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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Care Provided to a Patient Who Died by Suicide, Marion VA Health Care System in Illinois

Healthcare Inspection | **24-02987-27** | **January 8, 2026**

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Executive Summary

The VA Office of Inspector General (OIG) initiated a healthcare inspection in July 2024, and conducted a virtual site visit September 9–19, 2024, to evaluate allegations related to Marion VA Health Care System (facility) staff's care of a patient who died by suicide. Specifically, the OIG evaluated allegations that facility staff failed to adequately address the patient's traumatic brain injury (TBI), back pain, and mental health treatment needs.[1]

Additionally, the OIG identified concerns related to the management of the patient's repeated falls with strikes to the head, and the patient's TBI evaluation, care coordination, and high risk for suicide patient record flag (high-risk flag) management. The OIG also identified concerns regarding facility leaders' lack of consideration for completing an institutional disclosure.

Synopsis of the Patient's Care

The patient, in their early 40s, died by suicide in spring 2024 and had a medical history of chronic back pain, migraine headaches, depression, and insomnia.[2] Beginning in early summer 2018, the patient received care at the facility. Over the next several years, the patient reported falls that often involved a strike to the head or loss of consciousness.[3]

Starting in fall 2021, the patient met with a mental health nurse practitioner (MHNP) for treatment of depression and anxiety. In winter 2021, the patient began receiving pain management through community care, which included multiple procedures to address back pain. The MHNP referred the patient for individual psychotherapy in spring 2022 following the patient's reports of suicidal behaviors, depressive symptoms, and psychosocial stressors that included financial, legal, and child custody concerns. A high-risk flag was subsequently placed on the patient's chart and the patient received case management services from suicide prevention staff through telephone contact until early 2023 when the high-risk flag was inactivated.[4]

After a fall in spring 2023, the patient was admitted to a community hospital and diagnosed with a TBI. The patient was transferred to a community care rehabilitation facility (rehabilitation facility) and participated in 15 days of physical, occupational, and speech therapy. At discharge, rehabilitation facility staff sent the facility a discharge summary, which included recommendations for the patient to continue physical and occupational therapy. A facility primary care provider (PCP) referred the patient to physical therapy and speech therapy and

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

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

[3] The patient's care discussed in this report was provided by the facility or through VA-approved community care.

[4] The patient met with a social worker eight times for psychotherapy between summer 2022 and summer 2023.

recommended that the patient discuss returning to work with a neurologist. The neurologist, who was only treating the patient for migraine headaches, cleared the patient to return to work.

The high-risk flag was reactivated in summer 2023 after the patient reported suicidal ideation with a plan, and the patient received telephone contacts from suicide prevention staff until early 2024, when the flag was inactivated.[5] The neurologist continued to treat the patient's migraines until spring 2024. However, the patient reported continued anxiety symptoms, depression, thoughts of being "better off dead," and "significant financial" and health-related stress to the MHNP. Approximately six weeks later, a suicide prevention coordinator documented contacting an acquaintance of the patient who reported that the patient died approximately two weeks prior by suicide from a firearm injury to the head.

Inspection Results

The OIG found that the PCP and neurologist did not address the patient's reports of multiple falls with strikes to the head and did not consider a TBI evaluation. The OIG also identified deficiencies in primary care nursing staff's and mental health staff's management of the patient's reported falls. Following the patient's TBI diagnosis and discharge from the rehabilitation facility in mid-spring 2023, the PCP and neurologist did not address the patient's TBI-related needs or add TBI to the patient's problem list, and facility staff did not adequately manage the patient's community care records. Further, the PCP did not coordinate pain management with the patients' community care pain management provider and suicide prevention staff did not notify the patient of high-risk flag status change.

Management of the Patient's Falls

Facility policy requires that trained staff evaluate a patient's mobility, fall risk, actions to reduce fall risk, and "risk of injury from falls" when there is a significant change in a patient's condition, including a fall.[6] Providers are expected to complete a physical assessment to consider causes of the fall and "take appropriate action."[7] Between summer 2018 and spring 2024, the patient reported experiencing a fall at home to facility staff members 18 times, with 16 of the reported falls including a strike to the head or loss of consciousness.

[5] The OIG determined that due to a procedural error, the high-risk flag inactivation note was not documented in the patient's EHR when the high-risk flag was deactivated in early 2024.

[6] Facility Medical Center Memorandum 002-118-16-658, *Fall Prevention Program*, February 24, 2016, updated to Facility Medical Center Memorandum 002-118-19-658, *Fall Prevention and Mobility Program,* July 11, 2019. The memoranda contain similar language related to fall risk assessment requirements.

[7] Facility Medical Center Memorandum 002-118-19-658.

PCP's Assessment of the Patient's Falls

Between spring 2022 and fall 2023, the PCP was notified that the patient fell five separate times but did not evaluate the patient's mobility, fall risk, and risk of injury from falls; document clinical decision-making for the falls from other possible diagnoses; or ensure that the patient received appropriate care to reduce fall risk, as required.[8]

The PCP acknowledged awareness of the patient's multiple falls and reported a belief that the patient's back pain was causing the falls and that treating the pain was addressing the falls. The PCP reported expecting the neurologist to evaluate the patient for gait and balance issues or other reasons for the falls. The PCP not completing a comprehensive workup to determine the frequency, pattern, potential vulnerabilities to further falls, and establish a plan of care to address the falls, limited the treatments made available to the patient.

Neurologist's Evaluation of Falls and Management of Care Coordination

The patient reported a fall to the neurologist during three separate visits between fall 2022 and summer 2023, but the neurologist did not assess the patient for causes of the falls or coordinate the patient's neurology treatment with the PCP. The neurologist also did not consider evaluation or treatment of possible cognitive consequences of the patient's falls and when asked who was addressing the cognitive consequences, the neurologist told the OIG that "it doesn't seem as though anybody was addressing those issues." Further, the neurologist failed to adjust the patient's treatment plan following the patient's reports of continued falls with injury to the head.

Primary Care Nursing Staff's Response to Falls

From summer 2018 through fall 2023, primary care nursing staff were made aware of the patient reporting nine separate falls. Primary care nursing staff did not complete a fall note as required by facility policy, which would have prompted further evaluation and consideration of interventions, for any of the nine falls.

The primary care nurse, who was notified of six of the falls, reported an incorrect belief that the patient's falls were related to seizures that neurology was addressing and did not consider interventions to reduce the patient's falls. Primary care nursing staff's failure to complete the required fall note likely contributed to limited awareness of the patient's needs.

[8] Facility Medical Center Memorandum 002-118-16-658; Facility Medical Center Memorandum 002-118-19-658. The OIG defines medical providers in the context of this policy as medical staff who provided direct patient care and are capable, by training and experience, of evaluating and referring the patient for additional services.

Mental Health Staff's Fall Notifications

Mental health staff did not alert primary care staff of five of the seven falls that the patient reported to them.[9] A suicide prevention coordinator reported that alerting providers to falls is typical practice and was uncertain as to why it did not occur. The MHNP incorrectly believed that neurology was addressing the patient's falls. Facility staff's failure to address the patient's repeated falls with head injury and intervene with fall prevention strategies may have resulted in preventable injury.

Consideration of a TBI Evaluation

The Veterans Health Administration (VHA) explains that providers treating a patient who may have a TBI "should send a consult requesting evaluation and treatment" to a "rehabilitation team that completes the CTBIE [comprehensive TBI evaluation]."[10] Prior to the patient's TBI diagnosis in spring 2023, the patient reported 13 falls to multiple facility staff that included a strike to the head or loss of consciousness. Neither the PCP nor the neurologist referred the patient for a comprehensive TBI evaluation when notified of the falls with head injury due to a lack of knowledge regarding available TBI evaluation services.[11] The PCP reported minimal experience with TBI referrals at the facility and specified a practice of sending patients with TBI to neurology for assessment. The chief of medicine reported an expectation that a neurologist would be able to conduct TBI evaluations and make necessary referrals for care; however, the neurologist reported being unaware about specific TBI evaluation services available to patients and expected that PCPs would refer patients with head injuries to the TBI clinic first, rather than neurology, for TBI evaluation and care.

TBI Care and Records Management

The OIG substantiated that the neurologist did not provide the patient with TBI treatment following the patient's diagnosis of TBI from a community hospital and treatment from the rehabilitation facility in spring 2023. During an appointment with the neurologist, that occurred approximately one month after the patient's discharge from the rehabilitation facility, the neurologist did not address the patient's TBI, instead focused on the patient's report of "migraine." The neurologist also approved the patient to return to work in two weeks even though the patient was placed on work restrictions for head injury, not migraine headaches.

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[9] Mental health staff include the MHNP, social worker, suicide prevention case manager, and suicide prevention coordinator 1.

[10] "Traumatic Brain Injury Program Documents, TBI Directive-Attachment C- Frequently Asked Questions," VHA Rehabilitation and Prosthetic Services, accessed November 18, 2025, https://vaww.rehab.va.gov/ProgramDocuments/TBI/index.asp. (This site is not publicly accessible.)

[11] VHA Directive 1184. The OIG determined that triage nursing staff added primary care staff to each note documenting the patient's report of a fall at home.

Although the neurologist told the OIG that care coordination with other providers typically occurs "through the chart," the neurologist did not add the PCP as an additional signer to any notes regarding the patient's neurology care.[12] The neurologist's failure to address and coordinate the patient's TBI treatment impeded the patient's ability to receive recommended comprehensive and interdisciplinary TBI care.[13]

The PCP did not ensure receipt of the patient's late spring 2023 discharge summary from the rehabilitation facility and did not manage the patient's recommended follow-up care, as required.[14] Although the PCP referred the patient to physical therapy and encouraged the patient to speak with the neurologist about returning to driving, the PCP did not address the patient's TBI or assess for current or persisting symptoms. The PCP reported a belief that referring the patient to physical therapy and suggesting follow up with the neurologist would address the patient's TBI rehabilitation needs.

The PCP and neurologist did not add TBI to the patient's problem list, as required.[15] Failure to add a TBI diagnosis to the problem list may have resulted in mental health and suicide prevention staff's limited understanding of the patient's functional challenges and TBI-related needs, affecting the patient's ability to receive TBI-informed mental health care.

Community care staff did not ensure receipt of the patient's rehabilitation facility discharge summary and did not make community care records available to staff within the required time frame, which may have contributed to the patient not receiving recommended TBI follow-up care.[16]

Care Coordination for the Patient's Back Pain

The OIG did not substantiate that facility staff provided inadequate evaluation and initial management of the patient's back pain; however, the PCP did not coordinate pain management with the patient's community care pain management provider and monitor treatment

[12] Facility Medical Center Policy 11-111-20-149, *Primary Care Program,* November 27, 2020.

[13] VHA Directive 1172.01, *Polytrauma System of Care,* January 24, 2019, rescinded and replaced by VHA Directive 1172.01, *Polytrauma System of Care,* April 18, 2024. The policies contain similar language related to Rehabilitation Standards in the Polytrauma System of Care.

[14] Facility Medical Center Policy 11-111-20-149.

[15] Facility SOP 136-005, "Patient Problem List," July 1, 2022.

[16] VHA Office of Health Informatics, *Practice Brief Community Care – VistA Imaging Capture Best Practice And Minimum Documentation Requirements*, March 2021.

effectiveness, as required.[17] When the patient continued to report falls to the PCP that the patient attributed to pain, the OIG would have expected the PCP to communicate with community care pain management providers to assess the effectiveness of pain management interventions. Facility staff did not use the "community care-care coordination plan note" (care plan note) that identifies the facility interdisciplinary teams relevant to the patient's care, as required.[18]

Scheduling Follow-up Care

VHA requires that outpatient appointment requests are "managed safely, timely and accurately, and are scheduled based on clinical need."[19] According to facility policy, nursing staff are expected to work with PCPs "to provide continuity of care."[20] On three separate occurrences between summer 2022 and fall 2023, the PCP gave the primary care nurse instructions to schedule follow-up care, but the patient was not scheduled for an appointment. The OIG did not find documentation in the electronic health record (EHR) that the primary care nurse took action to schedule the patient for follow up appointments as requested by the PCP. The primary care nurse's failure to follow up on the scheduling requests likely contributed to the patient not receiving the requested primary care follow-up appointments.

Medication Management and Mental Health Care

The OIG did not substantiate that facility staff failed to provide the patient appropriate mental health medication management and treatment. Throughout the patient's psychiatric care, the MHNP regularly reviewed the patient's medications with the patient and adjusted prescriptions and dosage as indicated. Further, the social worker adequately provided mental health care to address the patient's concerns and to accommodate treatment preferences and availability.

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[17] VHA Directive 2009-053, *Pain Management*, October 28, 2009. This directive was in place during the time of the events discussed in this report. It was amended June 24, 2024. Unless otherwise specified, the 2024 directive contains the same or similar language regarding pain assessment and management; VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook,* February 5, 2014, amended May 26, 2017. This handbook was in place during the time of the events discussed in this report. It was amended to VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook,* February 29, 2024. The handbooks contain similar language regarding care coordination requirements.

[18] VHA Office of Integrated Veteran Care (IVC), "Care Coordination-Community Care Plan Note and Addendums," chap. 3 in Office of Integrated Veteran Care (IVC) Community Care Field Guidebook. The guidebook is a continually updated process and information guide outlining specific functions of community care operations. The OIG determined that community care staff categorized the patient's pain management care coordination needs as moderate.

[19] VHA Directive 1230, *Outpatient Scheduling Management,* June 1, 2022.

[20] Facility Medical Center Policy.

Management of High-Risk Flag

Suicide prevention staff did not notify the patient of high-risk flag activations and inactivation and did not place an inactivation note in the patient's EHR when the high-risk flag was removed, as required.[21] The failure to inform the patient of the high-risk flag activations may have contributed to an incomplete understanding of the suicide prevention care and discouraged the patient from fully engaging with staff. Suicide prevention staff did not routinely complete safety plan reviews during high-risk flag case management contacts, nor did staff accommodate the patient's preference regarding timing of contacts, which may have resulted in the patient not receiving consistent safety plan review. [22]

Institutional Disclosure Consideration

Facility leaders did not consider an institutional disclosure due to not identifying concerns with the patient's care.

The OIG made 13 recommendations to the Facility Director related to a review of the patient's care; adherence to facility fall prevention policy; mental health staff's role in responding to falls; education and training on TBI clinic services; consultation between primary care and specialty care providers; patient problem list standard operating procedure; community care records management; care coordination with community care providers; use of the care plan note; primary care scheduling processes; high-risk flag activation and inactivation; safety planning; and consideration of an institutional disclosure in light of the findings in this report.

[21] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010, rescinded and replaced by VHA Directive 1166, *Patient Record Flags*, November 6, 2023. The 2010 directive includes general guidance for all patient record flags. The 2023 directive adds responsibilities for the suicide prevention coordinator to notify a patient of a high-risk flag; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Implementation of Caring Communications for Veterans with Inactivated High Risk for Suicide Patient Record Flags (HRS-PRF)," memorandum to VISN Director (10N1-23) et al., May 5, 2023; The OIG determined that due to a procedural error, the high-risk flag inactivation note was not documented in the patient's EHR.

