Directive 1160.01.

need must receive an evaluation "the same day or no later than the next business day." When gaps between a patient's needs and available behavioral health care exist, VHA requires services to be extended by increasing staffing, using telemental health, or referring patients to nearby services or care in the community.[8]

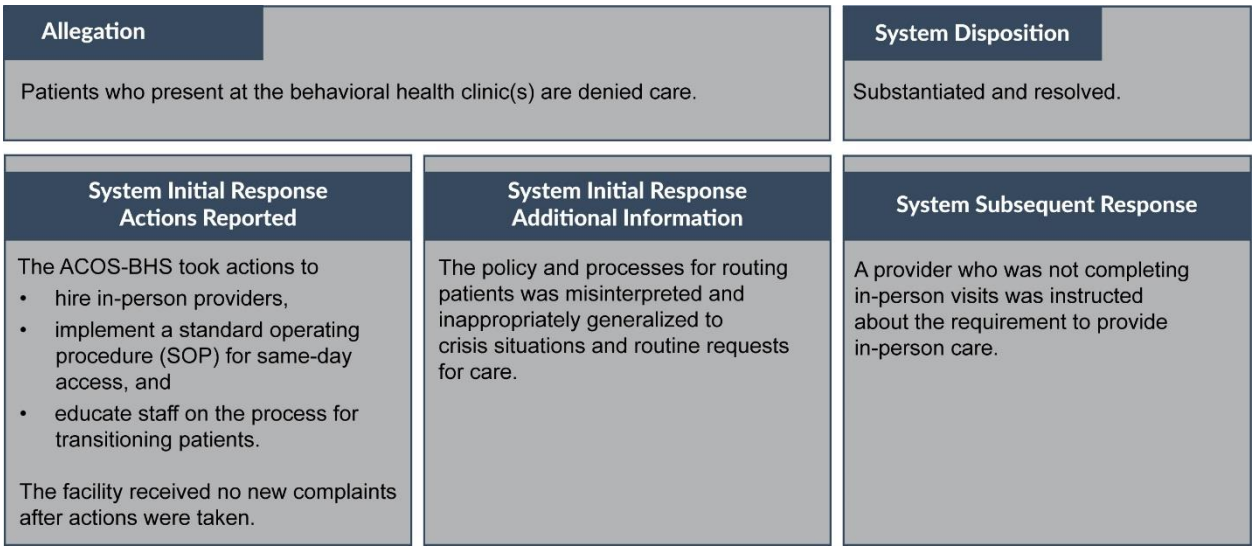

Figure 1. *System Disposition and Responses to Access to Care Allegation*
Source: Facility and OIG communications and documents.

Following the OIG's request for a response from system leaders addressing the allegations, the ACOS-BHS investigated the concern that patients, including those in crisis, were denied care at the site where they presented. The ACOS-BHS reported finding that behavioral health clinic staff routed patients to the location where they had established care rather than meeting their needs at the point of contact. For example, prior to the OIG inquiry and inspection, a patient who reported being in crisis presented to the facility but did not receive same-day care and was redirected to another location.[9]

> *The patient, in their twenties, with a psychiatric history significant for depression and chronic thoughts of self-harm, called the Veterans Crisis Line on a day in summer 2022, after presenting to the facility. The patient reported suicidal ideations and access to a firearm. The patient detailed multiple stressors, including chronic pain and unstable housing and finances, and reported seeking care earlier in the day at the facility but being redirected to the South Central Clinic for further assistance. The Veterans Crisis Line responder called the facility and spoke with a primary care nurse who directed the patient to return to the Clinic where care for the patient was expedited at a primary care clinic. A*

[8] VHA Directive 1160.01(1); VHA Directive 1160.01.

[9] The OIG reviewed the EHRs of nine patients who were identified in the allegations and one patient identified in an interview. The OIG found documentation within the EHR of provided care. The OIG was unable to confirm two additional patients who were discussed during on-site observations.

psychologist later evaluated the patient and facilitated an acute psychiatric admission for further treatment.

