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VETERANS HEALTH ADMINISTRATION

Delays and Deficiencies in the Mental Health Care of a Patient at the Michael E. DeBakey VA Medical Center in Houston, Texas

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate concerns at the Michael E. DeBakey VA Medical Center (facility) in Houston, Texas, regarding staff's failure to effectively arrange an evidence-based psychotherapy (EBP) referral for a patient with a high risk for suicide patient record flag (high-risk flag).[1] The OIG also evaluated concerns that staff did not adequately conduct and document a lethal means safety plan with the patient and did not provide required high-risk flag management.

Synopsis of the Patient's Care

The patient, in their sixties at the time of this inspection, with a history of major depressive disorder, began receiving psychiatric care at the facility in 2003.[2] In spring 2018, staff assigned the patient a high-risk flag after the patient reported a suicide attempt by taking pain medications one month prior and with a firearm in the 1990s. The patient participated in outpatient care with a psychiatrist from 2018 to fall 2023. In summer 2021, the patient told a high risk case manager (high risk case manager 1) about lacking equipment for virtual psychotherapy and a preference for in-person care.

In early 2022, the psychiatrist placed a therapy treatment planning (TTP) consult (day 1) for the patient that was scheduled for over two months later.[3] On day 85, during the TTP appointment, a psychologist submitted an individual EBP consult after the patient declined "a Community Care consult due to wait time" for an appointment at the facility. On day 91, during a scheduled appointment with a non-mental health physician, the patient reported having intentionally ridden their wheelchair "in front of a car within the last few days but the car stopped." At an in-person visit, a primary care-mental health integration (PC-MHI) psychologist completed a safety plan

[1] EBPs are research-supported "specific psychotherapeutic treatments" that have shown effectiveness in improving patients' mental health conditions and are typically used by licensed mental health providers, such as psychologists and social workers, who have received specialized EBP training. VHA Directive 1160.05, *Evidence-Based Psychotherapies and Psychosocial Interventions for Mental and Behavioral Health Conditions*, June 2, 2021; The OIG identified these concerns while reviewing the patient's electronic health record for another healthcare inspection; 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] A TTP visit is a telephone appointment that occurs prior to scheduling a patient for individual EBP and includes educating the patient about EBPs, discussing expectations, and engaging in shared decision-making to facilitate selection of an EBP to meet the patient's goals.

with the patient and the next day, a suicide prevention coordinator reactivated the patient's high-risk flag that had been inactivated in fall 2021.[4]

Although the patient attended five psychiatrist appointments during days 98–227, the patient did not participate in EBP. During this time, schedulers documented in the electronic health record (EHR) no EBP appointment availability multiple times along with two unsuccessful attempts to reach the patient.[5] On day 240, a scheduler canceled the patient's individual EBP consult due to a "failed mandated scheduling effort."[6] On day 273, the psychiatrist submitted another EBP TTP consult and over the next few weeks, schedulers could not reach the patient to arrange an EBP appointment, and the patient declined a loaner iPad for virtual psychotherapy.

On day 367, the patient was admitted to the inpatient mental health unit after reporting holding a firearm to the head the previous week. In spring 2023, on day 413, social worker 2 conducted session 1 of 16 planned EBP sessions in person with the patient. At session 7, social worker 2 documented a plan to transition from in-person sessions to high-risk case management calls "due to another Veteran being scheduled" at the patient's existing appointment time. Two weeks later, the patient told social worker 2 about ingesting a "whole bunch of pills" sometime within the past three months. Social worker 2 continued weekly high-risk case management calls with the patient.

OIG Findings

The OIG found that although the patient was receiving psychiatric care, staff failed to provide in-person EBP until over a year after the patient's request, which was inconsistent with Veterans Health Administration (VHA) requirements.[7] As a result of the delay in the provision of focused psychotherapy, the patient's mental health challenges were not adequately addressed and eventually required inpatient care.

[4] PC-MHI staff work within primary care teams to "provide assessment and time-limited treatment of uncomplicated mental disorders." VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017.

[5] For the purposes of this report, OIG refers to medical support assistant, advanced medical support assistant, and program support assistant staff as schedulers. The associate director, General Mental Health Clinic told the OIG that program support assistants typically conducted mental health appointment scheduling; however, due to staffing shortages at the time of the patient's TTP and EBP consult requests, medical support assistants also scheduled appointments.

[6] Staff document "failed mandated scheduling effort" when canceling a mental health consult due to an inability to reach the patient after a minimum of four contact attempts. VHA, "Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure (SOP)," updated July 28, 2022.

[7] VHA Directive 1160.05; VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022. Unless otherwise specified, the two directives contain the same or similar language regarding outpatient scheduling requirements.

The OIG found that staff offered virtual and community care options that the patient declined; however, staff did not offer the patient equipment to participate in virtual sessions until over a year after the patient reported not having a video-capable device. The OIG determined that staff failed to provide the patient with a TTP appointment within 30 days, as required at the time.[8] The OIG also found that over five months, schedulers noted lack of staff to provide EBP in the patient's EHR, although did not consistently document attempts to contact the patient as required.[9]

Facility leaders provided the OIG with data that indicated General Mental Health Clinic vacancies of 14 percent, 55 percent, and 13 percent for administrative support staff, EBP psychologists, and EBP social workers, respectively, at the time of consult requests for the patient. In interviews with the OIG, administrative staff described utilizing a spreadsheet to determine EBP availability and reported the process took 30–45 minutes per consult. The OIG concluded that staffing vacancies and inefficient consult management practices contributed to staff's failures to schedule the patient's EBP.

The OIG determined that the PC-MHI psychologist and the psychiatrist did not sufficiently address the patient's access to lethal means. Given the patient's firearm access and past firearm-related suicidal behavior, the OIG would have expected the PC-MHI psychologist to address the patient's potential to obtain ammunition. In an OIG interview, the PC-MHI psychologist reported that the patient described the firearm "as though that would not be a real viable means for [the patient]." When asked whether the patient's future purchase of ammunition was considered, the PC-MHI psychologist reported not having that discussion with the patient because that would be a "sensitive conversation" and better received from an "established provider."

The OIG found, however, that during a telephone call three days after the patient's PC-MHI visit, the psychiatrist did not evaluate the patient's access to ammunition. The psychiatrist told the OIG that the patient explained "I was just saying that" during the PC-MHI psychologist visit and denied having a firearm. However, the psychiatrist did not document the patient's explanation. Although the OIG did not find that the psychiatrist's lack of documentation resulted in negative outcomes for this patient, failure to document lethal means discussions may result in an incomplete understanding of a patient's suicide risk and impede care coordination.

[8] VHA Directive 1230, July 15, 2016; VHA Directive 1230, June 1, 2022. The 2016 directive was in place at the time the psychiatrist submitted the TTP consult for the patient. The 2022 directive did not include the requirement to schedule appointments within 30 days of the clinically indicated date.

[9] VHA, "Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure (SOP)," updated October 26, 2021. This standard operating procedure was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA, "Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure (SOP)," updated July 28, 2022. The 2022 standard operating procedure contains the same or similar language regarding minimum scheduling effort requirements.

In the safety plan, the PC-MHI psychologist documented that the patient would ride the wheelchair outside as a coping strategy. Given the patient's recent wheelchair-related suicidal behavior, the OIG would have expected the PC-MHI psychologist to document a discussion of the patient's risk reduction strategies while using the wheelchair. Staff's failure to comprehensively discuss and document lethal means safety with patients may contribute to underestimated suicide risk.

The OIG found that in the 30 days following high-risk flag initiation, staff did not meet with the patient four times as required by VHA.[10] On day 100, the special programs coordinator instructed high risk case managers to contact a supervisor or suicide prevention coordinator if "having difficulty engaging a [high-risk patient] in follow-up." During the 30 days following high-risk flag initiation, staff met with the patient twice, and high risk case manager 2 unsuccessfully attempted to contact the patient twice. However, the OIG did not find documentation that high risk case manager 2 contacted a provider, supervisor, or suicide prevention coordinator when unable to reach the patient. Although the OIG did not identify that high risk case manager 2's failure to follow up when unable to reach the patient resulted in any negative outcomes for this patient, lack of consultation with a supervisor or suicide prevention coordinator may contribute to insufficient suicide prevention actions in the care of high-risk patients.