[22] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Update to High Risk for Suicide Patient Record Flag (HRS-PRF) Changes," memorandum to VISN Directors, VISN CMOs, VISN Chief Mental Health Officers, October 5, 2021.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations (see appendixes B and C). Based on information provided, the OIG considers recommendations 1, 4, and 13 closed. The Facility Director shared plans to update procedures on fall prevention, care coordination, and management of high risk for suicide flags. The Facility Director also planned to ensure compliance with community care coordination and scheduling practices. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

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Principal Deputy Assistant Inspector General,
In the role of Acting Assistant Inspector General
for Healthcare Inspections

Contents

Abbreviations

EHR	electronic health record
MHNP	mental health nurse practitioner
OIG	Office of Inspector General
PCP	primary care provider
TBI	traumatic brain injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection on July 24, 2024, and conducted a virtual site visit September 9–19, 2024, at the Marion VA Health Care System (facility) in Illinois, to evaluate allegations related to staff's care of a patient who died by suicide. Specifically, the OIG evaluated allegations that facility staff did not adequately address the patient's traumatic brain injury (TBI), back pain, and mental health treatment needs.

Additionally, the OIG identified concerns related to the management of the patient's repeated falls with strikes to the head, and the patient's TBI evaluation, care coordination, and high risk for suicide patient record flag (high-risk flag) management. The OIG also identified a concern that facility leaders did not consider completing an institutional disclosure.

Background

The facility, part of Veterans Integrated Service Network (VISN) 15, is composed of a medical center and 11 outpatient clinics. The facility offers primary care, surgical services, and specialty services including pain management and physical medicine and rehabilitation.[1] The facility has an affiliation with Southern Illinois University School of Medicine.

TBI

Individuals with a TBI may experience significant lasting cognitive, emotional, and behavioral changes that can include mood and anxiety symptoms, impulsivity, suicidal behavior, and lack of emotion. Repeated TBIs may worsen these effects and lead to cumulative deficits.[2]

Suicide risk significantly increases for veterans with TBI.[3] In the United States between 2018–2019, death by suicide accounted for 35.5 percent of injury-related death for individuals with TBI, and "TBI-related firearm suicide increased" among men and women.[4]

[1] "Health Services," VA Marion Health Care, accessed January 7, 2025, https://www.va.gov/marion-health-care/health-services/.

[2] Leila L. Etemad et al., "Longitudinal Recovery Following Repetitive Traumatic Brain Injury," Jama Network Open 6, no. 9 (September 26, 2023): 1-17, https://doi.org/10.1001/jamanetworkopen.2023.35804.

[3] VA, "VA Research on Traumatic Brain Injury," (fact sheet), updated July 2020.

[4] "Surveillance Report: Traumatic Brain Injury-Related Deaths by Age Group, Sex, and Mechanism of Injury," Centers for Disease Control and Prevention, accessed December 5, 2024, https://www.cdc.gov/traumaticbraininjury/pdf/tbi-surveillance-report-2018-2019-508.pdf. Injury-related deaths included: unintentional motor vehicle crashes, falls, strikes by or against an object, and unspecified injury; suicide; homicide; and unknown causes.

Veterans Health Administration (VHA) Directive 1172.01, *Polytrauma System of Care,* requires that patients who sustained a qualifying "deployment and non-deployment" TBI receive comprehensive medical and rehabilitation services through the polytrauma system of care.[5]

Allegations and Related Concerns

On June 24, 2024, the OIG received allegations that facility staff did not adequately address the patient's TBI, back pain, and mental health treatment needs including medication management. Specifically, the complainant alleged that a neurologist "didn't do anything" in spite of the patient's head injury following a fall in spring 2023 and the patient's back "pain was getting worse and the VA gave [the patient] the run around."

During evaluation of these allegations, the OIG identified concerns related to a primary care provider's (PCP) and a neurologist's failure to address the patient's reports of repeated falls with strikes to the head and to consider a TBI evaluation.

The OIG also identified concerns related to staff's inadequate

- evaluation of the patient's reported repeated falls,
- TBI care coordination,
- management of the patient's problem list,
- management of community care records,
- use of the "community care-care coordination plan note" (care plan note), and
- follow-up scheduling.

The complainant also alleged that the patient "got depressed," and was "put on huge amounts of medication" and mental health staff "wouldn't call [the patient] or canceled appointments," and "the appointments [the patient] did have were via telephone."

The OIG also identified concerns related to staff's management of the patient's care while assigned a high-risk flag and leaders' lack of consideration of completing an institutional disclosure.

[5] VHA Directive 1172.01, *Polytrauma System of Care,* January 24, 2019, rescinded and replaced by VHA Directive 1172.01, *Polytrauma System of Care,* April 18, 2024. The policies contain similar language related to Rehabilitation Standards in the Polytrauma System care; VHA's polytrauma system of care "is an integrated network of specialized rehabilitation programs" for patients with TBI and polytrauma offering interdisciplinary evaluation and treatment, comprehensive care plans, case management services, patient education, and psychosocial support. "Polytrauma/TBI System of Care," VHA, accessed February 12, 2025, https://www.polytrauma.va.gov/.

Scope and Methodology

The OIG initiated the inspection on July 24, 2024, and conducted a virtual site visit September 9–19, 2024.

The OIG team interviewed a family member of the patient and facility staff and leaders familiar with the patient's care and relevant processes.

The OIG reviewed the patient's electronic health record (EHR); relevant VHA directives, handbooks, and memoranda; and facility policies, standard operating procedures, and organizational charts.

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

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 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

The patient, in their early 40s at the time of death by suicide in 2024, had a medical history of chronic back pain, migraine headaches, insomnia, and depression.[6] Beginning in early summer 2018, the patient received care at the facility. (See appendix A for a detailed account of the patient's care at the facility from summer 2018 through spring 2022.)

Starting in 2018, the patient was treated by primary care for back pain and mental health for depression and insomnia at the facility. The patient reported to a licensed practical nurse a fall due to "back spasms" in summer 2018. The patient reported continued back pain, neck pain, and

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

migraines to a primary care nurse practitioner in 2019 and engaged in physical therapy at the facility and chiropractic care through the community care program.[7] In summer 2020, the patient reported to a registered nurse having a fall with a strike to the head on the counter. The patient was later referred to community care for pain management procedures to address back pain by a facility anesthesiologist.

In 2021, the patient continued with community care pain management and was referred for mental health medication management after reporting "significant anxiety," "panic attacks," and using alcohol to cope with symptoms and suicidal thoughts. Also in 2021, the patient reported to a licensed practical nurse three additional falls over approximately eight months related to knee buckling due to a "pinch[ed] nerve in back." From fall 2021 to spring 2022, the patient regularly attended mental health medication management appointments.

Spring 2022 to Early Winter 2023

During an early spring 2022 visit with the mental health nurse practitioner (MHNP), the patient reported having "passed out" two to three times since the prior visit due to dizziness and legs "giving out" resulting in a fall and hitting of the head. The patient reported discontinuing pain management treatment because the community care provider's "lobby would be packed, and [the patient's] appointment would get rescheduled." The next day, the MHNP documented the patient's report of "passing out" and alerted the patient's PCP who submitted a cardiology consult to evaluate for syncope.

Approximately one month later, the patient told the MHNP about having held a loaded gun while contemplating suicide the previous week; increased financial, family, and transportation stressors; and worsened depression. The MHNP completed a suicide risk assessment and safety plan, notified the suicide prevention team, and referred the patient to psychotherapy. That same day, a suicide prevention coordinator (suicide prevention coordinator 1) assigned the patient a high-risk flag and the patient was later mailed gun locks.

In late spring 2022, during a scheduled primary care appointment, the patient reported to the licensed practical nurse a fall with head injury approximately three months prior due to the patient's "knees giving out." The patient also reported this fall to the PCP the same day. The PCP documented that the patient's chronic medical conditions were stable with a plan to see the patient in one year. Approximately three weeks later, in an initial psychotherapy appointment with a social worker, the patient denied suicidal thoughts and agreed to participate in psychotherapy for depression.

In early summer 2022, a cardiologist documented that the patient's symptoms were "not syncope, more like a mental distraction or fogginess following a head injury. Likely more

[7] The patient's care discussed in this report was provided by the facility or through VA-approved community care.

neurologic than cardiac … symptoms started after a fall with concussion." The cardiologist documented that a computed tomography scan of the patient's head had "normal" results and referred the patient to neurology for assessment of "Migraines and Concussion with periods of [amnesia]." The next day, the social worker documented that the patient walked "slowly, deliberately, and with a limp" due to back problems, and denied suicidal ideation.

In mid-summer 2022, the patient sent a message to the PCP requesting a referral to a different community care pain management site. The patient reported that two days prior "my back locked up," resulting in a fall with head injury, dizziness, and loss of consciousness.

During a psychotherapy visit three days later, the patient reported vision problems, confusion, and headaches following a recent fall. The patient also described recent suicidal ideation due to "severe, disabling back pain" last occurring approximately five days prior." The social worker completed a suicide risk evaluation and alerted the MHNP who notified the PCP of the patient's concerns regarding pain and black outs. In an appointment approximately a week later, a neurologist documented the patient's fall history and headaches and diagnosed the patient with migraine and a "history of head injury with loss of consciousness but no apparent sequelae." The neurologist noted a plan to prescribe migraine medication and follow up in two months. Two weeks later, another community care pain management provider administered a pain management procedure to the patient.

In late summer 2022 during a psychotherapy visit, the patient discussed getting temporary relief from the pain management procedure, falling recently, and not remembering a recent motor vehicle accident. The patient reported last experiencing suicidal thoughts with a plan to die by firearm two days before the visit and agreed to have a friend take possession of the firearm. The social worker alerted the suicide prevention team, reviewed the safety plan with the patient, and assessed the patient as "high acute risk" and "high chronic risk" for suicide.[8]

Eleven days later, the patient contacted the facility call center and reported a fall with striking of the head on a brick wall, possible seizure, continued headaches, and blurry vision. The patient declined the call center nurse's recommendation to seek evaluation at an emergency department because the patient preferred to meet with the PCP. The following day, the patient presented to the facility and requested an unscheduled appointment with the primary care team. The MHNP met with the patient and documented the patient's report of an episode of blacking out and striking head on a brick wall followed by a possible seizure, and, in consultation with the primary care team and the suicide prevention team, the patient agreed to be transported via

[8] High acute risk for suicide indicates a patient who is assessed as having thoughts of death by suicide with intent to die and is unable to maintain safety independently. High chronic risk for suicide indicates a patient who is assessed as at "risk for becoming acutely suicidal." "Therapeutic Risk Management – Risk Stratification Table," VA Rocky Mountain Mental Illness Research, Education, and Clinical Center, accessed February 13, 2025, https://www.mirecc.va.gov/visn19/trm/docs/Therapeutic-Risk-Management-Risk-Stratification-Tool_June-2024_508.pdf#page=1.

ambulance to a community emergency department. The community emergency department physician documented suspecting the patient had "post-concussion syndrome" and discharged the patient the same day.

Approximately one week later, the neurologist documented the patient's migraine treatment benefits, recent fall, upcoming community care pain management procedure to "hopefully" eliminate the patient's back pain, falls, and "repeat head injuries." The neurologist planned to follow up with the patient in three months. In early fall 2022, the patient received two pain management procedures over a two-month period.

In late fall 2022, the patient presented for a primary care appointment. Nursing documentation from the appointment reflected the patient fell two months prior and sustained a head injury and that the nurse provided and reviewed a fall prevention handout with the patient. The PCP documented that the patient experienced "back spasms" with shooting pain that resulted in the patient's "legs to give out." Additionally, the PCP noted that an imaging study showed severe spinal arthritis and that the patient had upcoming appointments with neurology and pain management.

One week later, during a phone call, a suicide prevention case manager documented that the patient reported a concussion with loss of consciousness, blurred vision, and fatigue. The suicide prevention case manager encouraged the patient to present to an emergency department if symptoms worsened. Approximately two weeks later, the neurologist documented the patient's headaches were "doing very well" until the recent head injury with loss of consciousness and that the prescribed medication will relieve the headache. Further, the neurologist noted the patient was scheduled for a pain management procedure in approximately two weeks to "hopefully" solve the patient's problems from "pain induced" falls and a plan for the patient to return to the clinic in four months for follow up. The patient continued regular visits with the MHNP through late 2022.

In early 2023, a suicide prevention coordinator (suicide prevention coordinator 2) documented inactivating the patient's high-risk flag due to a lack of suicidal behaviors or recent suicidal thoughts with intent to die. Three days later, the patient underwent the planned pain management procedure. The same month, the patient missed a medication management appointment and the MHNP notified a medical support assistant via a note in the patient's EHR to reschedule the patient's appointment.

Spring 2023 to Spring 2024

In early spring 2023, the patient attended a community care pain management follow-up appointment and reported a continuation of pain relief since the last visit. Almost one month later, the patient reported experiencing three headaches a week and the neurologist prescribed an additional migraine medication. The neurologist also documented the patient received a pain management procedure that resulted in temporary back pain reduction and the patient had a

scheduled follow-up community care pain management appointment in the summer. Two weeks later, the patient contacted a clinical contact center triage nurse (triage nurse) to request a primary care appointment for complaints of back pain, spasms, and leg weakness.[9] The patient also reported a fall the same day that resulted in a broken tooth but declined the triage nurse's recommendation to go to an emergency department. Five days later, the patient again contacted a triage nurse to request a primary care appointment, complaining of back pain and vision problems. The following day, during a phone call with the PCP, the patient described the fall and having a "stabbing pain" at the back of the head. The PCP ordered a head computed tomography scan and six days later documented that the imaging study showed no intracranial abnormalities. The next day, the patient experienced another fall and was transported by ambulance to a community emergency department. The community emergency department provider documented that the patient reported a fall with concussion "about a week" prior followed by several repeated falls and progressively worsening balance, headaches, and a back spasm that caused a fall hitting the left side of the head. The patient was admitted to the community hospital for hydration, correction of electrolytes, and assessment of gait dysfunction.

During the community hospital admission, the patient underwent brain magnetic resonance imaging that revealed an area of diffuse axonal injury and cognitive screening indicated that the patient had mild cognitive impairment. The same day, a community care neurologist diagnosed the patient with TBI with post-concussive syndrome and recommended an acute inpatient rehabilitation program that focused on spine rehabilitation and TBI. Following the three-day community hospital admission, the patient was identified as having extensive medical, nursing, and rehabilitation needs and was admitted to a community care rehabilitation facility (rehabilitation facility) for 15 days for further treatment to include physical, occupational, and speech therapy. A community rehabilitation case manager faxed the discharge summary to the facility's community care program office. The summary included a request for a walker to be delivered to the rehabilitation facility prior to the patient's discharge and appointments scheduled for and transportation provided to optometry, physical, and occupational therapy appointments. Additionally, the faxed information included that the patient was "unable to perform" job functions due to the TBI until approximately fall 2023.