The OIG discovered from system-staff interviews and system-provided documents, including joint patient safety reports and email correspondence, that, in addition to the patient, other patients sought same-day care at the facility but were redirected to the South Central Clinic for care. The ACOS-BHS told the OIG that a majority of Behavioral Health Service staff located at the facility, with the exception of primary care mental health integration (PCMHI), were relocated to the South Central Clinic in spring 2022.[10]

In response to the reduced presence of Behavioral Health Service staff at the facility, the ACOS-BHS told the OIG that a New Patient Access Team (NPAT) was created and implemented. The NPAT is a multidisciplinary team (including members such as registered nurses, prescribers, and behavioral health therapists) who provide same-day behavioral health care for patients who have not established care within the system. The NPAT nurse told the OIG of providing services at the facility and South Central Clinic, and the ACOS-BHS reported that all locations provided emergent and urgent behavioral health care. In interviews while on-site, multiple staff verbalized patients presenting at one location and being referred elsewhere was no longer occurring after the ACOS-BHS educated service leaders and staff to not redirect patients. Behavioral Health Service leaders and staff told the OIG that same-day access is available through in-person, telemental health, and virtual modalities to accommodate patients with emergent or urgent needs. The OIG reviewed the facility's next-day appointment report and noted same-day access was available at the South Central Clinic.

In January 2023, system leaders established a standard operating procedure (SOP) that required all patients be provided timely behavioral health care, including immediate and same-day assessment, and states "There shall be 'no wrong door' for access to BH [behavioral health] care."[11]

Multiple Modalities of Care

The OIG determined that, after receiving allegations, system leaders took actions to ensure patients were seen through the modality (in-person, telemental health, or virtual) that met their preferences and needs.

[10] VHA Directive 1160.01. Although VHA Directive 1160.01(1) was in effect at this time, it does not use current terminology; therefore, VHA Directive 1160.01 is used in this reference. PCMHI is a required component of VA primary care that provides behavioral health expertise to patients whose conditions can be managed collaboratively with primary care. PCMHI providers are integrated in primary care clinics to provide consultation and time-limited mental health care.

[11] Facility SOP 116-09, "Same Day Access for Behavioral Health Services," January 5, 2023.

VHA offers multiple modalities of care within a patient-centered model; clinicians evaluate the needs and preferences of the patient to "determine the most appropriate care modality or combination of modalities."[12]

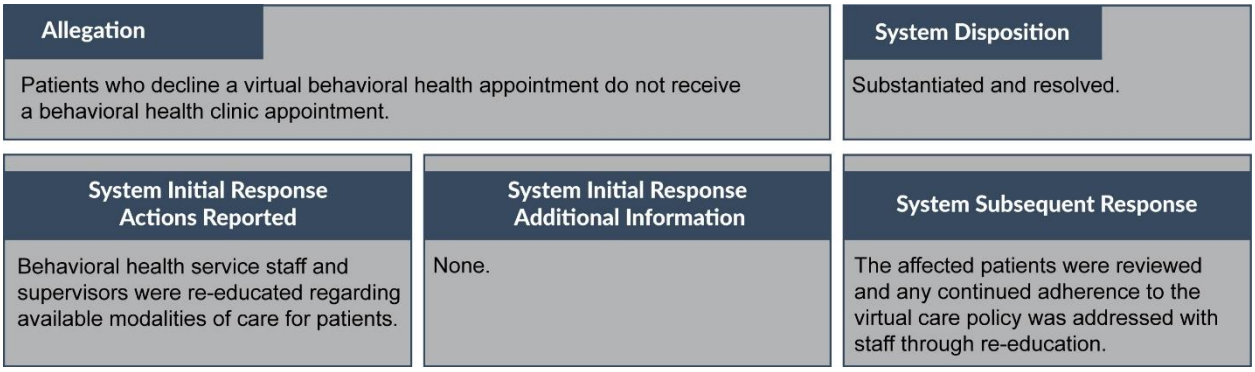

Figure 2. *System Disposition and Responses to Modality of Care Allegation*
Source: Facility and OIG communications and documents.