VHA requires staff to review or update the patient's safety plan and coping strategies.[11] Inconsistent with this requirement, however, an Office of Mental Health and Suicide Prevention leader reported that homeless program staff are not expected to review or update the safety plan. The OIG found that in the 30 days after high-risk flag initiation, neither the psychiatrist nor a homeless program social worker reviewed or updated the safety plan with the patient. Further, the homeless program social worker did not assess the patient for suicide risk, as required by facility procedures.[12]

The OIG found that during the patient's remaining 67 days of an active high-risk flag, staff met the monthly high-risk flag monitoring requirement through visits with the patient. However, staff did not document assessment of the patient's suicide risk and update or review the safety plan.[13] The OIG concluded that inconsistent high-risk flag requirements may have contributed to staff's

[10] 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 Veterans Integrated Services Network (VISN) Directors (10N1-23), VISN CMOs (10N1-23), and VISN Chief Mental Health Officers (10N1-23), October 5, 2021; VHA Directive 1166, *Patient Record Flags*, November 6, 2023.

[11] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memorandum; VHA Directive 1166.

[12] Facility Standard Operating Procedure, "Management of High Risk for Suicide Patient Record Flags," March 17, 2022.

[13] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memorandum; VHA Directive 1166.

failure to conduct suicide risk assessments and safety plan updates and reviews during high-risk flag follow-up appointments. The lack of routine suicide risk monitoring and safety planning could result in a failure to identify patients who are at risk of suicide and provide necessary treatment interventions.

The OIG made one recommendation to the Under Secretary for Health to clarify requirements for completion of suicide risk assessments and safety plan reviews. The OIG made five recommendations to the Facility Director related to EBP consult management, timely scheduling, and documentation; VA-issued devices; lethal means safety; and high-risk flag follow-up.

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

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Contents

Abbreviations

CSRE	comprehensive suicide risk evaluation
EHR	electronic health record
EBP	evidence-based psychotherapy
GMHC	General Mental Health Clinic
HIV	human immunodeficiency virus
LMS	lethal means safety
OIG	Office of Inspector General
PC-MHI	Primary Care-Mental Health Integration
TTP	therapy treatment planning
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate concerns regarding Michael E. DeBakey VA Medical Center (facility) staff's management of a patient's psychotherapy referral. The OIG identified these concerns while reviewing the patient's electronic health record (EHR) for another healthcare inspection. Additionally, the OIG evaluated facility staff's completion of a suicide prevention safety plan with the patient and management of the patient's high risk for suicide patient record flag (high-risk flag).[1]

Background

The VA Houston Health Care System, part of Veterans Integrated Service Network (VISN) 16, includes the facility and 11 community-based outpatient clinics and provides services to more than 131,000 patients. The facility provides a range of services, including emergent, inpatient, long-term, and outpatient care. The VA Houston Health Care System is affiliated with the Baylor College of Medicine and the University of Texas.

Concerns

In late fall 2022, the OIG identified concerns about facility staff's management of the patient's care while reviewing the patient's EHR for another healthcare inspection. Specifically, the OIG identified concerns in the patient's care regarding staff's failure to

- effectively arrange evidence-based psychotherapy (EBP) treatment with the patient,
- adequately conduct and document a lethal means safety (LMS) plan, and
- provide required high-risk flag monitoring and management.[2]

Scope and Methodology

The OIG initiated the inspection on January 26, 2023, and conducted a virtual site visit from February 13–16, 2023.

[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] EBPs are research-supported "specific psychotherapeutic treatments" that have shown effectiveness in improving patients' mental health conditions and are typically provided by licensed mental health providers such as psychologists and social workers who have received specialized EBP training. VHA Directive 1160.05, *Evidence-Based Psychotherapies and Psychosocial Interventions for Mental and Behavioral Health Conditions*, June 2, 2021.

The OIG team interviewed the National Clinical Director for Suicide Prevention and National Suicide Prevention Program Coordinator; Office of Mental Health and Suicide Prevention; facility leaders; and staff knowledgeable about the patient's care and relevant processes.

The OIG reviewed relevant Veterans Health Administration (VHA) and facility policies, facility organizational charts, and staff training records. The OIG team also reviewed the patient's EHR and facility High Risk Flag Advisory Committee charter and meeting minutes.

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

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

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

Patient Case Summary

The patient, in their sixties at the time of this inspection, with a medical history of human immunodeficiency virus (HIV) infection, chronic pain, major depressive disorder, and suicide attempts, first presented to the facility in 2002.[3] In winter 2003, the patient began receiving psychiatric care for treatment of depression and generally continued in consistent and regular psychiatric care through the fall of 2023.[4] Since 2009, the patient has used a wheelchair for mobility due to "unsteady gait/[chronic] fatigue."

Spring 2018 through Fall 2021

In spring 2018, the patient met with a psychologist who noted that the patient attempted to overdose on over-the-counter pain medications one month prior to the visit and had attempted suicide with a firearm in the 1990s. Staff assigned the patient a high-risk flag. In summer 2019, the patient established services with the supportive housing program due to a lack of stable

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

[4] The patient discontinued psychiatric care in spring 2011 and then resumed in winter 2013.

housing.[5] In early 2020, the patient reported suicidal ideation with a plan and was admitted to the facility inpatient mental health unit. Following discharge, the patient continued in outpatient psychiatric care and, in spring 2021, was referred for mental health EBP. The associate director, General Mental Health Clinic (GMHC) alerted a psychologist assigned as the patient's high risk case manager (high risk case manager 1) to "incorporate therapy" into the patient's case management.[6]

Approximately six weeks later, high-risk case manager 1 called the patient, who reported worsening depression symptoms and declined to participate in individual psychotherapy until it could be provided in person at the facility. Nearly three months later, in summer of 2021, the patient reported to the psychiatrist an interest in individual therapy with high risk case manager 1. High risk case manager 1 called the patient, who "denied wanting to engage in therapy at this time."

Nearly six weeks later, the psychiatrist emailed high risk case manager 1 that the patient requested psychotherapy. The patient told high risk case manager 1 about lacking video-capable equipment for virtual psychotherapy and agreed to telephone appointments. The patient missed the next appointment and approximately a week later, expressed a preference to be seen in person for psychotherapy. High risk case manager 1 documented having "explained [the] current status" and that the patient "will be informed when writer has any availability to meet in person."[7] In fall 2021, a suicide prevention coordinator (suicide prevention coordinator 1) inactivated the patient's high-risk flag at the request of the psychiatrist.

Early 2022 through Early 2024

In early 2022, the patient missed a scheduled psychiatric appointment, the rescheduled psychiatric appointment, and the last planned appointment with high risk case manager 1. Staff did not reach the patient by phone and sent a letter. Four days after the second missed psychiatric appointment, during an infectious disease appointment, the patient requested "mental health follow up." The infectious disease physician notified the psychiatrist of the patient's request and noted that the patient "would prefer [a] face to face appointment" due to "difficulty hearing the phone." In a psychiatric appointment the following month, the patient reported a depressed mood and passive suicidal ideation related to medical concerns. The patient requested individual therapy with a new therapist. That day (day 1), the psychiatrist placed a therapy treatment

[5] VA supportive housing program staff assist homeless patients in finding permanent housing and coordinate with healthcare services. "U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) Program," VA Homeless Programs, accessed on June 26, 2023, https://www.va.gov/homeless/hud-vash.asp.

[6] When a patient's high-risk flag is activated, facility procedures include the assignment of a high-risk case manager who serves as a point of contact for coordinating the patient's care and is responsible for fulfilling VHA and facility follow-up appointment requirements.

[7] High risk case manager 1 told the OIG that "current status" meant services had been provided virtually since the start of the COVID-19 pandemic.

planning (TTP) consult and a week later, a scheduler (scheduler 1) did not reach the patient by phone and mailed a letter.[8] (See figure 1 for TTP and individual EBP consults timeline.)