The patient and a family member presented to the facility two days after the patient's discharge from the rehabilitation facility to request a primary care follow-up appointment, transportation assistance, walker for mobility, and physical and occupational therapy consults. A medical support assistant provided the patient and family member physical therapy self-referral

[9] Clinical contact centers are virtual care centers that offer support to veterans enrolled in VA health 24 hours a day, seven days a week. "VA Glossary," U.S. Department of Veterans Affairs, Office of Information and Technology. https://apps.gov.powerapps.us/play/e/default-e95f1b23-abaf-45ee-821d-b7ab251ab3bf/a/e600f309-4b0b-4969-b6dc-b55151e685b5?tenantId=e95f1b23-abaf-45ee-821d-b7ab251ab3bf&hint=d993cc19-500c-4d8c-97db-63ee21fc88a4. (This web page is not publicly accessible.)

instructions. The patient, accompanied by the family member, presented as a walk-in to physical therapy that same day and obtained a walker. Two days later, a medical support assistant documented speaking with the family member who reported the patient is "waiting on referral" for physical and occupational therapy and a follow-up appointment with primary care. The medical support assistant added the primary care nurse as an additional signer to the note. The primary care nurse responded by adding another nurse as an additional signer to the note adding that the patient needs an appointment with the PCP. After two days, the patient's family member spoke with another medical support assistant and again requested a primary care follow-up appointment and physical and occupational therapy consults. The patient's family member declined the next available primary care appointment and requested a sooner option; the medical support assistant added the primary care nurse as an additional signer to the note. That day, the PCP submitted a facility physical therapy consult and a community care speech therapy consult.

Ten days after discharge from the rehabilitation facility, the PCP met with the patient and documented that the patient had been diagnosed with post-concussion syndrome, gait abnormality, cognitive communication deficit, and TBI, and documented encouraging the patient to speak with the neurologist and physical therapist about the patient's ability to return to driving. The following day, the patient attended an initial physical therapy appointment and agreed to attend physical therapy two times per week for four weeks with reassessment after eight visits. A physical therapy assistant documented speaking with the patient regarding an occupational therapy consult and determined that the patient did not have specific concerns to warrant occupational therapy. The patient attended seven physical therapy appointments and then declined to reschedule.

In early summer 2023, the neurologist met with the patient and documented the patient's fall that led to the community care inpatient and community care rehabilitation program admissions, a recommendation that the patient discontinue alcohol use due to possible impact on migraines, and prescribed a new migraine medication. Two days later, the neurologist cleared the patient to return to work two weeks from the date of the recent neurology visit.

Five days later, the patient resumed individual therapy and the social worker documented the patient's suicidal thoughts of being "better off dead" almost daily; financial and legal stress; medical difficulties at work; and challenges with migraines, nausea, unintentional weight loss, and leg tremors. Nine days later, the patient received another community care pain management procedure and had returned to work. Less than a week later, during an individual therapy appointment, the patient reported experiencing suicidal thoughts with a plan but declined to discuss the plan. The social worker alerted the suicide prevention team, completed a comprehensive suicide risk evaluation, and reviewed safety planning with the patient. In the next two weeks, suicide prevention coordinator 1 attempted to contact the patient twice and left a message. Two days later, the suicide prevention case manager briefly spoke to the patient who reported being at work and requested scheduling calls in the late afternoon. On the same day,

suicide prevention coordinator 1 activated a high-risk flag in the patient's EHR for "precautionary purposes." Over the next 11 days, schedulers made four attempts to contact the patient by phone and sent two letters to schedule individual therapy and a mental health medication management appointment but were unable to reach the patient. During the same period, the suicide prevention case manager made one contact attempt by phone and spoke with the patient "to assess status and complete safety plan," but the patient was working and needed to end the call. Approximately one week later, the suicide prevention case manager spoke with the patient and documented that the patient did not wish to be engaged in mental health care.

Almost one week later, suicide prevention coordinator 1 spoke to the patient who reported a fall with "concussion." Suicide prevention coordinator 1 encouraged the patient to go to an emergency department, but the patient reported the fall was not as "bad as the last time." The patient reported suicidal thoughts that "come and go" and last experienced suicidal ideation the previous week. The same day, the patient presented to a community care emergency department and, following an evaluation that included a head imaging study showing no acute abnormalities, the patient was discharged to home with a plan to follow up with primary care. One week later, the patient spoke to a triage nurse and reported experiencing another fall with hand injury. The triage nurse encouraged the patient to be seen in an emergency department, but the patient was treated at a community urgent care facility as preferred.

In early fall 2023, the MHNP received an alert that the patient's medication for depression would soon expire and attempted to reach the patient to schedule a follow-up medication management appointment. Over the next approximately two weeks, suicide prevention staff attempted to contact the patient six times and were unable to leave a message. About three weeks after the last contact, the suicide prevention case manager spoke to the patient, but the patient could not talk due to work and noted a good time to call was "later in the day." Three days later, suicide prevention coordinator 2 attempted to contact the patient and left a message. Over the next two and a half weeks, the suicide prevention case manager attempted to contact the patient two times and was unable to leave a message

Four days later, the patient met with the primary care team and reported to a nurse a fall the prior weekend and feeling unsteady when standing or walking. The patient told the PCP of foot pain due to dropping a bottle on the foot. The PCP documented the patient's fall that occurred three months prior and the patient was to follow up in one year. The patient had an x-ray of the foot the same day, which showed degenerative changes. Two days later, another suicide prevention case manager contacted the patient who reported increased "anxiety and depression," could not talk long, and requested a call back later that day. Five days later, suicide prevention coordinator 2 continued the patient's high-risk flag and the same day the MHNP alerted a medical support assistant to offer the patient a follow-up appointment.

Over a week later, during a telephone neurology appointment, the patient reported improvement in migraine headaches, and the neurologist documented a plan to follow up with the patient in

four months. In early 2024, almost two weeks later, a suicide prevention case manager spoke to the patient who reported doing "ok" and denied suicidal ideations but could not "really talk at this time." A few days later, the patient checked in for a mental health appointment but left prior to being seen by the MHNP and did not respond to telephone contact attempts that same day. Four days later, a suicide prevention case manager reviewed and continued the patient's high-risk flag for 30 days. On the same day, another suicide prevention case manager contacted the patient who reported being unable to "really talk right now" and acknowledged leaving the last mental health appointment without being seen because of having "to get out of there." The suicide prevention case manager documented that the patient did not endorse suicidal or homicidal ideations.

The patient subsequently met with the MHNP and reported not taking mental health medications, "uncontrolled anxiety and depression," panic attacks, sleep disturbance, and denied active suicidal thoughts with a plan but expressed thoughts of being "better off dead." The patient declined an outpatient mental health therapy referral, and the MHNP prescribed medications for sleep and anxiety and requested a follow-up appointment in two months. The next week, the suicide prevention case manager inactivated the patient's high-risk flag.[10]

In early spring 2024, the MHNP documented that the patient reported medication compliance but continued to experience anxiety symptoms with panic attacks, depression, sleep disturbance, passive suicidal thoughts of being "better off dead," and "significant financial" and health-related stress. The patient reported one fall since the previous appointment, throbbing and constant back pain, and that pain management recommended a neurosurgeon referral. The MHNP recommended outpatient mental health therapy and the patient declined. The MHNP prescribed a medication for depression, and increased the anxiety medication dosage, and requested follow up in two to three months.

Two weeks later, the patient attended a telephone neurology appointment, and the neurologist documented that the patient reported experiencing two headaches per week, described the headaches as "more mild," and declined medication changes. The neurologist requested follow up in six months.

Following the patient's missed appointment with the MHNP, approximately one month later, suicide prevention coordinator 1 documented contacting a patient acquaintance who reported that the patient had died approximately two weeks prior by suicide from a firearm injury to the head.

[10] The OIG determined that due to a procedural error, the high-risk flag inactivation note was not documented in the patient's EHR when the high-risk flag was deactivated in early 2024.

Inspection Results

1. Management of the Patient's Falls with Repeated Strikes to the Head, TBI, Community Care Records, Back Pain, and Follow-Up Appointments

The OIG found that the PCP and neurologist did not address the patient's reports of multiple falls with strikes to the head and did not consider a TBI evaluation. The OIG also identified deficiencies in primary care nursing staff's and mental health staff's management of the patient's reported falls. Further, the OIG found that following the patient's TBI diagnosis and discharge from the rehabilitation facility in mid-spring 2023, the PCP and neurologist did not address the patient's TBI-related needs or add TBI to the patient's problem list, and facility staff did not adequately manage the patient's community care records.

The OIG did not substantiate that facility staff provided inadequate evaluation and management of the patient's back pain. However, the OIG found that the PCP did not coordinate pain management with the patient's community care pain management provider to monitor treatment effectiveness. The OIG also identified deficiencies in facility staff's use of the care plan note to coordinate the patient's treatment and in scheduling follow-up requests.

Management of the Patient's Falls

The OIG found that between summer 2018 and spring 2024, the patient reported to facility staff experiencing a fall at home 18 times, with 16 of the falls including a strike to the head or loss of consciousness (see figure 1). The OIG determined that the PCP did not address the patient's falls with strikes to the head or take actions to prevent future falls. The OIG also found that the neurologist failed to evaluate the causes of the patient's falls or coordinate neurology care with the PCP. The OIG identified deficiencies with primary care nursing staff's and mental health staff's response to the patient's multiple reported falls.

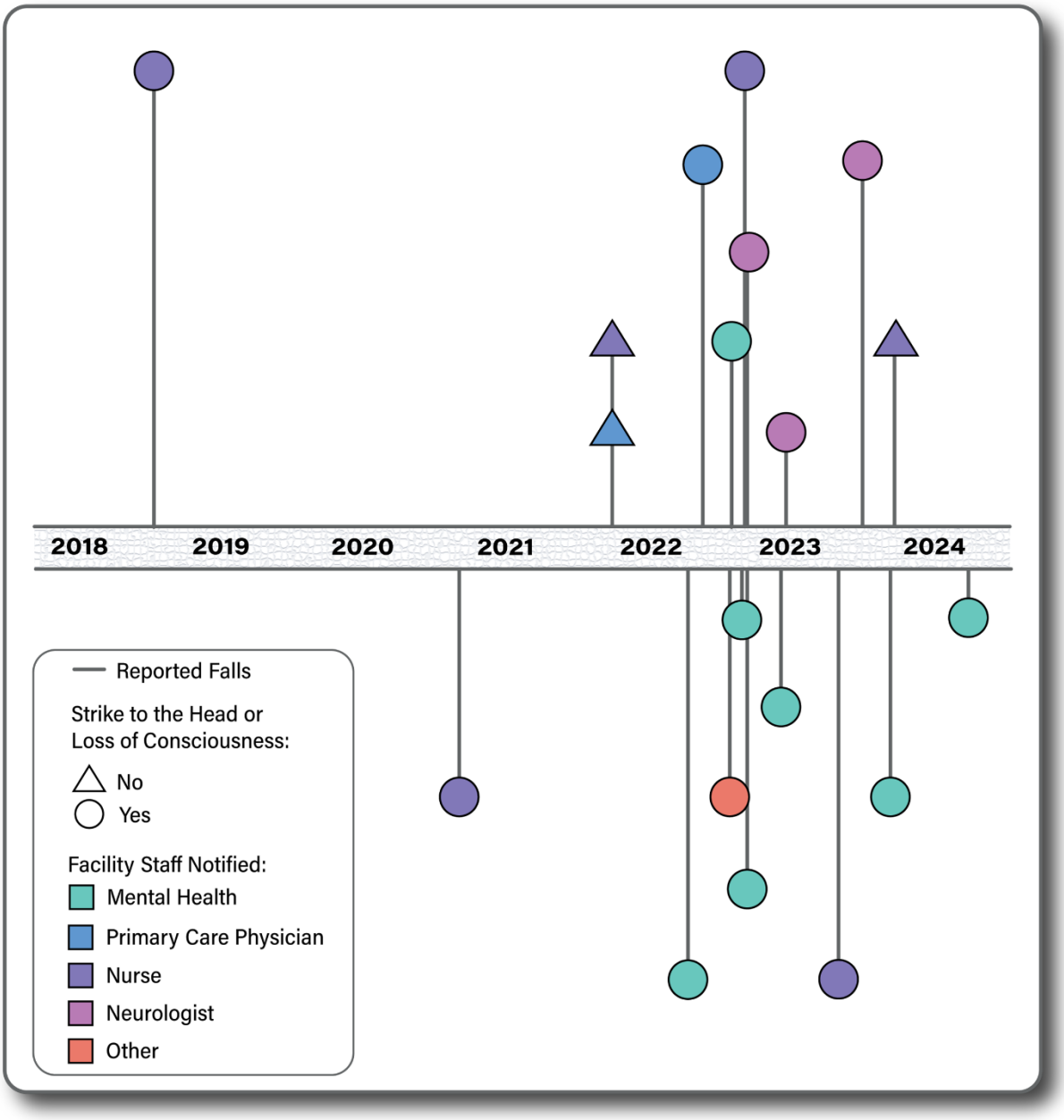

Figure 1. *Patient reports of falls at home to facility staff 2018–2024.*
Source: OIG analysis of reported falls from the patient's EHR.
Note: On one occasion, the patient reported a fall to two separate facility staff on the same day, which is shown by placement on the same line. Facility Staff Notified "Other" category represents a secure message sent by the patient to primary care that was entered into the patient's EHR by a medical support assistant.

In 2023, falls served as a leading cause of death from unintentional injury in the United States, and a primary cause of death in individuals with TBI in 2018 and 2019.[11] The VA National Patient Safety Center promotes the implementation of practices that reduce falls and associated injuries among patients, to include using a standardized assessment to identify fall risk factors (such as environmental hazards, balance difficulties, or muscle strength) and addressing identified risk factors in a patient's plan of care.[12]

Facility policy requires that trained staff evaluate a patient's mobility, fall risk, actions to reduce fall risk, and "risk of injury from falls" annually and when there is a significant change in a patient's condition including a fall.[13] The Chief of Staff and providers are responsible for evaluating patients, reviewing medical conditions to identify fall risks, and referring patients to additional services, such as physical therapy, to reduce fall risk and improve mobility function.[14] When a patient reports a fall, providers are expected to complete a physical assessment to consider causes of the fall and "take appropriate action."[15]

PCP's Assessment of the Patient's Falls

Between spring 2022 and fall 2023, the PCP was notified that the patient fell five separate times but did not evaluate the patient's mobility, fall risk, and risk of injury from falls; document clinical decision-making for the falls from other possible diagnoses; or ensure that the patient received appropriate care to reduce fall risk, as required.[16] In spring 2022, the PCP was alerted to the patient's reported fall "a few weeks back" with strike to the head. A primary care nurse contacted the patient the same day and the patient reported "not so much of passing out but blacking out." The next day, the PCP placed a cardiology consult for "syncope and collapse." Approximately one month later, the PCP documented the patient's medical issues as "stable" and provided a 12-month follow-up appointment despite the patient having an unexplained fall the previous month with reported strike to head, loss of consciousness, chronic and acute pain, and a concern for syncope. In fall 2022, while the PCP noted a recent fall approximately two months prior to the visit, the PCP did not document any changes to the patient's diagnosis or make significant changes to the patient's treatment plan. The PCP indicated that the patient would

[11] "Deaths By Demographics," National Safety Council, accessed March 5, 2025, https://injuryfacts.nsc.org/all-injuries/deaths-by-demographics/deaths-by-age/data-details/; "Surveillance Report: Traumatic Brain Injury-Related Deaths by Age Group, Sex, and Mechanism of Injury," Centers for Disease Control and Prevention.