The system's responses to the OIG inquiries indicated that from April through July 2022, an acting ACOS-BHS mandated virtual appointments, regardless of patients' preferences, and authorized medical support assistants (MSAs) to change all in-person appointments to remote appointments to include telemental health or virtual appointments.[13] The ACOS-BHS reported that when the acting ACOS-BHS made this decision, staff were notified of a new Behavioral Health Service policy mandating patients to accept virtual appointments even if they indicated a preference for in-person care, which was against requirements.[14] The acting ACOS-BHS provided guidance to all Behavioral Health Service staff, and MSAs were authorized to convert previously scheduled in-person appointments to virtual.

The OIG learned that during those months, the acting ACOS-BHS also hired full-time remote providers to fill vacant positions and offered remote work to in-person providers to reduce provider burnout.

The acting ACOS-BHS reported focusing on adding remote staff to help the system reach the minimum staffing levels, as they had not been able to recruit qualified applicants in the past.[15] The acting ACOS-BHS told the OIG of hiring staff, and offering incentives and expedited hiring, from more than 70 vacancies, and "by October . . . [2022], 40 new [Behavioral Health Service providers and staff] were coming," including "about 6 new administrative support" staff.

[12] VHA Directive 1160.01; VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022.

[13] The ACOS-BHS told the OIG that the acting ACOS-BHS served in the position from mid-March 2022 through mid-July 2022.

[14] VHA Directive 1230.

[15] VHA Directive 1161 provides the minimum number of full-time equivalent clinical employees that a facility should have for every 1,000 patients receiving mental health care.

The ACOS-BHS told the OIG that, upon returning from extended leave, an estimated 80 percent of remote appointments and 20 percent or less of in-person appointments were available, creating a gap in access for in-person appointments. Therefore, the ACOS- BHS placed a moratorium on hiring remote providers and initiated a plan to hire in-person providers. As of the end of September 2023, the ACOS-BHS estimated 40 percent of remote and 60 percent of in-person staff were available for appointments.

In addition, in interviews, behavioral health clinic staff told the OIG that patient preference for the modality of the appointment differs by patient and appointment type (medication or therapy) and efforts are made to accommodate the patient preference in conjunction with appointment type. Behavioral Health Service leaders told the OIG of ongoing efforts to hire providers to fill the remaining vacant positions to improve access to care across the system. Continued challenges included limited applicants due to the system's remote Texas location by the Mexican border, competition for hiring with a community hospital, balancing the need to hire in-person providers with applicants' desire for remote and flexible schedules, and delays in the human resource process for posting positions, making job offers, and onboarding. The ACOS-BHS told the OIG of efforts to address the Behavioral Health Service staffing challenges by hosting hiring fairs and offering recruitment incentives.

Preferred Appointment Dates

The OIG reviewed patient scheduling practices and determined that actions taken by the system supervisor ensured patients who requested behavioral health care were scheduled according to their preferences and that oversight audits confirmed compliance with expected practice.

VHA's outpatient scheduling directive requires managing appointments "safely, timely, and accurately" that are "based on clinical need and [the patient's] preference," including using patient preferred dates (or patient indicated dates). To ensure compliance with scheduling and managing appointments, MSA supervisors are to provide feedback from ongoing scheduling audits, and remediate when needed.[16]

In an interview, an MSA supervisor told the OIG that, upon starting the position in summer 2023, the need for training in general scheduling practices was identified and that training to address knowledge gaps was provided to MSA schedulers. The supervisor also reported completing scheduling audits monthly for each MSA scheduler to ensure that patients receive their preferred appointment date and that these audits monitored other aspects of MSA scheduling performance as well, the results of which were shared with the MSAs.[17] An MSA

[16] VHA Directive 1230(5), *Outpatient Scheduling Processes and Procedures,* July 15, 2016, amended September 24, 2021. This directive was in place for the beginning of the review period and rescinded and replaced by VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022. VHA National Standardization Scheduling Audit Guidebook, revised August 7, 2023.