On day 29, the patient told the psychiatrist about feeling depressed due to a recent melanoma diagnosis and was "eager to process" the medical concerns during the upcoming TTP appointment. That same day, another scheduler (scheduler 2) created a TTP appointment for day 94, over two months later.[9]

On day 64, the patient reported to the psychiatrist "moderate anxiety" related to potential melanoma treatments. On day 85, a psychologist (psychologist 1) and the patient had a six-minute telephone TTP appointment.[10] The patient declined psychologist 1's offer of "a Community Care consult due to wait time" at the facility.[11] Psychologist 1 submitted an individual EBP consult with a clinically indicated date of day 99, two weeks later.[12]

On day 91, a scheduler (scheduler 3) was unsuccessful in contacting the patient by phone to schedule an individual EBP appointment and mailed a letter. That same day, during a visit with the infectious disease physician, the patient reported suicidal ideation, auditory hallucinations, and having intentionally ridden the wheelchair "in front of a car within the last few days but the car stopped and didn't hit [the patient]." The patient asked about "taking a break and staying" on the inpatient mental health unit. The infectious disease physician notified the suicide prevention team and contacted a primary care-mental health integration (PC-MHI) psychologist.[13] The PC-

[8] The TTP visit is a telephone appointment that occurs prior to scheduling a patient for individual EBP and includes educating the patient about EBPs, discussing expectations, and engaging in shared decision-making to facilitate selection of an EBP to meet the patient's goals.

[9] For the purposes of this report, the OIG refers to medical support assistant, advanced medical support assistant, and program support assistant staff as schedulers. The associate director, GMHC told the OIG that program support assistants typically conducted mental health appointment scheduling; however, due to staffing shortages at the time of the patient's TTP and EBP consult requests, medical support assistants also scheduled appointments.

[10] Psychologist 1 told the OIG that the patient's TTP appointment occurred nine days before the scheduled date due to contacting patients earlier when possible.

[11] "Community Care Overview," VA Community Care, accessed February 5, 2024, https://www.va.gov/communitycare/. "VA provides care to Veterans through community providers when VA cannot provide the care needed."

[12] VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022. The 2016 directive defines clinically indicated date as "the date an appointment is deemed clinically appropriate" by a provider. The 2022 directive replaces clinically indicated date with "patient indicated date" that is defined as "the date the health care provider and Veteran agree is clinically indicated for care."

[13] PC-MHI staff work within primary care teams to "provide assessment and time-limited treatment of uncomplicated mental disorders." VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017.

MHI psychologist completed a comprehensive suicide risk evaluation (CSRE) that indicated the patient was at intermediate acute risk for suicide.[14]

The PC-MHI psychologist noted that the patient owned a gun and recently attempted to purchase ammunition and did not find it available in stores. The patient denied current suicidal ideation, intent, or a plan; declined inpatient mental health unit admission; and reported an ability to remain "safe for the next week." The PC-MHI psychologist completed a safety plan with the patient and placed a suicide prevention consult for high-risk flag activation. The PC-MHI psychologist noted that the patient was "unclear about the plan for psychotherapy and could benefit from a follow-up conversation to clarify." The PC-MHI psychologist alerted the psychiatrist of the plan for the patient to continue treatment with the psychiatrist, with the next appointment scheduled for day 141.

The next day, on day 92, another suicide prevention coordinator (suicide prevention coordinator 2) reactivated the patient's high-risk flag. On day 94, the psychiatrist held an unscheduled telephone visit with the patient, who reported "significant distress lately" related to relationship stressors and auditory hallucinations occurring for the prior two years. The patient reported passive suicidal ideation without a plan or intent for suicide. The psychiatrist documented the patient's "intense anxiety or agitation with recent exacerbation" and a recent reported suicide attempt as imminent risk factors, and noted that the availability of firearms in the household was not an imminent risk factor to consider for the patient. The patient expressed continued interest in individual therapy and requested follow-up with the psychotherapy team. The psychiatrist alerted psychologist 1 of the patient's request and documented a plan to start the patient on a new antipsychotic medication. Four days later, on day 98, another scheduler (scheduler 4) documented in the patient's individual EBP consult, "Waiting on updated EBP therapist's availability."

On day 101, another high-risk case manager (high risk case manager 2) called the patient to conduct a case management session and left a voicemail.[15] On days 102, 108, and 114, scheduler 4 documented in the individual EBP consult, "Waiting for updated EBP therapist's availability." On day 115, high risk case manager 2 updated the patient's safety plan with the psychiatrist and high risk case manager 2's contact information, mailed the patient a copy, and left the patient a voicemail. On day 122, scheduler 4 again documented in the individual EBP consult, "Waiting for updated EBP therapist's availability."

[14] Intermediate acute risk for suicide indicates a patient who is assessed as having thoughts of death by suicide and is able to maintain safety. "Therapeutic Risk Management – Risk Stratification Table," VA Rocky Mountain Mental Illness Research, Education, and Clinical Center, accessed January 23, 2024, https://www.mirecc.va.gov/visn19/trm/docs/RM_MIRECC_SuicideRisk_Table.pdf.

[15] High risk case manager 1 told the OIG that that the patient may have been assigned a different case manager due to high risk case manager 1's increased administrative duties at the time.

One week later, on day 129, a psychiatry physician resident called the patient, who reported continued auditory hallucinations and a preference to continue the same medication and meet for psychiatric appointments in person. The next day, high risk case manager 2 called the patient to conduct a case management session, left a voicemail, and documented "will continue to follow up." On day 136, scheduler 3 noted on the individual EBP consult, "there are no available therapist [*sic*], waiting on updated therapist availability." The psychiatrist met with the patient that day and again on day 141.

On day 148, scheduler 4 documented being unable to reach the patient by phone and that a letter was mailed. Another week later, on day 155, the psychiatrist met with the patient and submitted a second EBP TTP consult and noted, "Patient with depression, high risk for suicide, has been trying to get an appointment with team. [W]as previously seeing [high risk case manager 1], but not able to see veteran. Needs [individual therapy] to support pharmacotherapy." A psychologist (psychologist 2) canceled the consult, noting "duplicate request" and that the patient was "recently contacted on [day 148] to schedule for therapy."

On day 158, scheduler 4 noted in the individual EBP consult that no virtual appointments were available. On day 164, high risk case manager 2 called the patient to conduct a case management session and left a voicemail. On days 168, 177, and 186, schedulers 3 and 4 documented in the individual EBP consult that virtual or both virtual and in-person appointments were not available. On day 189, suicide prevention coordinator 1 inactivated the patient's high-risk flag following consultation with the psychiatrist and high risk case manager 2, noting a suicide risk reduction and that the patient was "engaged in VHA mental health care and/or has responded to documented mental health contacts within the last 30 days."

The next day, on day 190, the psychiatrist saw the patient, who reported housing, transportation, and relationship stressors, passive suicidal ideation, and recent self-injurious behavior of cutting of the forearms. The patient expressed continued interest in individual therapy and the psychiatrist contacted the therapy team. That same day, scheduler 3 documented that the patient requested an in-person appointment and offered the patient a virtual appointment for the following day.[16]

Approximately one week later, on day 198, scheduler 3 documented in the individual EBP consult that no virtual or in-person appointments were available. On days 207 and 219, scheduler 4 made unsuccessful attempts to call the patient. Scheduler 3 documented that no virtual or in-person appointments were available on day 227. On day 232, the psychiatrist met with the patient, who reported feeling "relatively stable" and declined individual therapy due to the lack of availability for in-person treatment. Eight days later, on day 240, scheduler 4 canceled the

[16] Based on an absence of a scheduled appointment and ongoing scheduling efforts, it appears that the patient declined the next-day virtual appointment.

individual EBP consult due to a "failed mandated scheduling effort."[17] In a psychiatric appointment approximately a month later, on day 267, the patient reported a depressed mood related to medical concerns, "staying in bed all day," and limited social support. The patient expressed interest in in-person and HIV-related psychotherapy.

On day 273, the psychiatrist submitted a third EBP TTP consult and documented that the patient is "high risk needs help as soon as possible" and at risk of "decompensation." On day 285, a scheduler (scheduler 5) made the patient's TTP appointment for three days later, on day 288. During the TTP appointment, a psychologist (psychologist 3) noted the patient's preference for in-person group or individual therapy for managing HIV and depression. Psychologist 3 documented, "it should be noted that [the] veteran declined a referral to obtain a loaner iPad from the VA. [The patient] indicated no desire to learn how to use a device to facilitate virtual psychotherapy services." Three days later, on day 291, psychologist 3 submitted an individual EBP consult.