[12] VA National Center for Patient Safety, *Implementation Guide for Fall Injury Reduction*, revised February 2015.

[13] Facility Medical Center Memorandum 002-118-16-658, *Fall Prevention Program*, February 24, 2016, updated to Facility Medical Center Memorandum 002-118-19-658, *Fall Prevention and Mobility Program,* July 11, 2019. The memoranda contain similar language related to fall risk assessment requirements.

[14] Facility Medical Center Memorandum 002-118-16-658; Facility Medical Center Memorandum 002-118-19-658. The OIG defines medical providers in the context of this policy as medical staff who provided direct patient care and are capable, by training and experience, of evaluating and referring the patient for additional services.

[15] Facility Medical Center Memorandum 002-118-19-658.

[16] Facility Medical Center Memorandum 002-118-16-658; Facility Medical Center Memorandum 002-118-19-658.

follow up with neurology and pain management and requested a follow-up primary care appointment in six months.

The PCP reported to the OIG a belief that the patient's back pain was causing the falls and that treating the pain was addressing the falls. Further, the PCP reported expecting the neurologist to evaluate the patient for gait and balance issues or other reasons for the falls. The associate chief of primary care explained an expectation that providers who are documenting a fall would also document an action to address the fall, such as a referral to physical therapy or occupational therapy, and that physical therapy for an assessment is often the first referral. Consistent with the associate chief of primary care's expectation, the OIG would expect the PCP to document a plan to address the patient's falls and risk of future falls.

As the patient's falls were serious and repetitive, the OIG would have also expected the PCP to assess for specific circumstances of the fall, evaluate for injuries and any persisting symptoms, and document each fall and clinical decision-making to include a physical examination, imaging, other studies, or referrals. Further, the OIG would have expected the PCP to establish the frequency, pattern, potential vulnerabilities with further falls, and to provide a plan of care that addresses and prevents harm to the patient. The PCP's failure to complete a comprehensive evaluation for the cause of the patient's falls limited treatment options available to the patient.

Neurologist's Evaluation of Falls and Management of Care Coordination

The patient reported a fall to the neurologist during three separate visits between fall 2022 and summer 2023. The OIG found that the neurologist did not identify the patient's need for a fall risk evaluation to assess for causes of the repeated falls and coordinate the patient's neurology treatment with the PCP. The neurologist also did not consider evaluation or treatment of possible cognitive consequences related to the patient's falls. Further, the neurologist did not adjust the patient's treatment plan following the patient's reports of continued falls with injury to the head.

In summer 2022, the patient was referred to neurology for treatment of migraines, concussions, and periods of amnesia. The neurologist diagnosed the patient with intractable migraine and suggested a new medication. However, the neurologist did not address the patient's concussions or periods of amnesia.

Similar to the PCP, the neurologist also believed that the patient was falling due to pain, that the pain interventions by the pain management provider would "hopefully" eliminate the patient's falls, and that the patient's muscle spasms would be addressed by the PCP. When asked about who was addressing the possible cognitive consequences of the patient's report of repeated falls with strikes to the head, the neurologist told the OIG that "it doesn't seem as though anybody was addressing those issues." Additionally, the neurologist reported that the focus of the patient's neurology care was on "migraines and nothing else." The neurologist also reported an expectation that the patient's providers would communicate through instant message if additional

evaluation was needed, such as if the patient continued to fall, but reported that no one reached out about the patient.

The OIG would have expected the neurologist to assess the patient for migraines, concussions, and periods of amnesia following the neurology consult received in summer 2022, and to adjust the patient's treatment plan beyond the treatment of migraines when the patient continued to report multiple falls with injury to the head to assess for TBI. Further, the OIG would have expected the neurologist to communicate directly with the PCP about the patient's care when the patient continued to report falls with head injury to clarify the scope of the neurologist's current treatment specific to headache management, identify additional services that may be needed, and collaborate on a plan of care.

The OIG concluded that the neurologist's failure to address the patient's repeated falls with head injury and intervene with fall prevention strategies may have resulted in preventable injury. The neurologist's failure to consider an evaluation or treatment of possible cognitive consequences related to the patient's falls may have led to an inadequate understanding of the patient's medical and functional conditions and missed treatment intervention opportunities. Further, the lack of care coordination among the neurologist and PCP regarding the repeated falls likely limited providers' knowledge of the recurring nature of the falls.

Primary Care Nursing Staff's Response to Falls

From summer 2018 through fall 2023, primary care nursing staff were made aware of the patient reporting nine separate falls. The OIG found that primary care nursing staff did not complete a facility templated fall note (fall note), which would prompt further evaluation and consideration of interventions, for any of the nine falls. Facility policy requires nurses to complete a fall evaluation using the facility Nurse Fall Prevention Clinical Reminder (fall evaluation) when a patient reports experiencing a fall at home.[17] Should the patient endorse concerns on the fall evaluation, the nurse is expected to notify the medical provider and the registered nurse then completes fall note which identifies fall factors and includes the Morse Fall Scale.[18] If the patient's Morse Fall Scale score is greater than 45, the treatment team will consider pharmacy and physical therapy consults and staff will "educate [the] patient and/or [the patient's] family" on fall prevention and provide approved literature.[19]

The primary care nurse who was notified of six of the falls told the OIG that when a patient calls to report a fall, the primary care nurse typically asks the patient what caused the fall but does not complete any specific fall assessment. Further, the primary care nurse reported a belief that the

[17] Facility Medical Center Memorandum 002-118-16-658; Facility Medical Center Memorandum 002-118-19-658.

[18] Facility Medical Center Memorandum 002-118-16-658; Facility Medical Center Memorandum 002-118-19-658. The memorandum further explains that a patient answering "yes" to any question on the fall evaluation results in a positive screen.

[19] Facility Medical Center Memorandum 002-118-19-658.

patient's falls were related to seizures and that neurology was addressing and did not consider any interventions to reduce the patient's falls. Primary care nursing staff's failure to complete the required fall note likely contributed to limited awareness among other care providers of the patient's needs and prevented an opportunity to create an individualized fall intervention for the patient to decrease the likelihood of future falls.

Mental Health Staff's Fall Notification

The patient reported seven falls to mental health staff.[20] The OIG found that mental health staff did not alert primary care staff of five of the seven falls. The chief of mental health reported to the OIG an expectation that mental health staff would notify primary care when a patient reports a fall with loss of consciousness. Suicide prevention coordinator 1 did not alert providers when the patient reported a fall in summer 2023. In an interview with the OIG, suicide prevention coordinator 1 reported that alerting providers to falls is typical practice and was uncertain as to why it did not occur at this time. The MHNP reported alerting the patient's primary care team when initially informed that the patient fell in spring 2022 and believing that primary care staff would conduct a fall evaluation and provide needed scans or treatment. However, the MHNP did not alert any provider when informed that the patient was continuing to fall in early spring 2024, and reported a belief that neurology was addressing the patient's falls.

Consistent with mental health leader expectations, the OIG would also expect that mental health providers alert the primary care team of any new reports of falls. However, the OIG also acknowledges the importance of leaders ensuring applicable facility staff's awareness of expectations when responding to patient needs usually addressed by other services such as primary care.

Consideration of a TBI Evaluation After the Patient's Reports of Falls with Head Injury

Prior to the patient's TBI diagnosis in spring 2023, the patient reported 13 falls to multiple facility staff that included a strike to the head or loss of consciousness. The OIG found that neither the PCP nor the neurologist referred the patient for a comprehensive TBI evaluation when notified of the patient's fall with head injury due to a lack of knowledge regarding TBI evaluation services available to patients.[21]

VHA explains that providers treating a patient who may have TBI "should send a consult requesting evaluation and treatment" to a "rehabilitation team that completes the CTBIE

[20] Mental health staff include the MHNP, social worker, suicide prevention case manager, and suicide prevention coordinator 1.

[21] The OIG determined that triage nursing staff added primary care staff to each note documenting the patient's report of a fall at home.

[comprehensive TBI evaluation]."[22] The comprehensive TBI evaluation includes determining the origin of the injury, assessing for neurobehavioral symptoms, examining physical symptoms, and creating a treatment plan.[23] The comprehensive TBI evaluation must be completed by a trained TBI specialist such as a physiatrist or neurologist.[24]

The facility TBI coordinator and chief of physical medicine and rehabilitation explained to the OIG that the facility offers the comprehensive TBI evaluation through the facility TBI clinic, and patients with a TBI receive case management and referrals such as occupational therapy, speech therapy, or to a care facility if the patient's needs cannot be met at the facility.[25] The VISN lead for the Rehabilitation and Extended Care Integrated Clinical Community reported to the OIG that a range of TBI services are available to patients through the VISN, and facility providers are expected to reach out to the local TBI clinic or point of contact to refer patients for those services. The TBI coordinator explained that any provider can refer a patient to the facility TBI clinic through a physiatry consult if the provider suspects a patient has had a TBI.

The chief of physical medicine and rehabilitation explained that new staff who perform TBI evaluations complete VA training upon hire as required, but no additional trainings are offered regarding TBI clinic referrals or other available services.[26] The TBI coordinator reported not having any interactions with facility providers unless a provider reaches out directly. The VISN lead for the Rehabilitation and Extended Care Integrated Clinical Community explained that the facility TBI clinic lead is responsible for ensuring that primary care and specialty care providers are aware of services available in the TBI clinic.[27] The OIG found that the PCP and the neurologist completed the required TBI screening and evaluation training that includes information on rehabilitation services offered through the national VA polytrauma system of care, prescribing interventions, developing an individualized plan of care, the role of the interdisciplinary treatment team, and TBI screening and evaluation.[28] However, the training does not include information specific to facility services.

Between spring 2022 and spring 2023, primary care staff were made aware of the patient's report of a fall with head injury or loss of consciousness six separate times. In response to the patient's six reported falls, the PCP placed a cardiology consult for the patient's reported episode of passing out, ordered a computed tomography scan, conducted a back exam, and requested a

[22] "Traumatic Brain Injury Program Documents, TBI Directive-Attachment C- Frequently Asked Questions," VHA Rehabilitation and Prosthetic Services, accessed November 18, 2025, https://vaww.rehab.va.gov/ProgramDocuments/TBI/index.asp. (This site is not publicly accessible.)

[23] VHA Directive 1184.

[24] VHA Directive 1184.

[25] The facility TBI clinic is referenced by VHA as a Polytrauma Point of Contact site in the TBI System of Care.

[26] VHA Directive 1172.01; VHA Directive 1184.

[27] The chief of physical medicine and rehabilitation is the TBI clinic lead for the facility.

[28] VHA Directive 1172.01.

follow-up appointment. The PCP did not ensure that the patient received a comprehensive TBI evaluation to assess for symptoms and treatment needs following multiple strikes to the head from falls. The PCP reported a minimal experience with TBI referrals at the facility and specified a practice of sending patients with TBI to neurology for assessment. The PCP explained an expectation that the neurologist would assess the patient for gait or balance issues, consider potential causes of balance issues, and recommend additional actions. The chief of primary care reported considering neurology as an appropriate referral but expressed uncertainty about referral options and evaluation services available through the TBI clinic when compared to neurology.

The OIG also found that despite the patient reporting a fall with head injury two separate times to the neurologist within an approximate three-month time frame, the neurologist did not consider referring the patient to the facility TBI clinic or other TBI evaluation. The neurologist reported being unaware of specific TBI evaluation services available to patients and expected that PCPs would refer patients with head injuries to the TBI clinic first rather than neurology for TBI evaluation and care. Further, the neurologist acknowledged reviewing the patient's neurology consult, submitted by cardiology services, that included a request for assistance with migraines, concussions, and periods of amnesia, but did not recall consideration of a more detailed assessment for the patient regarding TBI and was not aware of VHA requirements for the components of a comprehensive TBI evaluation. The chief of medicine reported an expectation that a neurologist would "know when and how to evaluate somebody for TBI … whether or not that care is warranted and then if it is, make a referral to get that care provided."

The OIG determined that the PCP's limited experience and the neurologist's lack of awareness regarding specific facility TBI evaluation services contributed to the failure of the PCP and neurologist to consider additional referral options with the patient after the patient's repeated reports of falls with injury to the head. However, given that TBI is within the PCP and neurologist's scope of practice as medical providers, the OIG would have expected that the PCP and neurologist appropriately assess for TBI to make an accurate diagnosis and identify the patient's treatment needs or to seek consultation from supervisors or other physicians if unsure how to access TBI specialty services within the facility.

TBI Care and Records Management

The OIG substantiated that the neurologist failed to provide TBI treatment to the patient following the patient's diagnosis of TBI from a community hospital admission in spring 2023. The OIG also found that the PCP mismanaged the patient's recommended follow-up care and that the neurologist did not coordinate TBI-related care with the PCP. Further, the OIG found that multiple deficiencies in records management contributed to a lack of continuity in TBI care.

Neurologist's Management of the Patient's TBI Treatment and Care Coordination

Facility policy requires that specialty providers offering consultation communicate with the patient's PCP regarding patient concerns.[29]

The OIG found that during an appointment with the neurologist that occurred approximately one month after the patient's discharge from the rehabilitation facility, the neurologist did not address the patient's TBI, focused on the patient's report of "migraine," and approved the patient to return to work in two weeks even though the patient was placed on work restrictions for head injury, not migraine headaches. In an interview with the OIG, the neurologist acknowledged awareness of the patient's TBI and reported addressing the patient's headaches and that this was the patient's focus.

The OIG was unable to determine the extent of information the neurologist reviewed related to the patient's community care rehabilitation treatment course and discharge recommendations due to conflicting information. Over a month after the patient's discharge from the rehabilitation facility, a specialty clinic nurse documented in the patient's EHR providing the "hospital records" to the neurologist to review. The neurologist reported not recalling having seen the patient's "medical records" with recommendations from the rehabilitation facility and acknowledged that it was not referenced in the neurologist's documentation at the time. However, the neurologist's documentation included information from the community hospital admission including that the "MRI [magnetic resonance imaging] scan showed an abnormal area … but there is no clinical stroke evident" and from the rehabilitation facility admission related to medication changes.

The OIG found that the neurologist did not conduct an adequate functional assessment of the patient's motor and cognitive status and ability to meet job requirements in determining the patient's ability to return to work. The neurologist told the OIG about assessing the patient's ability to return to work following discharge from the rehabilitation facility by the patient's ability to communicate clearly and the patient's belief of being able to work. However, the neurologist did not document this information in the patient's EHR. The OIG would have expected the neurologist to document the assessment and relevant conclusion that resulted in the determination for the patient to return to work in two weeks.