[17] An MSA supervisor told the OIG that MSAs meet the requirement for the initial scheduling attempt to occur within three days of the provider order and utilize provider schedules appropriately.

scheduler confirmed scheduling audits were completed and feedback was provided. The OIG reviewed behavioral health clinic scheduling audits documentation completed by system staff that showed 95 percent of appointments were scheduled correctly in fiscal year 2022 and an increase to 97 percent in fiscal year 2023.[18]

Patient Privacy

The OIG determined that actions taken by the system ensured patient privacy was maintained during behavioral health services when patients use tablets. The actions were taken in response to the allegation that the behavioral health clinic staff violate privacy and quality by putting patients with tablets in the same room as patients being counseled. Behavioral Health Service staff told the OIG that patients sometimes use system-supplied tablets at clinics to meet virtually with a behavioral health clinic provider who is not physically present at the same location.

VHA requires facilities to ensure safeguards are established for the security and confidentiality of personally identifiable information, including protected health information, to guard against threats or hazards that would result in substantial harm, embarrassment, inconvenience, or unfairness to the patient.[19] During times when a patient has suicidal ideations and is awaiting an immediate appointment, the patient must not be left unaccompanied.[20]

Telemental health "differs from in-person care because the treating health care professional is not physically at the patient's location."[21] According to a VHA telemental health operations supplement, when a patient participates in a telemental health appointment from a system clinic, staff introduce the telemental health provider and patient to one another and may then leave the room; however, staff may also physically assist the provider with the assessment or visit.[22] In the event a patient experiences a medical or behavioral health emergency and staff are not in the room with them, the telemental health provider must notify assigned on-site personnel to respond and provide emergency care.[23]

[18] The fiscal year runs from October 1 of a calendar year through September 30 of the next calendar year. Fiscal year 2023 data provided by the facility ended on September 14, 2023, two weeks prior to the end of the fiscal year. The OIG did not validate the audit results.

[19] VHA Directive 1605.01, *Privacy and Release of Information*, August 31, 2016.

[20] Facility SOP MHS-26, "Suicide Risk Assessment & Management," July 30, 2019.

[21] VHA SOP, "Standard Telehealth Emergency Handoff Procedures For Patient Emergencies During Synchronous Video Telehealth Visits Into A VA Clinic," September 2022.

[22] "TeleMental Health Supplement," August 2017. Staff assigned to the patient at the location of the telemental health visit are the eyes, ears, nose, and hands of the virtual provider, and are expected to be easily accessible in the event an emergency situation arises that may include physical actions such as cardiopulmonary resuscitation.

[23] VHA SOP, "Standard Telehealth Emergency Handoff Procedures For Patient Emergencies During Synchronous Video Telehealth Visits Into A VA Clinic."