On day 295, the psychiatrist met with the patient and encouraged follow-up with the psychotherapy team. On day 301, scheduler 3 documented on the individual EBP consult an inability to reach the patient by phone and that a letter was mailed. On days 310 and 323, scheduler 4 and scheduler 3, respectively, called and were unable to reach the patient for scheduling. On day 336, scheduler 3 arranged an individual EBP appointment to occur on day 371 for the patient. Four days later, on day 340, scheduler 3 canceled the appointment, noted that the assigned social worker (social worker 1) requested the appointment be rescheduled, and left the patient a voicemail.

On day 350, scheduler 4 left the patient a voicemail to reschedule the individual EBP appointment. The next day, on day 351, the psychiatrist met with the patient, who reported anxiety and passive suicidal ideation related to unstable housing. That same day, the psychiatrist accompanied the patient to meet with a homeless program social worker (homeless program social worker 1) to address housing concerns. One week later, on day 358, high risk case manager 2 called the patient and scheduled an in-person individual therapy appointment for day 385, almost four weeks later. Three days later, on day 361, high risk case manager 2 documented a plan to call the patient weekly until the scheduled in-person appointment. That same day, a social work supervisor called the patient to offer an earlier appointment with another therapist and left a voicemail requesting a return call. On day 364, the social work supervisor scheduled the patient with a social worker (social worker 2) to occur a week later on day 371. Two days later, social worker 2 called the patient to provide an introduction prior to the scheduled

[17] Staff document "failed mandated scheduling effort" when canceling a mental health consult due to an inability to reach the patient after a minimum of four contact attempts. VHA, "Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure (SOP)," updated July 28, 2022.

appointment, and noted that the patient "sounded depressed," was tearful, and expressed housing concerns.

The following day, on day 367, an infectious disease resident physician documented that the patient reported suicidal ideation "this month with intention to use a firearm" and asked for assistance securing the firearm. A social worker (social worker 3) completed a suicide behavior and overdose report, reviewed the patient's safety plan, and escorted the patient to the Emergency Department.[18] Later that day, an Emergency Department psychiatrist (Emergency Department psychiatrist 2) noted that the patient reported multiple symptoms of depression, having held an unloaded firearm to the head during the previous week, later disposing of the bullets. The patient was admitted to the inpatient mental health unit. The following day, suicide prevention coordinator 1 reactivated a high-risk flag for the patient and identified social worker 2 as the assigned high risk case manager. On day 371, scheduler 5 canceled the therapy appointment scheduled with social worker 2 for that day due to the patient's inpatient admission.

On day 381, two weeks after admission to the inpatient mental health unit, an inpatient psychiatrist discharged the patient and documented that the patient reported improved mood and denied suicidal ideation. An inpatient social worker documented a housing plan for the patient and noted that the patient planned to "pawn" the firearm and was provided a gunlock to secure the firearm. On day 385, scheduler 4 scheduled the patient for a virtual individual therapy appointment on day 421, over a month later. On day 386, the patient met with the psychiatrist and reported housing stressors, decreased appetite, and passive suicidal ideation.

On day 393, social worker 2 conducted a high-risk case management session and reviewed a safety plan that the patient described as "'a joke,' just some things [the patient] said at the time" and acknowledged not using the plan. The patient requested in-person therapy with social worker 2 and agreed to an appointment approximately three weeks later, on day 413. On day 396, the REACH VET coordinator identified that the patient "might benefit from enhanced treatment" and requested that the psychiatrist evaluate the patient's care and notify the patient of the REACH VET program.[19] Three days later, the psychiatrist documented reviewing the patient's EHR and treatment plan and recommended enhancing care with "caring communications intervention," "safety planning," "increased monitoring of stressful life events," and "improved

[18] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Update to Suicide Behavior and Overdose Reporting," memorandum to Veterans Integrated Services Network (VISN) Director, VISN CMOs, and VISN Chief Mental Health Officers, May 9, 2023. The suicide behavior and overdose report is a VHA standardized template used to document patients' "suicidal and undetermined [self-directed violence] behaviors and overdose events" that occurred within 12 months prior to the notification date.

[19] VHA's REACH VET program utilizes data to identify veterans currently using VA healthcare services who are statistically at high risk for adverse events, including suicide and overdoses. Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Update to Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET)," memorandum to Veterans Integrated Services Network (VISN) Director, VISN CMOs, and VISN Chief Mental Health Officers, May 9, 2022.

coping skills."[20] The psychiatrist noted that "access to care" was discussed with the patient on day 395 and documented a plan to continue to evaluate the patient's "clinical risk."

In spring 2023, on day 413, social worker 2 conducted the first individual EBP session (session 1) in person with the patient and noted a plan for the patient to participate in a total of 16 weekly sessions. Over the next three months, social worker 2 held six EBP sessions (sessions 2–7) with the patient, who continued to engage in psychiatric medication management and remained on a high-risk flag. During session 7, the patient reported difficulty sleeping, restlessness, and an inability to "shut [the patient's] mind off." The patient's depression screen indicated moderate depression. Social worker 2 documented a plan to meet with the patient for another 60-minute in-person EBP session two weeks later on day 518 and to then transition to 30-minute telephone high-risk case management calls "due to another Veteran being scheduled" at the patient's existing appointment time. Social worker 2 "offered to find in-person availability for continuation of EBP, but [the patient] agreed to check-in [high-risk case management] phone calls." Almost four hours before the patient's in-person appointment on day 518, an administrative staff member documented that the appointment was "cancelled by clinic."

On day 532, while discussing previous suicide attempts, the patient told social worker 2 about ingesting a "whole bunch of pills, and it put me out for three days." The patient reported being unable to recall the exact date of the attempt, noting that it had occurred sometime within the previous three months. Social worker 2 completed a suicide behavior and overdose report and a CSRE that indicated the patient was at intermediate acute risk for suicide. Over the following month, social worker 2 continued weekly high-risk case management calls to the patient and, in late summer 2023, transitioned to biweekly calls. As of fall 2023, the patient continued to receive case management calls and engage in medication management with the psychiatrist. The patient's high-risk flag remained active with a plan for reevaluation approximately 90 days later.

Inspection Results

1. Failure to Effectively Arrange EBP Treatment with the Patient

The OIG found that although the patient was receiving consistent psychiatric care, staff failed to provide in-person individual EBP until over a year after the patient's initial request in early 2022, inconsistent with VHA requirements.[21] Further, the OIG found that although staff did not provide the patient in-person EBP as requested, staff offered virtual and community care psychotherapy options that the patient declined. The OIG determined, however, that staff did not

[20] Caring communications are periodic mailings such as postcards or letters sent to a patient to reduce suicide risk. VA and Department of Defense, *VA/Department of Defense Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*, May 2019.

[21] VHA Directive 1160.05; VHA Directive 1230, July 15, 2016; VHA Directive 1230, June 1, 2022.

offer the patient the equipment to participate in virtual sessions until over a year after the patient reported not having a video-capable device. The OIG concluded that inefficient facility mental health consult management practices and EBP therapist and administrative support staffing vacancies contributed to staff's failures to schedule the patient as requested.

Beginning in 2015, VHA has required mental health staff to develop a treatment plan with patients that "reflects the patient's goals and preferences for care."[22] VHA advises that clinic processes "support timely Veteran access to high-quality mental health care, including EBPs . . . and optimize Veterans [*sic*] outcomes."[23] VHA requires that staff ensure patients' "sustained and timely access" to EBP.[24]

In an interview, the executive director, Mental Health Care Line told the OIG about the expectation that staff adjust schedules to accommodate patient preferences, and also stated that at the time of the patient's care, fewer in-person appointments were available as a result of the COVID-19 pandemic. The executive director, Mental Health Care Line reported to the OIG that VA-issued devices have been available for staff to provide to patients for virtual appointments since approximately 2017. The associate director, GMHC reported being unaware of challenges in scheduling patients for in-person treatment.

During the patient's care (days 1 through 85), VHA required staff to schedule appointments within 30 calendar days from the clinically indicated date that a VA healthcare provider deemed appropriate.[25] Consult options for the facility's GMHC include referrals for EBP TTP, individual EBP, and group EBP. The TTP visit is a telephone appointment that occurs prior to scheduling a patient for individual EBP and includes educating the patient about EBPs, discussing expectations, and engaging in shared decision-making to facilitate selection of an EBP to meet the patient's goals.