The patient met with the neurologist by phone in late 2023 and the neurologist noted the patient's improvement with "headaches." Approximately four months later, the neurologist met with the patient by phone and documented the patient reported headache improvement. The neurologist did not document addressing the patient's TBI at either appointment.

[29] Facility Medical Center Policy 11-111-20-149, *Primary Care Program,* November 27, 2020.

Further, the OIG found that the neurologist did not communicate with the PCP regarding the patient's care, as required.[30] Although the neurologist told the OIG that care coordination with other providers typically occurs "through the chart," the neurologist did not add the PCP as an additional signer to any of the notes regarding the patient's neurology care.

The OIG concluded that despite the patient's new TBI-related deficits, the neurologist continued to focus on treating the patient's headaches and did not coordinate care with the PCP. The neurologist's failure to address and coordinate the patient's TBI treatment likely impeded the patient's ability to receive the recommended comprehensive and interdisciplinary TBI care.[31]

Given the patient's recent rehabilitation facility discharge and TBI diagnosis, the OIG would have expected the neurologist to attempt to obtain the patient's discharge summary, including the rehabilitation facility inpatient admission information on TBI treatment needs and work restrictions. Absence of the discharge summary contributed to the neurologist's limited understanding of the patient's TBI treatment and return to work needs following discharge from the rehabilitation facility.

PCP's Management of the Patient's TBI Treatment and Care Coordination

The OIG found that the PCP did not address the patient's TBI or assess for persisting symptoms. Further, the OIG determined that the PCP did not manage the patient's rehabilitation facility recommended follow-up care, as required. [32]

VHA requires that eligible patients with TBI "have access to all medical and rehabilitation services" offered through VA's polytrauma system of care.[33] VHA's rehabilitation services for TBI are "individualized, comprehensive and interdisciplinary" and includes healthcare services based on a patient's preferences and needs.[34] Further, PCPs coordinate long-term rehabilitation care for TBI with the support of "rehabilitation specialists with TBI training and experience." [35] PCPs are required to provide "appropriate assessment, treatment, education, and follow-up in a timely and responsible manner," and to coordinate follow-up treatment after a patient's hospitalization.[36]

Within four days of the patient's discharge from the rehabilitation facility, the patient's family member called and presented to the facility and spoke to two facility scheduling staff and requested the patient receive the physical and occupational therapy recommended in the

[30] Facility Medical Center Policy 11-111-20-149.
[31] VHA Directive 1172.01.
[32] Facility Medical Center Policy 11-111-20-149.
[33] VHA Directive 1172.01.
[34] VHA Directive 1172.01.
[35] VHA Directive 1172.01.
[36] Facility Medical Center Policy 11-111-20-149.

rehabilitation facility's discharge summary. Two days later, the patient's family member called and spoke to a facility scheduling staff member and requested physical therapy, occupational therapy, and speech therapy. Later that day, the PCP placed a facility physical therapy consult and a community care speech therapy consult for the patient but did not refer the patient to occupational therapy.

Ten days after the patient's discharge, the PCP met with the patient and documented the patient's inpatient community care hospital admission for post-concussion syndrome and that the "MRI [magnetic resonance imaging] showed evidence of DAI [Diffuse Axonal Injury]."[37] The PCP also documented advising the patient to discuss return to driving with the physical therapist and the neurologist, to contact ophthalmology for an appointment, and that the patient had obtained a walker by contacting the physical therapy office directly two days after the patient's discharge. The PCP requested to follow up with the patient in six months. The OIG would have expected the PCP to obtain and read the community care records to guide patient treatment and education needs, and document review of the records in the patient's EHR.

Over a week later, the patient's family member spoke to a facility scheduling staff member requesting the patient receive occupational therapy. On this same day, the PCP submitted a second physical therapy consult for the patient. In an interview with the OIG, the PCP reported referring the patient for physical therapy and trying "to set up" occupational therapy for the patient. As a result of the second consult, a physical therapy assistant contacted the patient regarding requests for occupational therapy and determined that additional occupational therapy was not necessary.

The OIG found that the PCP referred the patient to speech therapy, despite the rehabilitation facility provider not recommending the treatment and the PCP not meeting with the patient to assess treatment needs prior to submitting the referral. The PCP did not refer the patient to occupational therapy as recommended by the rehabilitation facility.[38]

The patient met with the PCP in late fall 2023, however, the OIG found that the PCP did not address the patient's TBI or assess for persisting symptoms. In an OIG interview, the PCP reported a belief that referring the patient to the neurologist and to physical therapy would address the patient's continuing TBI rehabilitation needs after the patient's discharge. However, the PCP reported not communicating with the neurologist about the referral to address TBI rehabilitation for the patient but stated that the patient was encouraged to speak to the neurologist. Additionally, the PCP was not sure what was discussed between the patient and the neurologist, but believed the patient discussed TBI issues with the neurologist since the patient

[37] Based on the date that the discharge instructions were scanned into the patient's EHR, the OIG was unable to determine the documentation that was available to the PCP at the time of the patient's appointment.

[38] The patient did not attend the speech therapy appointment; the consult was discontinued after facility community care staff were unable to reach the patient to reschedule.

was cleared to drive. Given that the patient was treated by the neurologist (as discussed above) after the rehabilitation facility discharge, the OIG would have expected the PCP to review the neurologist's EHR note regarding the patient's condition to determine if further evaluation or assistance was needed for TBI and to coordinate future TBI care with the neurologist as the patient continued to experience subsequent falls.

The OIG would also expect the PCP to determine what further tests or specialist referrals were recommended and assess if TBI-related sequelae were stabilized. Failure to identify and address the patient's TBI symptoms may have hindered the opportunity to provide timely and effective interventions to improve the patient's outcome.

The PCP not obtaining and reviewing the patient's community care records, to include the discharge summary, may have resulted in the patient not receiving an occupational therapy consult as recommended and instead receiving a referral for speech therapy (as discussed above). The OIG acknowledges that while occupational therapy and speech therapy treat cognitive issues that interfere with activities of daily living, a referral to physical therapy was not a reasonable substitute. Further, the lack of the discharge summary may have limited the PCP's understanding of the patient's community care rehabilitation treatment course and subsequent TBI-related treatment needs. In the absence of a discharge summary from a recent hospitalization, the OIG would have expected the PCP to refer the patient for evaluation with an appropriate specialist or assess the patient's degree of disability from TBI, including possible mental health-related TBI symptoms.

Use of Patient Problem List

Facility policy states that PCPs "are responsible for the content of the [patient's] problem list" and requires that all providers add a new diagnosis to the problem list.[39]

The OIG found that the PCP and neurologist did not add TBI to the patient's problem list, as required.[40] In an OIG interview, the neurologist reported never previously considering who adds a diagnosis to a patient's problem list, but noted that either the PCP, cardiologist, or the neurologist could have added TBI for the patient. The chief of primary care told the OIG that any provider can add to the problem list, and that problems should be added when the condition is recognized as chronic. The associate chief of primary care reported an expectation that the first provider to identify and document the patient's TBI should update the problem list so that other providers do not have to look through the EHR for the patient's diagnoses. The chief of medicine explained that TBI was not on the patient's problem list and questioned whether it would have led to more services or care coordination among the patient's providers.

[39] Facility SOP 136-005, "Patient Problem List."
[40] Facility SOP 136-005, "Patient Problem List."

Given that the PCP and neurologist were aware of the patient's TBI diagnosis in spring 2023 and had appointments with the patient after that inpatient admission, the OIG would have expected either provider to add TBI to the patient's problem list. Failure to add a TBI diagnosis to the problem list may have resulted in mental health and suicide prevention staff's limited understanding of the patient's functional challenges and TBI-related needs, affecting the patient's ability to receive TBI-informed mental health care.

Management of Community Care Documents

The OIG found that facility community care staff did not ensure receipt of the patient's rehabilitation facility discharge summary and did not make community care records available to staff within the required time frame.[41]

VHA community care staff are expected to "request, receive and upload" documentation from community care providers.[42] When documentation is received from community care providers, VHA community care staff must review the documents for "any follow up care, assessments, and recommendations for the referring VA provider" and "coordinate between the VA ordering provider and the interdisciplinary team regarding treatment, planning, and follow up referral."[43] The chief of community care told the OIG that community care providers submit request for service documents to the facility, which "trigger the continuation of any care that is needed" for the patient, such as physical therapy.[44]

Two days prior to the patient's discharge from the rehabilitation facility, the community care provider faxed the patient's discharge summary to the facility's community care office including request for services forms for a walker, follow-up outpatient physical therapy, occupational therapy, and optometry, and work restriction documentation.[45] However, the OIG found that the

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[41] VHA Office of Health Informatics, *Practice Brief Community Care – VistA Imaging Capture Best Practice And Minimum Documentation Requirements*, March 2021.

[42] VHA Office of Integrated Veteran Care, "Roles and Responsibilities of Administrative and Clinical Staff" chap. 3:05.03.05 in *VHA IVC Community Care FGB,* accessed November 19, 2024, https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001031/content/554400000278540/FGB-Chapter-3-050305-Roles-and-Responsibilities-of-Administrative-and-Clinical-Staff. (This site is not publicly accessible). The guidebook is a continually updated process and information guide outlining specific functions of community care operations.

[43] VHA Office of Integrated Veteran Care, "How to Perform Clinical Review of Documentation and Coordinate Follow Up Care" chap. 3:05.03.20 in *VHA IVC Community Care FGB*, accessed November 19, 2004, https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001031/content/554400000226029/FGB-Chapter-3-050320-How-to-Perform-Clinical-Review-of-Documentation-and-Coordinate-Follow-up-Care. (This site is not publicly accessible).

[44] Request for service documents include community care forms that community care providers use to communicate with the medical center community care staff when patients' need additional care either at the VA or in the community. "Community Care," VHA, accessed April 21, 2025, https://www.va.gov/COMMUNITYCARE/providers/Care-Coordination.asp#RFS.

[45] The OIG obtained all relevant medical records from the patient's spring 2023 rehabilitation facility admission including the discharge summary.

discharge summary was not received by facility community care staff despite being faxed to the correct number. The OIG was unable to determine why the information was not received. The facility nurse navigator reported that "the specific reason for the document not being included in the medical record remains unclear," and that the facility process used to receive community care documents at the time "relied on less advanced technology and was a manual process, which introduced opportunities for human error." Based on the patient's new TBI diagnosis, issues with mobility, and the comprehensive treatment received at the rehabilitation facility, the OIG would expect facility community care staff to contact the rehabilitation facility provider to discuss follow-up care needs since the request for service documents were not received.

VHA requires that facility staff scan community care documents into the EHR "within [five] business days of receipt."[46] Two days after the patient's rehabilitation facility discharge, facility staff received a community care document that included patient discharge instructions and recommendations for the patient to receive physical therapy and occupational therapy. A nurse manager explained to the OIG that community care staff scanned the discharge instructions into the patient's EHR 14 days later. The chief of community care and facility nurse navigator explained to the OIG that the reason the discharge instructions were not scanned into the patient's EHR within the expected time frame was due to community care staff's workload. The chief of community care and facility nurse navigator reported that facility leaders approved additional staffing to support the workload.[47]

The OIG determined that the lack of availability of the patient's discharge summary may have contributed to the patient not receiving recommended TBI follow-up care, as discussed in this report.

Care Coordination for the Patient's Back Pain

The patient received community care pain management from winter 2021 through winter 2024, during this time, the patient continued to inform facility staff about significant back pain and back spasms with subsequent falls.[48] The OIG found that the patient's PCP should have recognized the need to coordinate the patient's pain management care with community care pain management providers when the patient continued to report back pain with falls.

VHA requires that patients with complaints of pain receive a comprehensive pain assessment, treatment plan, and ongoing monitoring of treatment effectiveness, which may include assessment of timeliness of intervention, adequacy of pain control, appropriate use of referrals,

[46] VHA Office of Health Informatics, *Practice Brief Community Care – VistA Imaging Capture Best Practice And Minimum Documentation Requirements*, March 2021.

[47] The OIG received the information from the chief of community care in December 2024.

[48] The OIG confirmed that the patient received community care pain management services through winter 2024 but was unable to confirm or rule out if additional appointments occurred due to limited community care records.

patient satisfaction, and quality of life.[49] Care coordination practices must ensure the patient does not experience a lapse in care, necessary healthcare information is shared among relevant providers in a "timely manner," the receiving provider has the information needed to make health care decisions, and recommended treatment is "integrated to avoid duplication, poor timing, or missed care opportunities."[50] Further, VHA expects primary care staff to coordinate care for patients following hospitalization and when receiving care from a specialty provider and multiple VA or community providers.[51]

Consistent with VHA requirements, the associate chief of primary care, chief of primary care, and chief of medicine reported to the OIG expectations that PCPs should coordinate patient care with community care providers to include assessment of pain management effectiveness.[52] The chief of primary care also reported an expectation that PCPs coordinate with community care to ensure pain management providers have necessary treatment information. However, the chief of primary care explained that, due to time constraints, PCPs typically coordinate care by entering and reviewing documentation in the EHR, although was unclear what documentation was provided to community care providers for viewing.

In an OIG interview, the PCP reported an awareness of the patient's back pain since taking over the patient's care in late spring 2022. The PCP reported to the OIG about reviewing the patient's community care pain management notes and assuming the community care providers were addressing the patient's chronic back pain. The PCP told the OIG about encouraging the patient to communicate concerns to the community care providers and that the pain management procedures "might have helped [the patient] some."

The OIG would have expected the PCP to assess the effectiveness of the pain management interventions the patient received through community care when notified of the patient's continued (and accelerating) back pain and falls. Further, the OIG would have expected the PCP to communicate with the community care pain management providers when the patient continued to experience falls reportedly related to pain to discuss treatment effectiveness and if additional services were needed. The PCP's lack of care coordination may have resulted in the community care pain management providers' incomplete understanding of the patient's symptoms and failing to consider additional evaluations to determine the causes of the patient's falls and other interventions to address the patient's back pain.

[49] VHA Directive 2009-053.

[50] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook,* February 5, 2014, amended May 26, 2017. This handbook was in place during the time of the events discussed in this report. It was amended to VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook,* February 29, 2024. The handbooks contain similar language regarding care coordination requirements.

[51] VHA Handbook 1101.10(1); VHA Handbook 1101.10(2).

[52] VHA Directive 2009-053.