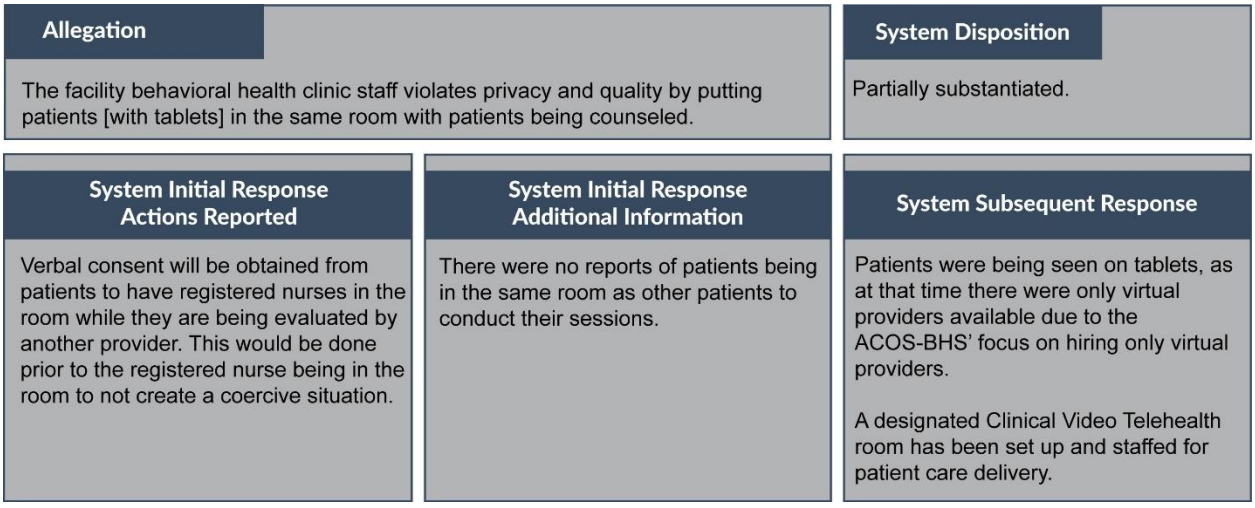

Figure 3. *System Disposition and Responses to Patient Privacy Allegation*
Source: Facility and OIG communications and documents.[24]

The system's action plan related to privacy included implementation of a process for staff to obtain a patient's verbal consent to allow staff in the room with the patient prior to the staff member staying in the room with the patient. The ACOS-BHS and a behavioral health clinic nurse told the OIG, and an NPAT nurse confirmed, that when staff deem a patient poses a risk to themselves or others during a virtual appointment, nursing staff remain with the patient to ensure patient safety. Behavioral health clinic nurses also noted obtaining the patient's verbal consent.

Although the implementation of an SOP to address privacy for patients being seen remotely was identified as an action on the system's response to the OIG, the ACOS-BHS and a system staff member reported to the OIG that the SOP was not developed. The ACOS-BHS told the OIG that rather than an SOP, Behavioral Health Service staff use relevant national directives as their guides. The OIG observed clinic processes at the South Central and Las Cruces clinics and found privacy requirements were upheld. Behavioral health clinic staff told the OIG that they do not accompany patients during telemental health visits unless clinically indicated. Staff members confirmed that patients with tablets were not placed in the same room with other patients. Privacy signage was observed throughout the system's clinics and the clinics were equipped with white noise devices to limit the travel of sound.

The OIG concluded that system leaders took impactful steps to increase access to behavioral health care and offer appointments and modalities based on patient preferences. The OIG also determined that behavioral health clinic processes were sufficient to maintain patient privacy during behavioral health virtual care.

[24] The System Director confirmed that this allegation was partially substantiated, and the response noted nursing staff reported being present in the room while patients were set up on tablets to meet virtual providers. There were no reports of patients being in rooms with other patients during virtual appointments.

2. Lack of Quality Oversight

The OIG determined that a quality review was not triggered or initiated because of the potential risk score that system staff assigned to the incident involving the patient. Although a quality review such as a root cause analysis (RCA) was not completed, the ACOS-BHS completed an administrative review of the incident prior to the OIG site visit and implemented a patient crisis protocol to adequately address the gaps.[25]

The reporting and review of patient incidents ensure care is provided according to expectations and to facilitate learning from potential system vulnerabilities. VHA requires staff to report adverse events and close calls. Once reported, VHA requires the facility patient safety manager to review the patient safety event and assign a safety assessment code (SAC) based on the outcome of the actual event as well as the potential outcome. The SAC score is a ranked matrix score of the severity and probability of harm using a score of 1 (lowest risk), 2 (intermediate risk), or 3 (highest risk). VHA requires an RCA for any event with a score of 3.[26]