Following the TTP appointment, the provider is expected to submit an individual EBP consult request as appropriate, and "set [the clinically indicated date] about 14 days out." The TTP note template indicates that "a direct scheduling consult has been entered" and the patient was informed that a scheduler would be reaching out within seven business days "to negotiate a start date for therapy."

[22] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. This 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 patient's treatment preference requirements as the rescinded handbook.

[23] VHA Directive 1160.05.

[24] VHA Directive 1160.05.

[25] VHA Directive 1230, July 15, 2016; VHA Directive 1230, June 1, 2022.

When scheduling mental health appointments, staff are required to conduct a minimum of "three documented contact attempts by telephone on separate days, followed by a letter."[26] The letter may be sent the same day as the initial telephone call and the second and third telephone calls should be completed during the 14 calendar days following the letter.[27] VHA requires that staff document all scheduling contact attempts in the patient's EHR.[28]

In spring 2021, the patient began requesting in-person individual psychotherapy and declined high risk case manager 1's offer for telephone appointments. In fall 2021, high risk case manager 1 documented that the patient was "unable to do video since [the patient's] device does not have the capacity" and that the patient agreed to telephone appointments.

In an interview, high risk case manager 1 told the OIG that staff were unable to provide in-person visits for the patient in 2021 because of the transition to virtual appointments during the COVID-19 pandemic and the equivalent effectiveness of virtual and in-person psychotherapy visits. High risk case manager 1 reported not recalling if the patient was offered a VA-issued device for video appointments after the patient reported lacking a video-capable device. High risk case manager 1 told the OIG about typically documenting the offering of a video device in patients' EHRs, however, the OIG did not find evidence in the patient's EHR that an offer was extended to the patient.

The OIG found that staff failed to provide the patient with a TTP appointment within 30 days of the clinically indicated date, as required at the time.[29] (See figure 1 for the TTP and EBP consults timeline.) On day 29, scheduler 2 made the patient's TTP appointment for day 94, over three months beyond the psychiatrist's clinically indicated date on the TTP consult request. Scheduler 2 told the OIG that the appointment was scheduled based on availability. A GMHC psychotherapy supervisor told the OIG that the unavailability of TTP appointments was due to limited staff. Psychologist 1 told the OIG about contacting patients with future appointments when there was an earlier opening and being able to complete the TTP appointment with the patient on day 85.

[26] VHA Notice 2019-09, "Minimum Scheduling Effort Required for Outpatient Appointments: Updates to VHA Directive 1230 and VHA Directive 1232(1)," April 24, 2019; VHA, "Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure (SOP)," updated October 26, 2021, and July 28, 2022. The 2021 standard operating procedure was in place during the time of the events discussed in this report. The 2022 standard operating procedure contains the same or similar language regarding minimum scheduling effort requirements as the 2021 version.

[27] VHA Notice 2019-09; VHA, "Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure (SOP)," updated October 26, 2021, and July 28, 2022.

[28] VHA Notice 2019-09; VHA, "Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure (SOP)," updated October 26, 2021, and July 28, 2022.

[29] VHA Directive 1230, July 15, 2016; VHA Directive 1230, June 1, 2022. The 2016 directive was in place at the time the psychiatrist submitted the TTP consult for the patient. The 2022 directive did not include the requirement to schedule appointments within 30 days of the clinically indicated date.

Facility leaders provided the OIG with data that indicated GMHC vacancies of 14 percent, 55 percent, and 13 percent for administrative support staff, EBP psychologists, and EBP social workers, respectively, at the time of the psychiatrist's submission of a TTP consult request for the patient. See table 1.

Table 1. GMHC Staffing Vacancies During Patient's Initial TTP Consult Request (Days 1–29) and EBP Consult Requests (Days 85–413)

Position	Days 1–29	Days 85–413
Schedulers	6 (14%)	8 (17%)
EBP Psychologists	30 (55%)	24 (41%)
EBP Social Workers	2 (13%)	7 (35%)

Source: OIG analysis of data provided by facility leaders.
Note: Percentage totals may appear greater than 100 due to rounding. Sometime between days 22 and 52, two additional scheduler positions were filled. Vacant staff positions for days 85–413 represent averages. An administrative deputy reported to the OIG being unable to "account for" six months of psychology staffing during days 85–413. Scheduler data reflects GMHC vacancies, not EBP-dedicated positions. The associate director, GMHC told the OIG that a scheduler's assignment to a clinic was based on scheduling demands.

The OIG also found that from days 85–240, over five months, schedulers documented lack of staff available to provide the patient's EBP, although did not consistently document attempts to contact the patient, as required.[30] On day 85, psychologist 1 submitted an individual EBP consult request with a clinically indicated date of two weeks later (day 99). The patient declined psychologist 1's offer to submit "a Community Care consult."

On day 91, scheduler 3 unsuccessfully called the patient to schedule the EBP and sent a letter. On 6 of the next 45 days (days 98–136), staff documented waiting for "updated EBP therapist's availability" in the patient's EHR.[31] Scheduler 4 told the OIG that although not documented, the presence of those notes implied that patients were contacted "to let them know hey we didn't forget about you. We don't have any slots at this time, just informing you, we'll keep in touch." Scheduler 4 explained that contact with the patient was not documented because "We were just in the rush of things and just probably didn't get to really notate it like how we should have notated it." Staff did not document efforts to contact the patient again until day 148, when scheduler 4 unsuccessfully called the patient and sent another letter. Between days 158 and 227, schedulers 3 and 4 documented in the patient's EHR that appointments were unavailable, scheduler 3 offered the patient a virtual appointment, and scheduler 4 reached out twice via phone to the patient. On day 240, scheduler 4 canceled the consult due to a "failed mandated scheduling effort."

[30] VHA, "Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure (SOP)," updated October 26, 2021, and July 28, 2022.

[31] Schedulers documented a lack of therapist availability on days 98, 102, 108, 114, 122, and 136.

Approximately one month after the EBP consult was canceled, on day 273, the psychiatrist submitted another TTP consult and 15 days later (day 288), psychologist 3 completed a TTP appointment. During the TTP appointment, over a year after the patient reported lacking capability for virtual appointments to high risk case manager 1, psychologist 3 offered the patient "a loaner iPad from the VA" and the patient declined. On day 291, psychologist 3 submitted an individual EBP consult for the patient. From days 301 to 323, schedulers 3 and 4 attempted to contact the patient, consistent with minimum scheduling effort requirements.[32] Scheduler 3 initially made the patient's EBP appointment for day 371 and canceled it four days later at social worker 1's request. The social worker supervisor told the OIG that the patient's appointment was canceled because social worker 1 was "double booked."

Schedulers 3 and 4 left the patient voicemails on days 340 and 350, respectively. On day 358, high risk case manager 2 called the patient and scheduled an in-person psychotherapy appointment for almost four weeks later on day 385. On day 364, the social work supervisor scheduled the patient to meet with social worker 2 on day 371. In an interview with the OIG, the social work supervisor reported contacting the patient in response to a supervisor's instruction to schedule the patient's EBP appointment sooner due to the "OIG complaint."

On day 367, the patient was admitted to the inpatient mental health unit for suicidal ideation and depression. Scheduler 5 canceled the appointment due to the patient's inpatient admission. The patient was discharged on day 381 and scheduled for a virtual individual therapy appointment on day 421, approximately five weeks later. On day 386, the patient met with the psychiatrist and one week later, social worker 2 scheduled the patient's first EBP appointment that was held approximately three weeks later, on day 413.

Facility leaders provided the OIG with data that indicated average vacancies of 17 percent, 41 percent, and 35 percent for administrative support staff, psychologists, and social workers, respectively during the time of the EBP consult requests (days 85–413) for the patient.

The OIG found that the administrative and therapist staffing vacancies, lengthy scheduling process, and EBP consult demand contributed to significant delays in scheduling the patient's care.

In an interview with the OIG, the associate director, GMHC reported that around the time of the patient's EBP consult request, the EBP clinic was "severely short" on scheduling staff and stated there had been "an explosion of consults." The associate director, GMHC told the OIG about requesting additional staff for a dedicated referral team of therapists and schedulers to process consults and indicated that facility leaders placed the request on hold due to the "staffing ceiling."[33] A supervisory program management analyst reported submitting a request to facility

[32] VHA, "Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure (SOP)," updated October 26, 2021, and July 28, 2022.