Facility Community Care Staff's Use of the Care Plan Note

The OIG found that facility staff did not use the care plan note that identifies the facility interdisciplinary teams relevant to the patient's care, as required.[53]

Following the submission of a community care consult, VHA community care staff assign a level of patient care needs that includes basic, moderate, complex/chronic, and urgent.[54] For patients assigned a level above basic, VHA requires that a medical center community care office clinician, such as a nurse or social worker, complete a care plan note that identifies VHA interdisciplinary teams that are relevant for the patient's care.[55] The aim of the care plan note is to facilitate awareness and communication among facility and community care providers.[56]

The facility chief of community care told the OIG that facility community care staff did not enter a care plan note for the patient's pain management care received between 2021 and 2024. The chief of community care reported care plan notes were not being entered due to facility community care staff prioritizing other community care efforts for patients, such as scheduling appointments and obtaining records. The chief of community care explained that during a routine site visit in May 2024, a VISN leader identified that facility community care staff did not complete all required care plan notes.

The VISN chief nurse community care program manager (VISN community care program manager) told the OIG that the purpose of the care plan note is to facilitate and oversee care coordination activities to ensure that patients receive appropriate care. The VISN community care program manager explained that after the May 2024 site visit, VISN leaders assigned the facility a goal to increase use of the care plan note to 90 percent and sites that have not met the completion goal will be assigned action plans to increase care plan note utilization. In a November 2024 interview with the OIG, the chief of community care reported a plan to increase care plan note compliance. However, the VISN community care program manager reported that as of April 2025, the facility was not meeting the 90 percent goal. Further, the VISN community care program manager reported a belief that national community care staffing models do not allow for enough staff at facilities to complete all of the care coordination activities that are

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[53] VHA Office of Integrated Veteran Care, "Care Coordination-Community Care Plan Note and Addendums," chap. 3:05.03.13 in *VHA IVC Community Care FGB*, accessed November 19, 2024, https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001031/content/554400000278580/FGB-Chapter-3-050313-Care-Coordination-Community-Care-Plan-Note-and-Addendums. (This site is not publicly accessible). The OIG determined that community care staff categorized the patient's pain management care coordination needs as moderate.

[54] VHA Office of Integrated Veteran Care, "Care Coordination-Community Care Plan Note and Addendums," chap. 3:05.03.13 in *VHA IVC Community Care FGB*.

[55] VHA Office of Integrated Veteran Care, "Care Coordination-Community Care Plan Note and Addendums," chap. 3:05.03.13 in *VHA IVC Community Care FGB*.

[56] VHA Office of Integrated Veteran Care, "Care Coordination-Community Care Plan Note and Addendums," chap. 3:05.03.13 in *VHA IVC Community Care FGB*.

required. Facility staff not completing the care plan note likely inhibited communication among facility and community care providers, limiting care coordination opportunities for the patient's back pain.

Scheduling Follow Up Care

The OIG found that on three separate occurrences between summer 2022 and fall 2023, the PCP added the primary care nurse as an additional signer to a note in the patient's EHR with instructions for scheduling an appointment for follow-up care, but the patient was not scheduled for the appointments.

VHA requires that outpatient appointment requests are "managed safely, timely and accurately, and are scheduled based on clinical need."[57] As of 2017, VHA required that facilities have care coordination processes in place to ensure primary care staff coordinates care for patients discharged from a hospital or emergency department.[58] According to facility policy, nursing staff are expected to work with PCPs "to provide continuity of care."[59]

Given the lack of EHR documentation, the OIG was unable to determine the extent of patient outreach regarding three occurrences between summer 2022 and fall 2023 when the PCP added the primary care nurse as an additional signer to a note in the patient's EHR with instructions for scheduling follow-up care. In summer 2022, the PCP added the primary care nurse to a note requesting the "patient to be seen in office" in response to a note from the MHNP that the patient was experiencing back and leg pain and "blacks out." The patient's next scheduled appointment with the PCP was approximately three months later.[60]

In fall 2023, the PCP added the primary care nurse to two separate notes requesting that the nurse schedule a follow-up appointment for the patient and obtain the patient's community care records following discharge from a community care emergency department after a fall. The OIG did not find evidence that the patient received a follow-up appointment or that the primary care nurse documented obtaining the requested medical records or responded to the note. The patient's next scheduled appointment with the PCP was approximately two and a half months later.[61] In an OIG interview, the primary care nurse reported contacting the patient in response to the fall 2023 note from the PCP but did not recall reaching the patient. The primary care nurse

[57] VHA Directive 1230, *Outpatient Scheduling Management,* June 1, 2022.

[58] VHA Handbook 1101.10(1); VHA Handbook 1101.10(2). The handbooks contain similar language regarding care coordination processes.

[59] Facility Medical Center Policy 11-111-20-149.

[60] The appointment with the PCP was scheduled in late spring 2022 and was not a result of the PCP's request for a follow-up appointment.

[61] The appointment with the PCP was scheduled in late spring 2023 and was not a result of the PCP's request for a follow-up appointment.

reportedly asked a medical support assistant to contact the patient and acknowledged that this "may not be" documented in the EHR.

The primary care nurse manager reported to the OIG an expectation that when responding to scheduling instructions as an additional signer, a primary care nurse would document contact with a medical support assistant for patient scheduling. If added as an additional signer for a request for records and follow up, the primary care nurse manager explained that the nurse should call the hospital to obtain the discharge summary (if not already sent to the facility) and contact a medical support assistant to schedule the appointment with the PCP. The associate chief nurse of primary care explained to the OIG that the preferred method of scheduling a follow-up appointment would be for the provider to enter a return to clinic order; however, if a nurse is added as an additional signer, the expectation would be for the nurse to facilitate the scheduling of the appointment and document in the EHR.

The OIG was unable to confirm contact between the primary care nurse and the medical support assistant related to scheduling follow-up care for the patient and did not find evidence of the nurse obtaining records as requested due to a lack of documentation in the EHR. The OIG did not find documentation in the EHR that the primary care nurse took action to schedule the patient for follow-up appointments as requested by the PCP. The primary care nurse's failure to follow up on the scheduling requests by the PCP likely contributed to the patient not receiving the requested primary care follow-up appointments for episodes of back pain, black outs, and hospital discharge after a fall. Consistent with facility leaders' expectations, the OIG would expect the primary care nurse to document any attempted actions in the patient's EHR related to the PCP's request to include patient outreach, medical records request, and scheduling follow-up appointments.

2. Medication Management and Mental Health Care

The OIG did not substantiate that facility staff failed to provide the patient with appropriate mental health medication management and treatment.

Mental Health Medication Management

The OIG found that throughout the patient's psychiatric care, the MHNP regularly reviewed the patient's medications with the patient and adjusted the patient's prescriptions and dosage as indicated. In late fall 2021, the patient met with the MHNP who prescribed the patient medication for depression and anxiety. The patient attended monthly mental health medication management appointments until fall 2022. The patient missed an early 2023 medication management appointment and resumed treatment with the MHNP in early 2024. The patient continued visits with the MHNP through spring 2024. The OIG concluded that the MHNP managed the patient's mental health medications as expected for treatment of the patient's diagnoses.

Mental Health Care

Patients must receive "timely" mental health services and "the least intensive level of care" that meets the patient's needs and "expressed preferences for treatment."[62] VHA requires that, when clinically indicated, "all veterans with depression or anxiety disorders must have access to" evidence-based therapy for anxiety and depression.[63]

In spring 2022, during a visit with the MHNP, the patient reported suicidal behaviors, depressive symptoms, and psychosocial stressors that included financial, legal, and child custody concerns. The MHNP noted, "patient has declined therapy in the past but is requesting" mental health therapy. The MHNP referred the patient to psychotherapy and approximately one month later, the patient attended an initial appointment with the social worker. During another individual psychotherapy appointment the following month, the social worker developed a treatment plan with the patient and documented the patient was "a good candidate for … Interpersonal Psychotherapy for Depression in the near future."[64] From summer 2022 through summer 2023, the social worker and patient met eight times for psychotherapy sessions. The social worker told the OIG that the patient's preference for treatment was to focus on the management of psychosocial stressors and that the patient was unable to attend weekly Interpersonal Psychotherapy for Depression sessions due to work obligations.

The OIG concluded that the social worker adequately provided mental health care to address the patient's concerns and to accommodate the patient's treatment preferences and availability.

3. Management of High-Risk Flag

The OIG determined that suicide prevention staff did not notify the patient of high-risk flag activations and inactivation and did not complete the required safety plan reviews.

High-Risk Flag Documentation and Notification

VHA utilizes high-risk flags to communicate a patient's elevated risk for suicide to VHA staff for consideration in treatment decisions.[65] In 2010, VHA required that notification to patients

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[62] VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.

[63] VHA Handbook 1160.01(1), *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. The 2015 handbook 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 evidence-based therapy.

[64] Interpersonal Psychotherapy for Depression is a "time-limited, evidence-based treatment for depression" with a goal of "reduction in depressive symptoms and improvement in the problems" that caused or continue depression. "Interpersonal Psychotherapy for Depression," Office of Mental Health SharePoint, accessed March 5, 2025, https://dvagov.sharepoint.com/sites/VHAIPT/SitePages/Overview.aspx. (This site is not publicly accessible.)

[65] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008, rescinded and replaced by VHA Directive 1166, *Patient Record Flags*, November 6, 2023. The 2023 directive includes requirement for utilization of high risk for suicide flags in EHR.

occur when patient record flags are placed in the patient's EHR and inform the patient of the contents of the flag.[66] As of 2020, VHA guidance noted that suicide prevention coordinators are responsible for notifying patients about high-risk flags when activated in the EHR and informing patients of "enhanced care services."[67] Since May 2023, VHA required that suicide prevention coordinators document high-risk flag inactivation in the EHR using a high risk for suicide progress note template (inactivation note) to initiate the patient's enrollment in caring communications.[68] In November 2023, VHA required suicide prevention coordinators to notify patients when high-risk flags are activated or inactivated and "of their right to request to amend their EHR."[69]

The OIG found that the high-risk flag activation notes in the patient's EHR in spring 2022 and summer 2023 included that the patient will be notified of flag placement; however, suicide prevention staff did not document informing the patient when the high-risk flag was activated for either flag.[70] Further, suicide prevention staff did not document notifying the patient of high-risk flag inactivation in early 2024, a few months prior to the patient's death by suicide. The OIG found that the patient received caring communications following the high-risk flag inactivation in early 2024; however, suicide prevention coordinator 2 did not document the required high-risk flag inactivation note in the patient's EHR.

In an interview with the OIG, the program manager, crisis services (suicide prevention supervisor) explained that the facility did not have a procedure in place to notify patients when a high-risk flag was activated or inactivated and could not confirm that the patient was informed of either flag activation or inactivation in early 2024. The suicide prevention supervisor informed the OIG that a new procedure was implemented in March 2025 to send patients a notification letter regarding the high-risk flag activation and inactivation as a result of the OIG's inquiries to the suicide prevention supervisor about facility processes. Further, the suicide prevention

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[66] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010, rescinded and replaced by VHA Directive 1166. The 2010 directive includes general guidance for all patient record flags, not specifically the high-risk flag. The 2023 directive adds responsibilities for the suicide prevention coordinator to notify a patient of a high-risk flag.

[67] VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Guide*, November 2020, updated December 2022. The guidebooks contain similar language related to notifying patients of high-risk flag activations. The OIG understands that suicide prevention tasks at the facility are completed by suicide prevention coordinators and suicide prevention case managers.

[68] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Implementation of Caring Communications for Veterans with Inactivated High Risk for Suicide Patient Record Flags (HRS-PRF)," memorandum to VISN Director (10N1-23) et al., May 5, 2023. The caring communication program, updated to "caring letters" in June 2023, involves the patient receiving required monthly mailings from VHA for a minimum of one year following inactivation of a high-risk flag.

[69] VHA Directive 1166.

[70] The OIG uses the term suicide prevention staff to include suicide prevention coordinators and suicide prevention case managers. The OIG learned from interviews that at the facility, suicide prevention coordinators and case managers complete tasks involving a patient's high-risk flag requirements; however, suicide prevention coordinators coordinate these tasks and typically manage high-risk flag activation and inactivation notes.

supervisor explained that suicide prevention staff are reviewing the list of patients with a high-risk flag and notifying each patient who did not receive a letter at high-risk flag activation.

Suicide prevention coordinator 2 reported taking action to inactivate the patient's high-risk flag in early 2024 but did not document the inactivation in the EHR. Further, suicide prevention coordinator 2 explained being unaware if documenting in the EHR was required and discussed a plan to be more diligent in the future when inactivating high-risk flags. The suicide prevention supervisor told the OIG that suicide prevention staff's failure to enter an inactivation note in the patient's EHR was an "oversight," and the lack of note resulted in providers not being alerted to the change. The suicide prevention supervisor reported finding the error during a review after the patient's death and notified the chief of mental health and reeducated the suicide prevention coordinators on the importance of entering the inactivation note when a high-risk flag is removed.

Suicide prevention staff's failure to inform the patient of the high-risk flag activations may have contributed to an incomplete understanding of the suicide prevention care and contacts the patient was receiving and may have discouraged the patient from fully engaging with staff. Failure to notify the patient of high-risk flag inactivation may have led to the patient receiving significantly fewer contacts from VHA abruptly without an understanding of why this change occurred or additional information on who to contact in the future if needed. Additionally, suicide prevention coordinator 2's failure to document the high-risk flag inactivation in the patient's EHR may have resulted in the patient's treatment providers being unaware that the high-risk flag had been inactivated, limiting clinical considerations of the patient's needs following a reduction in contacts by suicide prevention staff.

Safety Plan Review

VHA requires that suicide prevention coordinators ensure patients receive four mental health appointments within the first 30 days of a high-risk flag placement and one mental health appointment each month for the duration of the flag.[71] The mental health appointments should include a safety plan review and discussion of strategies to decrease suicide risk and build coping mechanisms.[72] VHA requires that outpatient appointments "are scheduled based on clinical need" and patient preference.[73]

In a review of the EHR, the OIG found that staff did not complete the required safety plan review during 5 of the 11 appointments held while the spring 2022 high-risk flag was active, nor

[71] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Update to High Risk for Suicide Patient Record Flag (HRS-PRF) Changes," memorandum to VISN Directors, VISN CMOs, VISN Chief Mental Health Officers, October 5, 2021; VHA Directive 1166.

[72] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Update to High Risk for Suicide Patient Record Flag (HRS-PRF) Changes," memorandum.

[73] VHA Directive 1230.

during three of four appointments held when the high-risk flag was reactivated in summer 2023.[74]

Since the high-risk flag was reactivated in summer 2023, the OIG also found that suicide prevention staff did not accommodate the patient's stated preference for time of contact after 4:00 p.m. or later in the afternoon and routinely attempted to contact the patient during the patient's work hours. In a review of the EHR, the OIG identified four instances when the patient expressed an inability to hold a call with suicide prevention staff due to being at work, and two instances when the patient requested calls later in the afternoon during the following five months of contact attempts. The OIG found, however, that staff did not accommodate the patient's requests.

In an OIG interview, the suicide prevention supervisor explained that high-risk flag follow-up contacts may occur over the phone and are required to include clinical discussion where the staff member offers support or talks to the patient about lethal means restriction, safety planning, or assesses the patient's mood.[75] The suicide prevention supervisor also reported that staff were expected to follow up on the patient's request for timing of contacts but acknowledged this did not occur.