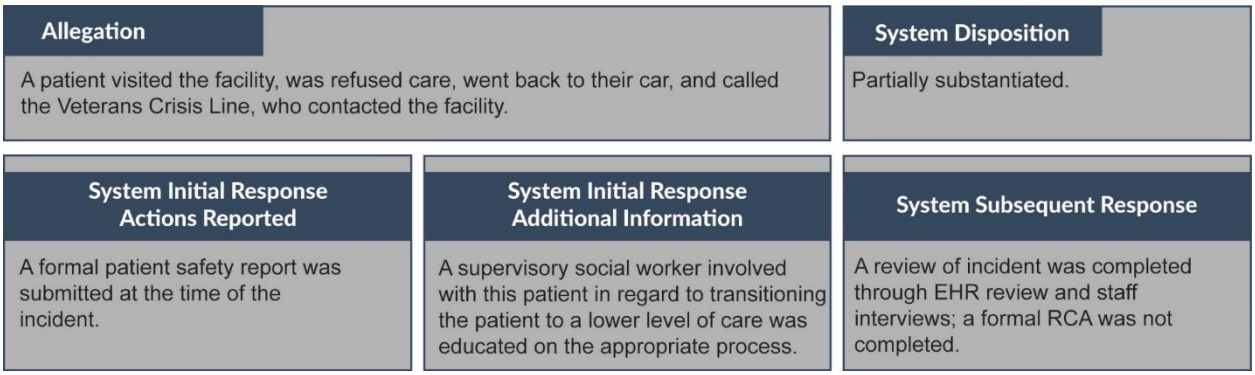

Figure 4. *System Disposition and Responses to Denial of Care Allegation*
Source: Facility and OIG communications and documents.

The system's initial reply to the OIG stated that in response to the patient's incident, the ACOS-BHS reviewed the patient's EHR and interviewed staff. The ACOS-BHS updated the process for responding to patients in crisis, including development of an SOP and corresponding algorithm. During the inspection, the OIG observed clinic processes, interviewed staff, and confirmed that the system's crisis patient protocol SOP described the steps in a corresponding algorithm, including staff responsibilities, and was easily accessible for staff reference. When asked about managing patients in crisis, staff verbalized the expected process.

[25] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. The handbook was in effect at the time of the incident. The handbook was rescinded and replaced by VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. An RCA is defined as a "comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." Unless otherwise specified, the handbook and the directive contain similar language regarding the SAC and requirements for an RCA.

[26] VHA Handbook 1050.01.

The system's initial response to the OIG also indicated that a patient safety report was entered following the incident related to the patient and that an RCA was in process. However, following an OIG request for more information in May 2023, the written response from the system provided clarification indicating that an RCA would not be done due to the SAC score. Documentation reviewed by the OIG showed that the system's patient safety manager gave the incident a SAC score of 1 for the actual incident severity category and 2 for the probability of harm category, thus not requiring an RCA.[27]

In an interview, the system's chief of Quality, Safety, and Value told the OIG of starting in the role in early summer 2023, after the patient's incident. The chief of Quality, Safety, and Value reported that a situation like that experienced by the patient would have been assessed as a SAC score of 3 for the probability of harm category, indicating higher potential risk, due to the patient being allowed to leave without being assessed. The OIG was unable to follow-up with the patient safety manager to gain further understanding of the rationale used for scoring the patient's incident.

Due to the threat of self-harm and immediate access to a firearm, the OIG would have expected the probability of harm category related to the incident to be scored as a 3 by the former patient safety manager and an RCA completed per VHA directive.[28] However, the OIG did not make a recommendation because the incident was reviewed by the ACOS-BHS, Quality, Safety, and Value leaders were aware of the concern about the scoring of this incident, and the staff member who assigned the score received education on SAC scoring.

3. Concern Related to Locations of Providers

The OIG identified a potential vulnerability resulting from the varied locations of providers and the settings in which patients receive care.

VHA facilities that do not have locked behavioral health acute inpatient units, such as the system, must "have agreements with appropriate agencies or hospitals to allow them to arrange involuntary hospitalization when clinically necessary."[29] VHA requires that facility processes for involuntary hospitalizations follow local and state laws.[30]

The system has clinics in Texas and New Mexico, and a clinic staff member told the OIG that each state has their own laws addressing emergency detentions and commitments. Due to system providers residing in both of these states, and virtual providers residing in different states altogether, the OIG is concerned about potential issues arising from advice given in emergent

[27] This patient safety manager left employment during this inspection.

[28] VHA Handbook 1050.01; VHA Directive 1050.

[29] VHA Directive 1160.01.

[30] VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023.

and urgent patient situations by virtual providers who may not be versed in Texas and New Mexico state emergency detention order laws.