[33] A staffing ceiling is the maximum number of approved employees.

leaders for additional schedulers that was denied. In an interview with the OIG, the executive director, Mental Health Care Line reported EBP treatment delays due to increased demand for therapy and ongoing hiring.

In interviews with the OIG, administrative staff described utilizing a spreadsheet to determine EBP availability and reported the process took approximately 30–45 minutes per consult. In an interview with the OIG, the supervisory program management analyst estimated that there were approximately 200 EBP consults awaiting scheduling when psychologist 1 submitted the patient's initial EBP consult (day 85).

The OIG concluded that the facility's inefficient mental health consult management practices and EBP therapist and administrative support staffing vacancies contributed to staff's failures to schedule the patient's EBP for over a year. As a result of the delay in the provision of focused psychotherapy, the patient's ongoing mental health challenges were not timely and adequately addressed and eventually required an inpatient level of care.

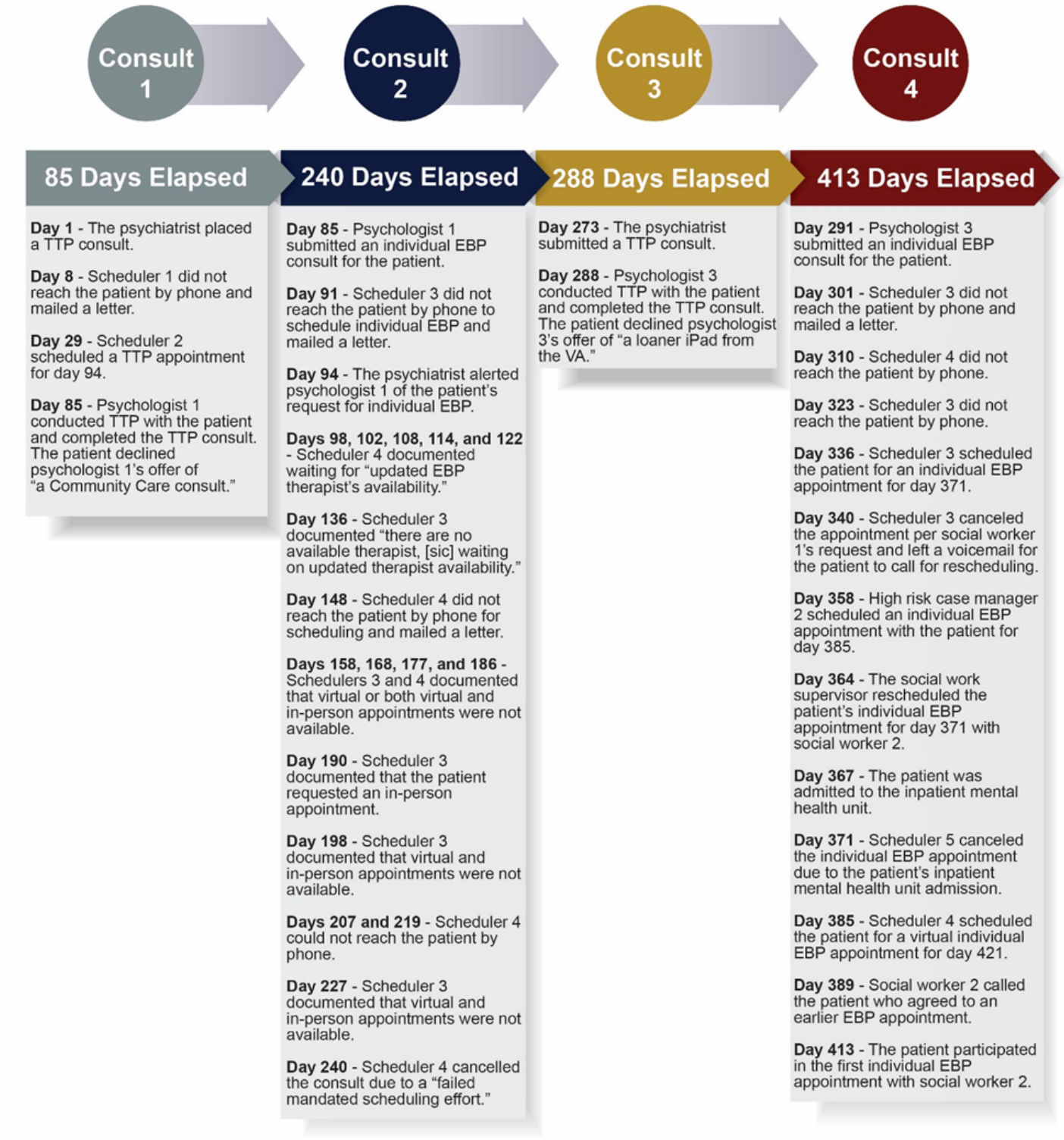

Figure 1. *TTP and individual EBP consults timeline.*
Source: OIG review of the patient's EHR.

2. Deficiencies in Lethal Means Safety Planning with the Patient

The OIG found that the PC-MHI psychologist and psychiatrist did not sufficiently address lethal means availability and access to ammunition. Additionally, the OIG found that the PC-MHI psychologist did not document addressing safety concerns about the patient's identified coping strategies due to concerns about the perceived sensitivity of discussing firearms.

VHA Lethal Means Safety Planning and Training

Since 2017, VHA has required annual suicide risk and intervention training for clinical staff and, in 2018, implemented a nationally standardized safety planning note template that includes firearms access information.[34] In November 2020, VHA required all "VHA health care providers" to complete a web-based "one-time mandatory" LMS course by January 31, 2021.[35] The LMS training included information about the "purpose of LMS Counseling, including how to work with Veterans and their friends and family to facilitate LMS during high risk periods."[36]

The CSRE template prompts clinicians to assess a patient's access to lethal means and firearms and to conduct LMS counseling.[37] As part of safety planning, VHA instructs clinicians to consider "options for improving safe storage" with patients who report access to firearms and "not [to] limit discussion of lethal object[s] to the one Veteran identifies as most likely."[38]

In 2022, the OIG surveyed VHA clinicians regarding perspectives on barriers to integrating firearms access and storage discussions during safety planning with patients. The OIG found most clinicians reported that educational and cultural barriers such as mistrust of authority or

[34] VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017. This directive was rescinded and replaced by VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, updated June 21, 2022. The 2017 and 2022 directives included required training annually and the 2022 directive clarified the requirement for clinicians; Deputy Under Secretary for Health for Operations and Management, "Suicide Prevention Safety Plan National CPRS Note Templates Implementation," memorandum to VISN Directors (10N1-23), VISN Mental Health Leads (10N1-23), June 1, 2018.

[35] VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017; VHA Directive 1071, Mandatory Suicide Risk and Intervention Training, May 11, 2022.

[36] VHA Assistant Under Secretary for Health for Operations, "Lethal Means Safety (LMS) Education and Counseling" memorandum to VISN Directors (10N1-23), Medical Center Directors (00), Readjustment Counseling Services (RCS) District Directors, and RCS Deputy District Directors, November 2, 2020.

[37] VHA Office of Mental Health and Suicide Prevention, "CSRE Printable Worksheet," June 16, 2020. This template was updated on April 27, 2023. The updated template contains the same or similar language regarding lethal means assessment and safety counseling as the previous version.

[38] "Safety Plan Reminder Dialogue Template: Instruction Guide," VHA Office of Mental Health and Suicide Prevention SharePoint site, https://dvagov.sharepoint.com/sites/VACOMentalHealth/Safety%20Planning%20%20SBR/Forms/AllItems.aspx?id=%2Fsites%2FVACOMentalHealth%2FSafety%20Planning%20%20SBR%2FSafety%20Planning%2FClinician%20Instructions%20and%20Quick%20Guides%2FSafety%20Plan%20Note%20Template%20User%20Guide%2Epdf&parent=%2Fsites%2FVACOMentalHealth%2FSafety%20Planning%20%20SBR%2FSafety%20Planning%2FClinician%20Instructions%20and%20Quick%20Guides. (This site is not publicly accessible.)

government systems, fear of infringement of Second Amendment rights, and reluctance to give up means of self-protection were factors that might impede patient disclosure of firearms access.[39]

Although LMS training appeared to increase clinicians' confidence that discussions with patients about their firearms access and storage decreases a patient's suicide risk, educational and cultural factors may continue to be barriers to staff's engagement in firearms access and safe storage discussions with patients. The OIG made a recommendation to the Under Secretary for Health to consider initiatives to evaluate and address educational and cultural barriers to conducting and documenting patient discussions related to firearms access and safe storage practices. The VHA Office of Mental Health and Suicide Prevention, Center for Integrated Healthcare, and Primary Care established a collaborative workgroup that developed a curriculum for primary care teams "to improve skills, comfort, confidence and overcome cultural and knowledge barriers to having secure storage discussions" with patients and family members.[40] As of April 2023, the OIG considered the recommendation closed.