The OIG determined that suicide prevention staff did not adhere to the required safety plan review when conducting high-risk flag contacts. Further, suicide prevention staff did not accommodate the patient's contact time preference, which may have contributed to brief telephone calls, resulting in the patient not receiving consistent safety plan review. The lack of required safety plan review during high-risk flag contacts may have contributed to a missed opportunity for the patient to develop additional coping skills and identify social supports to help address the patient's reported thoughts of suicide and ongoing stressors.

4. Institutional Disclosure Consideration

An institutional disclosure is a formal process for facility leaders and clinicians to inform a patient or patient's personal representative when an adverse event occurred that may have resulted in the patient's serious injury or death, including specific information about the patient or representative's rights and recourse.[76] An institutional disclosure must be completed

[74] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Update to High Risk for Suicide Patient Record Flag (HRS-PRF) Changes," memorandum.

[75] Facility Medical Center Policy 116-004, *Suicide Prevention*, May 19, 2023. Facility policy utilizes term "contacts" to refer to telephone, video, or in-person visits with a patient.

[76] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. VHA defines an adverse event as "untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers."

regardless of when the adverse event is discovered.[77] VHA requires an institutional disclosure of adverse events that cause death or disability, regardless of whether they resulted from an error.[78]

The Chief of Staff told the OIG that an institutional disclosure was not considered as facility leaders did not identify any concerns with the patient's care. The risk manager explained that an institutional disclosure was considered, but determined to not be necessary after discussions with the suicide prevention supervisor and chief of medicine, who reviewed the patient's care and did not have concerns. The Facility Director told the OIG that completion of institutional disclosures typically occurs for identified harm in care, but noted that it was most often for inpatient cases involving falls or injuries and not for outpatient deaths.

As discussed above, the OIG identified deficiencies in the patient's care including lack of care coordination with the community care pain management provider, failure to address the patient's falls, inadequate TBI evaluation and treatment, and inadequate management of the patient's high-risk flag. Given the OIG identified care deficiencies, facility leaders may want to consider an institutional disclosure.

Conclusion

Between summer 2018 and spring 2024, the patient reported experiencing a fall at home to facility staff 18 times, with 16 of the reported falls mentioning a strike to the head or loss of consciousness. The PCP did not evaluate the patient's mobility, fall risk, and risk of injury from falls; document clinical decision-making for the falls from other possible diagnoses; or ensure that the patient received appropriate care to reduce fall risk, as required. The neurologist did not evaluate the cause of the patient's falls or coordinate the patient's neurology treatment with the PCP. When alerted to falls, primary care nursing staff did not complete a fall note, which would prompt further evaluation and consideration of interventions. Mental health staff did not alert primary care staff when notified of the patient's falls. Facility staff's failure to address the patient's repeated falls and intervene with fall prevention strategies may have resulted in preventable injury.

Neither the PCP nor the neurologist referred the patient for a comprehensive TBI evaluation when notified of the patient's falls with head injury.

The OIG substantiated that the neurologist failed to provide TBI treatment to the patient in mid-spring 2023 following a TBI. Despite the patient's new TBI-related deficits, the neurologist continued to focus on treating the patient's headaches, did not coordinate care with the PCP, did not conduct an adequate functional assessment in determining the patient's ability to return to work, and did not attempt to obtain the patient's community care records, to include the

[77] VHA Directive 1004.08.
[78] VHA Directive 1004.08.

rehabilitation facility inpatient admission information on TBI treatment needs and work restrictions. The neurologist's failure to address and coordinate the patient's TBI treatment likely impeded the patient's ability to receive the recommended TBI care. Absence of the community care records contributed to the neurologist's limited understanding of the patient's TBI treatment and return to work needs following discharge from the rehabilitation facility.

The PCP did not address the patient's TBI or assess for persisting symptoms, manage the patient's recommended follow-up care including a referral to occupational therapy, or ensure receipt of community care records, to include the rehabilitation facility discharge summary. Failure to address the patient's TBI symptoms may have hindered the opportunity to provide timely and effective interventions to improve the patient's outcome. The lack of the discharge summary may have limited the PCP's understanding of the patient's TBI-related treatment needs.

Further the PCP and neurologist did not add TBI to the patient's problem list, which may have resulted in facility staff's limited understanding of the patient's TBI-related needs.

Facility community care staff did not ensure receipt of the patient's rehabilitation facility discharge summary and did not make timely community care records available to staff, which may have contributed to the patient not receiving recommended TBI follow-up care.

The OIG did not substantiate that facility staff provided inadequate evaluation and initial management of the patient's back pain. However, the PCP did not coordinate pain management with the patient's community care pain management provider to monitor treatment effectiveness when the patient continued to report back pain with falls. The lack of care coordination may have resulted in the community care pain management providers' incomplete understanding of the patient's back pain. Further, facility community care staff did not use the care plan note, which likely inhibited communication among providers, limiting care coordination opportunities for the patient's back pain.

Between summer 2022 and fall 2023, the PCP added the primary care nurse as an additional signer to a note three times in the patient's EHR with instructions for scheduling follow-up care, but the patient was not scheduled for an appointment. The primary care nurse reported asking a medical support assistant to contact the patient and acknowledged that this "may not be" documented in the EHR. The primary care nurse's lack of documented follow up may have contributed to the patient not receiving the requested primary care follow-up appointments.

The OIG did not substantiate that facility staff failed to provide the patient appropriate mental health medication management and treatment. However, suicide prevention staff did not notify the patient of high-risk flag activation and inactivation and did not document flag inactivation in early 2024. Failure to inform the patient of the high-risk flag activation and inactivation may have contributed to an incomplete understanding of suicide prevention care. Failure to document the high-risk flag inactivation may have resulted in the patient's treatment providers being

unaware of the flag inactivation and subsequent reduction in contacts by suicide prevention staff, thereby limiting clinical considerations of the patient's needs.

Suicide prevention staff did not complete safety plan reviews during high-risk flag case management contacts. The lack of safety plan review during high-risk flag contacts may have contributed to a missed opportunity for the patient to develop additional coping skills to address thoughts of suicide.

Facility leaders did not consider an institutional disclosure related to the patient's care due to not identifying concerns in independent reviews. Given the OIG identified care deficiencies, facility leaders may want to consider an institutional disclosure.

The VISN and Facility Directors concurred with the findings and recommendations (see appendixes B and C). In addition to reviewing the patient's care and completing an institutional disclosure, the Facility Director shared plans to update procedures on fall prevention, care coordination, and management of high risk for suicide flags. The Facility Director also planned to ensure compliance with staff training regarding TBI care management, community care coordination, and scheduling practices. The OIG will follow up on the planned actions until they are completed.

Recommendations 1–13

1. The Marion VA Health Care System Director ensures a review is conducted of the care provided to the patient by the primary care provider and the neurologist, consults with Human Resources and General Counsel Offices, and takes action as warranted.

2. The Marion VA Health Care System Director ensures primary care nursing staff's adherence to facility fall prevention policy and monitors compliance.

3. The Marion VA Health Care System Director evaluates the facility fall prevention policy to consider expectations for mental health staff's role in responding to patient reports of falls at home.

4. The Marion VA Health Care System Director reviews processes to ensure primary care and specialty care staff are appropriately educated and trained on making referrals to and the services available through the facility's Traumatic Brain Injury Polytrauma Clinic.

5. The Marion VA Health Care System Director ensures compliance with the primary care program facility policy concerning specialty consultation staff's communication with a patient's primary care provider regarding patient concerns.

6. The Marion VA Health Care System Director ensures compliance with the facility patient problem list standard operating procedure.

7. The Marion VA Health Care System Director strengthens processes to ensure compliance with Veterans Health Administration timeliness standards for obtaining and scanning community care records.

8. The Marion VA Health Care System Director reviews facility care coordination practices between primary care providers and community care providers, identifies barriers to sharing patient treatment information to inform clinical decision-making, and takes action as warranted.

9. The Marion VA Health Care System Director ensures community care staff adhere to requirements regarding completion of community care-care coordination plan notes and monitors compliance.

10. The Marion VA Health Care System Director conducts a review of the facility primary care scheduling processes to ensure compliance with Veterans Health Administration and facility policy on care coordination within Patient Aligned Care Teams.

11. The Marion VA Health Care System Director ensures suicide prevention staff document high-risk flag inactivation within patients' electronic health records and notify patients when a high-risk flag is activated or inactivated as required by the Veterans Health Administration policy, and monitors compliance.

12. The Marion VA Health Care System Director ensures mental health staff adhere to Veterans Health Administration requirements on safety planning during high risk for suicide patient record flag patient contacts.

13. The Marion VA Health Care System Director evaluates the care provided to the patient, determines if an institutional disclosure is warranted, and takes action as indicated.

Appendix A: Patient Case Summary 2018–2021

In summer 2018, at an initial primary care appointment, the patient reported seeking care at a community emergency department after a fall related to "back spasms" with injury near the left eye. The PCP documented a negative TBI screen.[79] The PCP submitted a mental health consult and approximately six weeks later, the patient attended a psychiatry appointment. The patient told the psychiatrist about poor sleep, lack of interest in activities, and distractibility, and denied suicidal thoughts. The psychiatrist diagnosed the patient with recurrent and mild major depressive disorder and insomnia and prescribed sleep and antidepressant medications. Two months later, the patient reported minimal changes in mood to the psychiatrist.

In an early 2019 primary care appointment, the patient reported neck and back pain and migraines. The same day, a nurse informed the patient that x-rays indicated moderate back and neck degenerative disc disease and the patient agreed to physical therapy. Over the next 14 months, the patient engaged in physical therapy and community care chiropractic treatment and reported improvement in back but not neck pain.

In summer 2020, a nurse documented that the patient "tripped and fell hitting head on a counter," and was a "fall risk patient." The PCP documented the patient's report of back pain and spasms and referred the patient to the facility pain clinic. In an early 2021 pain clinic appointment, the patient reported radiating neck pain and "sharp, dull, and tingling" low back pain. A pain management physician documented that the patient reported lack of relief from prior interventions such as physical therapy and acupuncture. The pain management physician referred the patient to a community care provider for a pain management procedure.

In mid-spring 2021, the patient received a pain management procedure from a community care pain management provider. Approximately two months later, the patient reported short-term pain relief and symptom improvement. In an early fall 2021 primary care appointment, the patient reported knee buckling due to a "pinch[ed] nerve in back" that resulted in three falls over a period of approximately eight months. A nurse completed a fall evaluation and noted that the patient "feels unsteady when standing or walking" and "worries about falling." The PCP documented that the patient was receiving community care pain management to address back pain, noted the patient's recent falls, and described the patient's pain symptoms as "stable."

[79] Since 2007, VHA requires "post 9/11" veterans to be screened for TBI to ensure provision of "appropriate treatments and services" upon entry into VA health care. VHA Directive 1184, Screening and Evaluation of Traumatic Brain Injury (TBI) in Operation Enduring Freedom (OEF) Operation Iraqi Freedom (OIF) and Operation New Dawn (OND) Veteran, April 6, 2017. The 2017 directive was rescinded and replaced by VHA Directive 1184, Screening and Evaluation of Post-9/11 Veterans for Deployment-Related Traumatic Brain Injury, January 3, 2022. Unless otherwise specified, the 2022 directive contains the same or similar language regarding TBI screening as the 2017 directive. The 2022 directive reflects the change to "post-9/11" veterans from Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn veterans.

In mid-fall 2021, the patient called the Veteran's Crisis Line and reported "significant anxiety, including panic attacks" due to life stressors including housing, work, and family concerns.[80] The patient reported alcohol use to cope with symptoms and suicidal thoughts. A facility suicide prevention case manager spoke with the patient who requested psychotherapy and medication management. Six days later, the patient denied suicidal thoughts and an MHNP prescribed the patient medication for depression and anxiety.

From late fall 2021 to early 2022, the patient attended monthly mental health medication management appointments. The patient reported continued alcohol use, some improvement in depression and anxiety symptoms, and suicidal thoughts without a plan, and declined psychotherapy and substance use disorder referrals.

[80] The Veterans Crisis Line is a confidential hotline, chat, or text service that connects veterans in crisis with VA responders. VHA, "Mental Health," accessed February 13, 2025, https://mentalhealth.va.gov/get-help/index.asp.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 14, 2025

From: Director, Department of Veterans Affairs (VA) Heartland Network (10N15)

Subj: VA Office of Inspector General (OIG) Report, Review of Care Provided to a Patient Who Died by Suicide, Marion VA Health Care System in Illinois (VIEWS #13903516)

To: Director, Office of Healthcare Inspections (54MHP1)
Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to work with the OIG's Office of Healthcare Inspections as we continuously strive to improve the quality of health care for the Nation's Veterans. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. I concur with the report findings and recommendations of OIG report, Review of Care Provided to a Patient Who Died by Suicide, Marion VA Health Care System in Illinois.

2. We recognize the profound impact of the loss of a Veteran and extend our deepest condolences to the family, loved ones, and care teams affected. Every loss is deeply felt and reinforces our commitment to continuous improvement. I have reviewed the documentation and concur with the facility's response as submitted.

3. Should you need further information, contact the Veterans Integrated Service Network Quality Management Officer.

(*Original signed by:*)

Angela N. Athmann, MHA, MBA, RHIA
Interim V15 Network Director

[OIG comment: The OIG received the above memorandum from VHA on November 17, 2025.]

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 13, 2025

From: Director, Marion VA Health Care System, Marion, IL (657A5)

Subj: VA Office of Inspector General (OIG) Report—Review of Care Provided to a Patient Who Died by Suicide, Marion VA Health Care System in Illinois (VIEWS #13903516)

To: Director, VA Heartland Network (10N15)

1. We sympathize with this Veteran's family and loved ones in this time of loss. We appreciate the opportunity to review and comment on the OIG report, Review of Care Provided to a Patient Who Died by Suicide, Marion VA Health Care System in Illinois.
2. Marion VA Health Care System concurs with the findings and will take appropriate actions as recommended.
3. Should you need further information, please contact Marion VA Health Care System's Quality Manager.

(*Original signed by*:)

Zachary M. Sage, MHA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on November 17, 2025.]

Facility Director Response

Recommendation 1

The Marion VA Health Care System Director ensures a review is conducted of the care provided to the patient by the primary care provider and the neurologist, consults with Human Resources and General Counsel Offices, and takes action as warranted.

_X_ Concur

____Nonconcur

Target date for completion: October 2025

Director Comments

Peer Reviews of the primary care provider and the neurologist were conducted to assess the quality and appropriateness of care provided in May 2025. Consultations with Human Resources (HR) and the Office of General Counsel (OGC) were completed on October 16, 2025, to ensure appropriate administrative and legal review.

Marion Department of Veterans Affairs (VA) Health Care System requests closure of this recommendation based on the evidence provided. Evidence supporting the request for closure is found in the Supplemental Information document.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 2

The Marion VA Health Care System Director ensures primary care nursing staff's adherence to facility fall prevention policy and monitors compliance.