While no cases of concern were identified, the OIG recommends that system leaders review Behavioral Health Service policies and guidance to ensure alignment with federal, Texas, and New Mexico state laws specific to the system's emergency detention orders, and ensures behavioral health licensed independent practitioners are familiar with the policies and laws.

Conclusion

Actions taken by system leaders, including those initiated before the OIG inspection and those implemented after OIG inquiries, ensured that the system's behavioral health clinic staff did not refuse access to care for patients, patients were seen in the time frame and at the location that met their preferences and needs, and patients' privacy was maintained during behavioral health services.

The OIG identified a potential vulnerability resulting from providers working in locations differing from the settings in which patients receive care. Due to the system having clinics in Texas and New Mexico and local providers who reside in either state, and virtual providers who reside in different states altogether, the OIG is concerned with potential issues arising from advice given by providers in emergent and urgent patient situations who may not be versed in Texas and New Mexico state emergency detention order laws.

Recommendation

The El Paso VA Health Care System Director ensures Behavioral Health Service policies and guidance are in alignment with federal laws and Texas and New Mexico state laws specific to the system's emergency detention orders, and educates behavioral health licensed independent practitioners on the policies, as needed.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 22, 2024

From: Director, VA Heart of Texas Health Care Network (10N17)

Subj: Healthcare Inspection—System Leaders' Response to Allegations Related to Access to Behavioral Health Care at the El Paso VA Health Care System in Texas

To: Director, Office of Healthcare Inspections (54HL05)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

We deeply regret the circumstances that impacted the care delivered to one of our Veterans.

1. I have reviewed the draft report and the Facility Response for System Leaders' Response to Allegations Related to Access to Behavioral Health Care at the El Paso VA Health Care System in Texas.

2. The El Paso Texas VA Health Care System is committed to honoring our Veterans by ensuring they receive high-quality healthcare services. I support the Director's response and the action plan of the El Paso VA Health Care System.

3. I would like to thank the Office of Inspector General for their thorough review of this case and if you have any additional questions, please contact, VISN 17 Deputy Quality Management Officer (DQMO).

(*Original signed by*:)

Wendell Jones, MD, MHA
VA Heart of Texas Health Care Network (VISN 17)

Appendix B: System Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 16, 2024

From: Executive Director, El Paso VA Health Care System (756)

Subj: Healthcare Inspection—System Leaders' Response to Allegations Related to Access to Behavioral Health Care at the El Paso VA Health Care System in Texas

To: Director, VA Heart of Texas Health Care Network (10N17)

1. I have reviewed and concur with the findings and recommendation in the report of the Healthcare Inspection of the El Paso VA Health Care System, El Paso, Texas.

2. Corrective action plans have been implemented with target dates set for completion of the items detailed in the attached report.

(*Original signed by*:)

Froylan Garza
Executive Director

System Director Response

Recommendation

The El Paso VA Health Care System Director ensures Behavioral Health Service policies and guidance are in alignment with federal laws and Texas and New Mexico state laws specific to the system's emergency detention orders, and educates behavioral health licensed independent practitioners on the policies, as needed.

_X _Concur

____Nonconcur

Target date for completion: July 1, 2024

Director Comments

The Behavioral Health Service will develop policies and guidance that are in alignment with federal laws and Texas and New Mexico state laws specific to the requirements for emergency detention orders. The Crisis Intervention Team (CIT) (a local law enforcement team), from the state where the encounter is made, will be contacted to evaluate, and transport the Veteran in need of emergency detention orders. Local law enforcement is aware of and follows state specific laws. Behavioral Health licensed independent practitioners will be educated about the updated processes and will receive refresher education annually, or as needed.

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	Susan Tostenrude, Director, MS, OT Erin Butler, LCSW Michelle Ernzen, MSN, RN Ping Luo, PhD Vanessa Masullo, MD Aja Parchman, MHA, RN Andrew Waghorn, JD
Other Contributors	Josephine Biley Andrion, MHA, BSN Christopher D. Hoffman, LCSW, MBA Natalie Sadow, MBA April Terenzi, BA, BS

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