The patient's history included two previous suicide attempts by over-the-counter pain medication overdose in spring 2018 and firearm in the 1990s. On day 91, the patient told the infectious disease physician about having ridden the wheelchair "in front of a car within the last few days but the car stopped and didn't hit [the patient]." That day, the PC-MHI psychologist and the patient completed the CSRE and a safety plan.

The patient reported having access to a firearm "in their home or elsewhere" and that the firearm was "unloaded and stored separately from ammunition." The PC-MHI psychologist noted that the patient declined a gunlock and "does not have any bullets." In response to "Ways to make my environment safer and barriers I will use to protect myself from these potentially lethal means," the PC-MHI psychologist documented the patient's statement of, "I cannot purchase ammunition for my gun because the stores do not have the ammunition in stock." On the same day, the PC-MHI psychologist added the psychiatrist as an additional signer to the EHR note and instant messaged the psychiatrist to consult about the patient's care. Three days later, the psychiatrist documented the patient did not have access to firearms in the household.

In an OIG interview, the PC-MHI psychologist reported that the patient described the firearm "as though that would not be a real viable means for [the patient]," the means was more about "rolling out into oncoming traffic." When asked whether the patient's future purchased ammunition was considered, the PC-MHI psychologist reported not having that discussion with the patient because it would be better received from an "established provider" and that firearm

[39] VA OIG, *Deficiencies in Lethal Means Safety Training, Firearms Access Assessment, and Safety Planning for Patients with Suicidal Behaviors by Firearm*, Report No. 21-00175-19, November 17, 2022.

[40] VA OIG, *Deficiencies in Lethal Means Safety Training, Firearms Access Assessment, and Safety Planning for Patients with Suicidal Behaviors by Firearm*.

access discussions are a "sensitive conversation." In an interview with the OIG, the PC-MHI psychologist explained being "very intentional about trying to identify steps on the safety plan that would ideally distract [the patient] enough for the [suicidal] thoughts to pass" and by fostering "hope" by telling the patient "that I was going to really be intentionally [*sic*] about connecting with [the patient's] psychiatrist."

The OIG found, however, that during the telephone call three days after the patient's visit with the PC-MHI psychologist, the psychiatrist did not evaluate the patient's potential access to ammunition. In an interview with the OIG, the psychiatrist explained not assessing the patient's access to ammunition because the patient reported "I was just saying that" about having access to a firearm during the PC-MHI psychologist visit and "never endorsed having a firearm." However, the psychiatrist did not document the patient's explanation about the conflicting information. The psychiatrist told the OIG, "It didn't come out as a red flag in my appointment. If it was, I would have documented it thoroughly." Although the OIG did not find that the psychiatrist's lack of documentation resulted in negative outcomes for this patient, failure to document critical lethal means discussions may contribute to an incomplete understanding of a patient's suicide risk and impede effective care coordination.

The special programs coordinator, Mental Health Care Line (special programs coordinator) reported to the OIG the expectation that the PC-MHI psychologist would have explored with the patient a plan to store ammunition if it became available and family and friends' involvement in reducing access to lethal means.[41] The OIG found that the PC-MHI psychologist had completed suicide prevention trainings as required over the three years prior to meeting with the patient. Given the patient's access to firearms and past firearm-related suicidal behavior, the OIG would have expected the PC-MHI psychologist to address the potential for future ammunition access within the patient's safety plan.

In the "What public places, groups, or social events help you feel better?" section of the safety plan, the PC-MHI psychologist documented "Go outside the apartment and ride my wheelchair." However, the OIG found that the PC-MHI psychologist did not document discussing safety concerns about this activity, in light of the patient's reported prior suicidal behavior using the wheelchair. In an interview with the OIG, the PC-MHI psychologist reported discussing "not going to the street, you know, where the cars are" with the patient. The PC-MHI psychologist reported unintentionally omitting this aspect of the discussion from the patient's EHR documentation and explained that the documented information about the patient's coping strategy "implies that a discussion was had about the usefulness of this strategy to distract" from suicidal thoughts. Given the patient's recent suicidal behavior of rolling a wheelchair into traffic, the OIG would have expected the PC-MHI psychologist to document, in the safety plan, a discussion of the patient's identified risk reduction strategies while using the wheelchair.

[41] The special programs coordinator reported supervising the facility suicide prevention team.

The special programs coordinator reported to the OIG that the PC-MHI psychologist's discussion with the patient should have included exploration of risk and protective factors related to the patient's wheelchair. The special programs coordinator told the OIG that the predetermined response options included in the safety plan template have "made it confusing for staff to know where and how to document" and may limit staff's inclusion of additional details discussed during safety planning. However, the OIG found that the safety plan template includes free text fields, including in response to "Ways to make my environment safer and barriers I will use to protect myself from these other potentially lethal means."

The PC-MHI psychologist noted in the patient's safety plan that the patient replied, "'Nobody,'" when asked who would help limit access to "dangerous items." The PC-MHI psychologist told the OIG that the patient had difficulty identifying social contacts during safety plan development. The OIG would have expected the PC-MHI psychologist and psychiatrist to address LMS for the patient's wheelchair and firearm more thoroughly given the patient's limited support system, history of suicidal behavior with a firearm and wheelchair, and lethal means access. Staff's failure to comprehensively discuss and document lethal means safety with patients may contribute to unidentified suicide risk.

3. Inadequate Follow-Up for the Patient and Inconsistent High Risk for Suicide Patient Assessment and Safety Plan Requirements

The OIG found that inconsistent with VHA requirements for follow-up appointments, Office of Mental Health and Suicide Prevention leaders reported that although homeless program staff visits fulfill the required high-risk patient follow-up appointments, homeless program staff are not expected to review or update the safety plan.

The OIG found that in the 97 days following initiation of the patient's high-risk flag (days 92–189), staff attempted the mandatory contact efforts with the patient; however, high risk case manager 2 did not contact a supervisor or suicide prevention coordinator when unable to reach the patient, as advised by the special programs coordinator. Additionally, the OIG found that homeless program and mental health staff did not complete required safety plan updates or reviews and suicide risk assessments with the patient.[42]

[42] 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 Veterans Integrated Services Network (VISN) Directors (10N1-23), VISN CMOs (10N1-23), and VISN Chief Mental Health Officers (10N1-23), October 5, 2021. This memorandum was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1166, *Patient Record Flags*, November 6, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language regarding high-risk flag mental health appointment requirements as the rescinded 2021 memorandum; Facility standard operating procedure, "Management of High Risk for Suicide Patient Record Flags."

Patient Follow-Up, Suicide Risk Assessment, and Safety Planning

VHA requires that suicide prevention coordinators ensure patients with a high-risk flag receive "four mental health appointments within the first 30 days after [high-risk flag] placement and at least one mental health appointment monthly thereafter until the [high-risk flag] has been inactivated."[43] VHA requires staff to "include review or update of the Veteran's safety plan, suicide risk mitigation strategies, and enhancement of coping mechanisms."[44] The safety plan should be "developed in collaboration with patients."[45] After a missed high-risk mental health appointment, patients "should receive follow-up attention from mental health providers."[46] Additionally, facility leaders require mental health and homeless program staff to document assessment of suicide risk in the patient's EHR "for all follow-up mental health visits for as long as the patient has" a high-risk flag.[47] On day 100, the special programs coordinator instructed high risk case managers, including high risk case manager 2, to contact a supervisor or suicide prevention coordinator if "having difficulty engaging a [high-risk patient] in follow-up."

In an interview with the OIG, the VHA National Suicide Prevention Program Coordinator reported that homeless program visits are considered mental health visits and therefore can count toward fulfilling the requirement for high-risk flag follow-up. The VHA National Suicide Prevention Program Coordinator told the OIG that suicide risk should be considered during high-risk flag follow-up appointments. However, staff may not necessarily ask the patient about suicidal thoughts; by addressing a patient's homelessness, staff are "in effect helping one of the drivers for the suicidality." Inconsistent with VHA policy, the VHA National Clinical Director for Suicide Prevention reported to the OIG that homeless program staff are not required to review or update the safety plan during every visit while the patient is on a high-risk flag.