_X_ Concur

____Nonconcur

Target date for completion: August 2026

Director Comments

Marion VA Health Care System's fall prevention policy is currently under review with a target completion date of December 31, 2025. Primary Care nursing staff will receive the updated policy with job aid by January 31, 2026. The Chief Associate Nurse of Primary Care will monitor fall risk screening monthly assessment through chart audits of 10 Veterans per month seen in Primary Care within the last 30 days. Compliance will be defined with the presence of

completed fall screening. Monitoring and compliance will continue until a minimum of 90% compliance is sustained for 6 consecutive months.

Fall Management Talent Management System (TMS) training (Module 1, TMS 131020879) will be assigned to Primary Care nursing staff with 90% completion rate by March 30, 2026. Compliance will be monitored monthly and reported to the Quality, Safety, Value, and High Reliability Executive Board.

Recommendation 3

The Marion VA Health Care System Director evaluates the facility fall prevention policy to consider expectations for mental health staff's role in responding to patient reports of falls at home.

_X_ Concur

____Nonconcur

Target date for completion: August 2026

Director Comments

Marion VA Health Care System will update the facility fall prevention policy to strengthen expectations for mental health staff's role in responding to patient reports of falls at home and provide staff training regarding their expectations.

Marion VA Health Care System's Associate Director of Patient Care Services will provide mental health clinical staff training on the updated fall prevention policy and their expectations. The compliance goal is 90% of mental health clinical staff to have received this training by the target completion date for 6 months. Monthly updates will be provided to the Quality, Safety, Value, and High Reliability Executive Board.

Marion VA Health Care System's Chief of Behavioral Health will complete monthly chart audits of 10 Veterans seen for mental health services who reported of falls at home to the mental health provider. Compliance is achieved when 90% of the mental health staff document communication of the Veteran reported falls at home to the primary care provider. Monthly updates will be provided to the Quality, Safety, Value, and High Reliability Executive Board.

Recommendation 4

The Marion VA Health Care System Director reviews processes to ensure primary care and specialty care staff are appropriately educated and trained on making referrals to and the services available through the facility's Traumatic Brain Injury Polytrauma Clinic.

_X_ Concur

____Nonconcur

Target date for completion: October 2025

Director Comments

Marion VA Health Care System's Chief of Staff conducted a review of the training requirements for Traumatic Brain Injury (TBI) described in VHA Directive 1184, Screening and Evaluation of Post-9/11 Veteran for Deployment-Related Traumatic Brain Injury.

Primary care and specialty care clinical staff completed education and training focused on TBI recognition, evaluation, and management in alignment with VA/Department of Defense Clinical Practice guidelines and to inform providers of resources available at the facility. Training was provided by the Chief, Physical Medicine and Rehabilitation Service, in April 2025, and additional training was provided in September 2025 by the facility's TBI Coordinator. This effort was implemented to enhance clinical awareness and improve referral practices for Veterans presenting with potential TBI-related concerns. This training was established as an annual requirement. New providers receive this training as part of their initial training regimen and are also assigned annual refresher training.

Following the completion of this training, referrals to the TBI Clinic increased by 37% from fiscal year (FY) 2024 to FY 2025, indicating strengthened clinical engagement and improved identification of TBI cases across our care teams.

Marion VA Health Care System requests closure of this recommendation based on the evidence provided.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 5

The Marion VA Health Care System Director ensures compliance with the primary care program facility policy concerning specialty consultation staff's communication with a patient's primary care provider regarding patient concerns.

_X_ Concur

____Nonconcur

Target date for completion: July 2026

Director Comments

Marion VA Health Care System confirms that education for facility providers has been completed regarding the expectations for communication of important Veteran information. In September 2024, the facility implemented a new policy titled "Use of Additional Signer

Function" to clarify when an "additional signer" should be used. This policy was disseminated across the organization, and education on the new expectations was provided to providers to ensure improved communication and care coordination expectations.

Marion VA Health Care System's Chief of Medicine will complete chart audits of 10 Veterans seen in medical specialty clinics per month. Compliance is measured by 90% of the charts having appropriate use of "additional signer" by the specialty care provider notifying the Veteran's primary care provider when appropriate for a period of 6 months.

Recommendation 6

The Marion VA Health Care System Director ensures compliance with the facility patient problem list standard operating procedure.

_X_ Concur

____Nonconcur

Target date for completion: July 2026

Director Comments

The Chief of Staff will provide the current Patient Problem List standard operating procedure (SOP) with expectations for all medical providers by December 1, 2025.

The Chief of Health Information Management will monitor compliance by monthly chart reviews with a sample of 10 (or audit 100% if less than 10 possible charts are available) Veterans with a diagnosis of TBI validating that the problem list captured the TBI diagnosis. Compliance will be monitored for 6 months with a 90% target sustained. Data will be reported monthly to the Quality, Safety, Value, High Reliability Executive Board.

Recommendation 7

The Marion VA Health Care System Director strengthens processes to ensure compliance with Veterans Health Administration timeliness standards for obtaining and scanning community care records.

_X_ Concur

____Nonconcur

Target date for completion: September 2026

Director Comments

Marion VA Health Care System continues to monitor and improve handling of community care records. Over the last 2 years, improved information systems have been deployed to enhance

effectiveness in obtaining and processing community care records, both for VA staff and for non-VA providers.

Marion VA Health Care System Associate Director for Patient Care Service will ensure community care records are attached within the electronic health record within 5 days of receipt. Compliance will be monitored for 6 months with a 90% target sustained.

Monthly updates will be provided to the Quality, Safety, Value, and High Reliability Executive Board.

Recommendation 8

The Marion VA Health Care System Director reviews facility care coordination practices between primary care providers and community care providers, identifies barriers to sharing patient treatment information to inform clinical decision-making, and takes action as warranted.

_X_ Concur

____Nonconcur

Target date for completion: October 2026

Director Comments

Marion VA Health Care System leadership reviewed the requirements of the VHA Office of Integrated Veteran Care (IVC) field guidebook for care coordination expectations. Based on these findings, standardized care coordination processes will be developed and implemented utilizing the Care Coordination Plan Note per IVC Field Guidebook.

Compliance will be monitored by the Chief of Primary Care and measured by the implementation of standardized care coordination processes by January 1, 2026. Primary Care providers will receive training on these new practices by February 1, 2026, and compliance is considered met when 90% of staff are trained. New primary care providers will receive this training as part of on-boarding.

Monthly updates will be provided to the Quality, Safety, Value, and High Reliability Executive Board.

Recommendation 9

The Marion VA Health Care System Director ensures community care staff adhere to requirements regarding completion of community care-care coordination plan notes and monitors compliance.

_X_ Concur

____Nonconcur

Target date for completion: July 2026

Director Comments

The Marion VA Health Care System leadership reviewed the IVC field guidebook for care coordination. The Care Coordination Plan Note (CCPN) will be utilized for all care coordination. Community Care Registered Nurses received additional training care coordination plan note compliance. Compliance will be monitored by the Associate Director for Patient Care Services through Power Business Intelligence -IVC IIA Reports (%CC-CCPN Compliance (Excludes Basic)) and reported monthly to the Quality, Safety, Value, and High Reliability Executive Board. Goal is considered met with sustained completion rate of 90% for six months.

Recommendation 10

The Marion VA Health Care System Director conducts a review of the facility primary care scheduling processes to ensure compliance with Veterans Health Administration and facility policy on care coordination within Patient Aligned Care Teams.

_X_ Concur

____Nonconcur

Target date for completion: July 2026

Director Comments

Marion VA Health Care System will implement training for all Patient Aligned Care Teams on the proper procedures and requirements for entering Return to Clinic (RTC) orders when recommending that a Veteran be seen by the clinic. This training will ensure consistent adherence to documentation standards and enhance continuity of care for Veterans.

The Group Practice Manager will track primary care RTC orders completed within 14 calendar days. Data will be reviewed and analyzed to measure compliance improvement and identify any additional training needs or process refinements. Monitoring and compliance will continue until a minimum of 90% compliance is sustained for 6 consecutive months.

Monthly updates will be provided to the Quality, Safety, Value, and High Reliability Executive Board.

Recommendation 11

The Marion VA Health Care System Director ensures suicide prevention staff document high-risk flag inactivation within patients' electronic health records and notify patients when a high-

risk flag is activated or inactivated as required by the Veterans Health Administration, and monitors compliance.

_X_ Concur

____Nonconcur

Target date for completion: January 2026

Director Comments

The Behavioral Health Leadership team completed a full review of the high-risk flag activation and inactivation process. As a result of the review, a new process for tracking and management of high-risk suicide prevention flags was implemented on November 4, 2024. The Suicide Prevention Coordinator monitored the new high-risk flag process to ensure that all high-risk flags are linked and documented. Monitoring has been completed and achieved 90% compliance for 6 consecutive months and is currently at 100%.

The Suicide Prevention Program initiated the practice of mailing notification letters to patients whenever a high-risk flag is activated or inactivated on March 3, 2025. In addition to the mailed notifications, Suicide Prevention team members also inform Veterans of high-risk flag activation or inactivation during telephone contacts. For the last 6 months, approximately 91% of Veterans who had a high-risk flag activated or inactivated were mailed notifications of the change (August 2025 at 100%, September 2025 at 97%, October 2025 at 100%).

The facility's standard operating procedure (SOP) does not currently include the process to notify Veterans about high-risk suicide flag changes. The Suicide Prevention Coordinator will update the SOP to include Veteran notifications of high-risk suicide flag changes as required by VHA Directive 1166, Patient Record Flags.

Recommendation 12

The Marion VA Health Care System Director ensures mental health staff adhere to Veterans Health Administration requirements on safety planning during high risk for suicide patient record flag patient contacts.

_X_ Concur

____Nonconcur

Target date for completion: July 2026

Director Comments

The Behavioral Health Leadership Team completed a full review of the safety plan process and staff actions when caring for a high-risk suicide patient. It was determined that more frequent training would reinforce the steps needed to adhere to safety plan requirements.

TMS Safety Planning training #36232 will be assigned to all Behavioral Health clinical staff. The Chief of Behavioral Health is responsible for monitoring and compliance is considered met when 90% of staff are trained. New Behavioral Health staff will receive this training as part of on-boarding.

Education regarding Safety Planning procedures and related documentation will be reviewed regularly at mental health all-staff meetings. All mental health personnel will receive education on the proper use of the Suicide Prevention Safety Plan Review/Decline note template. The Chief of Behavioral Health is responsible for monitoring and compliance is considered met when 90% of staff are trained. New Behavioral Health staff will receive this training as part of on-boarding.

The Chief of Behavioral Health is responsible for monthly monitoring and reporting chart audit results for ten high-risk for suicide patient records per month validating that a safety plan discussion was documented with compliance measured at 90% completion for 6 consecutive months.

Monthly updates will be provided to the Quality, Safety, Value, High Reliability Executive Board.

Recommendation 13

The Marion VA Health Care System Director evaluates the care provided to the patient, determines if an institutional disclosure is warranted, and takes action as indicated.

_X_ Concur

____Nonconcur

Target date for completion: October 2025

Director Comments

Marion VA Health Care System's Chief of Staff completed an institutional disclosure with the Veteran's family meeting the requirements of VHA Directive 1004.08, Disclosure of Adverse Events to Patients.

Marion VA Health Care System requests closure of this recommendation based on the evidence provided.

OIG Comments

The OIG considers this recommendation closed.

Glossary

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

amnesia. "The loss of memories, including facts, information and experiences" caused by damage to the brain.[1]

degenerative disc disease. A common cause of back pain and refers to changes to the fluid-filled flexible cushions, or discs, that fill the space between the spine's vertebrae allowing the spine to bend and flex. With aging or in response to injury the discs can degenerate, or break down, resulting in the loss of person's ability to fluidly bend and flex their back. As degeneration progresses, the disc disease can result in back pain and pain that sometimes radiates to a person's arms and legs.[2]

diffuse axonal injury. Tearing of brain nerve fibers from the brain shifting inside the skull and resulting in injury to many parts of the brain. Brain changes may be microscopic and "may not be evident" on computed tomography or magnetic resonance imaging scans.[3]

computed tomography scan. A type of scan that uses an x-ray beam to create cross-sectional images of the body to create a three-dimensional view of the body area.[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."[5]

magnetic resonance imaging. "A medical imaging technique" using a magnetic field and radio waves to "create detailed images of the organs and tissues" of the body.[6]

major depressive disorder. An episode of at least two weeks characterized by five or more symptoms that include depressed mood or loss of interest or pleasure in activities, considered recurrent when two consecutive months or more occur between episodes. A "mild" specification

[1] Mayo Clinic, "Amnesia," accessed February 13, 2025, https://www.mayoclinic.org/diseases-conditions/amnesia/symptoms-causes/syc-20353360.

[2] Cedars-Sinai, "Degenerative Disc Disease," accessed October 17, 2024, https://www.cedars-sinai.org/health-library/diseases-and-conditions/d/degenerative-disc-disease.html.

[3] Johns Hopkins Medicine, "Traumatic Brain Injury," accessed February 25, 2025, https://www.hopkinsmedicine.org/health/conditions-and-diseases/traumatic-brain-injury.

[4] Medline Plus. "CT scan," accessed February 13, 2025, https://medlineplus.gov/ency/article/003330.htm.

[5] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

[6] Mayo Clinic, "MRI," accessed February 26, 2025, https://www.mayoclinic.org/tests-procedures/mri/about/pac-20384768.

is used when the symptoms are "distressing but manageable" and result in "minor impairment in social or occupational functioning."[7]

neurobehavioral. "The way the brain affects emotion, behavior, and learning."[8]

sequelae. Aftereffects "of a disease, condition, or injury."[9]

spinal arthritis. "Inflammation in the joints between [the] vertebrae, the bones that link together" the spine.[10]

syncope. A brief loss of consciousness due to a sudden decrease in blood flow to the brain.[11]

traumatic brain injury. A condition that "usually results from a violent blow or jolt to the head or body," and can have a wide range of physical and psychological effects.[12]

x-ray. A test using x-ray beams to capture images inside the body including bones.[13]

[7] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), "Major Depressive Disorder," accessed February 4, 2025, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x04_Depressive_Disorders.

[8] National Cancer Institute, "neurobehavioral," accessed March 31, 2025, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/neurobehavioral.

[9] Merriam-Webster.com Dictionary, "sequela," accessed February 27, 2025, https://www.merriam-webster.com/dictionary/sequelae.

[10] Cleveland Clinic, "Spinal Arthritis," accessed February 18, 2025, https://my.clevelandclinic.org/health/diseases/spinal-arthritis.

[11] Cleveland Clinic, "Syncope (Fainting)," accessed February 12, 2025, https://my.clevelandclinic.org/health/diseases/17536-syncope.

[12] Mayo Clinic, "Traumatic brain injury," accessed March 20, 2025, https://www.mayoclinic.org/diseases-conditions/traumatic-brain-injury/symptoms-causes/syc-20378557.

[13] Mayo Clinic, "X-ray", accessed March 20, 2025, https://www.mayoclinic.org/tests-procedures/x-ray/about/pac-20395303.

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