The OIG found that in the 30 days following high-risk flag initiation (days 92–122), staff did not meet with the patient four times as required by VHA.[48] During that time, the psychiatrist and a homeless program social worker (homeless program social worker 2) each met with the patient once. High risk case manager 2 unsuccessfully attempted to contact the patient on days 101 and 115. In an interview with the OIG, high risk case manager 2 reported not recalling seeking

[43] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer "Update to High Risk for Suicide Patient Record Flag (HRS-PRF) Changes," memorandum; VHA Directive 1166.

[44] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer "Update to High Risk for Suicide Patient Record Flag (HRS-PRF) Changes," memorandum; VHA Directive 1166.

[45] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021.

[46] VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 2020. This guide was in place during the time of the events discussed in this report. It was updated in December 2022. Unless otherwise specified, the 2022 guide contains the same or similar language regarding follow-up after missed high-risk mental health appointments as the 2020 guide.

[47] Facility standard operating procedure, "Management of High Risk for Suicide Patient Record Flags."

[48] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer "Update to High Risk for Suicide Patient Record Flag (HRS-PRF) Changes," memorandum; VHA Directive 1166.

consultation with a provider or suicide prevention coordinator when unable to reach the patient. The OIG did not find EHR, email, or instant messaging documentation that indicated high risk case manager 2 pursued consultation after being unable to reach the patient twice during the first 30 days of the assigned high-risk flag.[49]

The OIG also found that neither the psychiatrist nor homeless program social worker 2 reviewed or updated the safety plan with the patient, as required by VHA.[50] Additionally, homeless program social worker 2 did not document assessing the patient for suicide risk, inconsistent with facility requirements.[51] On day 115, high risk case manager 2 was unable to reach the patient and documented updating the patient's safety plan with new outpatient providers' contact information and mailing the patient a copy.

The OIG found that during the remaining 67 days when the patient had a high-risk flag (days 123–189), the psychiatrist, another homeless program social worker (homeless program social worker 3), and the psychiatry physician resident met the minimum monthly high-risk flag monitoring requirement through visits with the patient.[52] High risk case manager 2 attempted to reach the patient twice unsuccessfully. Although homeless program social worker 3 documented in the patient's EHR, "No [suicidal ideation] thinking verbalized" during one visit on day 155 with the patient, homeless program social worker 3 did not document assessment of the patient's suicide risk during two other visits, inconsistent with facility requirements.[53] Staff who met with the patient from days 123–189 did not update or review the safety plan with the patient, as required by VHA.[54]

The special programs coordinator described to the OIG an expectation that staff assess for suicide during high-risk flag follow-up appointments. In a February 2023 interview with the OIG, homeless program social worker 2 reported that "there was never a flag alert that popped up" in the patient's EHR and that the high-risk flag was visible at the time of the OIG interview. Homeless program social worker 2 reported that as a result of being unaware that the patient was on a high-risk flag, the patient remained on a less-intensive homeless program case management level that did not include routine suicide risk assessment. In an interview, homeless program social worker 3 told the OIG about asking the patient about suicidal thoughts as part of a "general checkup of [the patient's] mental health status" on day 155. Homeless program social

[49] High risk case manager 2 provided the OIG with email and instant messages related to the patient's care.

[50] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer "Update to High Risk for Suicide Patient Record Flag (HRS-PRF) Changes," memorandum; VHA Directive 1166.

[51] Facility standard operating procedure, "Management of High Risk for Suicide Patient Record Flags."

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

[53] Facility standard operating procedure, "Management of High Risk for Suicide Patient Record Flags."

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

worker 3 reported not assessing the patient's suicide risk during the other two visits because the patient "presented as stable and fine" in the appointment.

The OIG concluded that inconsistent high-risk flag requirements may have contributed to staff's failure to consistently conduct suicide risk assessments and safety plan updates and reviews during high-risk flag follow-up appointments. Although the OIG did not identify that high risk case manager 2's failure to follow up when unable to reach the patient resulted in any negative outcomes for this patient, lack of consultation with a provider, supervisor, or suicide prevention coordinator may contribute to insufficient suicide prevention actions in the care of high-risk patients. Further, the lack of routine suicide risk monitoring and safety planning could result in a failure to identify patients who are at risk of suicide and provide necessary treatment interventions.

Conclusion

The OIG found that although the patient was receiving consistent psychiatric care, staff failed to provide in-person individual EBP until over a year after the patient's initial request in early 2022, inconsistent with VHA requirements. Although staff did not provide the patient in-person EBP as requested, staff offered virtual and community care psychotherapy options that the patient declined. However, staff did not offer the patient the equipment to participate in virtual sessions until over a year after the patient reported not having a video-capable device.

Staff failed to provide the patient with a TTP appointment within 30 days of the clinically indicated date, as required at the time. From days 85–240, over five months, schedulers documented lack of staff availability to schedule the patient's EBP, although did not consistently document attempts to contact the patient, as required. The OIG concluded that the facility's inefficient mental health consult management practices and EBP therapist and administrative support staffing vacancies contributed to staff's failures to schedule the patient's EBP for over a year. As a result of the delay in the provision of focused psychotherapy, the patient's ongoing mental health challenges were not timely and adequately addressed, and eventually required an inpatient level of care.

The PC-MHI psychologist and psychiatrist did not sufficiently address lethal means availability and access to ammunition. Additionally, the PC-MHI psychologist did not document addressing safety concerns about the patient's identified coping strategies due to concerns about the perceived sensitivity of discussing firearms. Staff's failure to comprehensively discuss and document lethal means safety with patients may contribute to unidentified suicide risk.

Inconsistent with VHA requirements for follow-up appointments, an Office of Mental Health and Suicide Prevention leader reported that although homeless program staff visits fulfill the required high-risk patient follow-up appointments, homeless program staff are not expected to review or update the safety plan. In the 97 days following initiation of the patient's high-risk flag

(days 92–189), staff attempted the mandatory contact efforts with the patient; however, homeless program and mental health staff did not complete required safety plan updates or reviews and suicide risk assessments with the patient. Inconsistent high-risk flag requirements may have contributed to staff's failure to consistently conduct suicide risk assessments and safety plan updates and reviews during high-risk flag follow-up appointments. Although the OIG did not identify that high risk case manager 2's failure to follow up when unable to reach the patient resulted in the patient experiencing negative outcomes, lack of consultation with a provider, supervisor, or suicide prevention coordinator may contribute to insufficient suicide prevention actions in the care of high-risk patients. Further, the lack of routine suicide risk monitoring and safety planning could result in a failure to identify patients at risk of suicide and provide necessary treatment interventions.

Recommendations 1–6

1. The VA Houston Health Care System Director evaluates the efficiency of evidence-based psychotherapy consult management procedures; identifies barriers to timely appointment scheduling, including scheduling processes and staffing needs; and takes action as warranted.

2. The VA Houston Health Care System Director ensures that administrative support staff document scheduling efforts in patients' electronic health records, as required by the Veterans Health Administration.

3. The VA Houston Health Care System Director ensures that staff document offering VA-issued devices for participation in virtual mental health appointments in patients' electronic health records.

4. The VA Houston Health Care System Director conducts a review of providers' lethal means safety assessment and planning with the patient, identifies barriers to effective lethal means safety discussions, and takes action as warranted.

5. The Under Secretary for Health clarifies the expectations and requirements for homeless program staff's completion of suicide risk assessments and updates or reviews of safety plans for high risk for suicide patients.

6. The VA Houston Health Care System Director reviews staff's compliance with high-risk flag patient care requirements, to include updating and reviewing safety plans, following up on failed contacts, and completing suicide risk assessments.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: June 13, 2024

From: Under Secretary for Health (10)

Subj: Healthcare Inspection—Delays and Deficiencies in the Mental Health Care of a Patient at the Michael E. DeBakey VA Medical Center in Houston, Texas

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the draft report regarding delays and deficiencies at the Michael E. DeBakey VA Medical Center.

2. The Veterans Health Administration appreciates the work performed by the OIG. I am proud to say that VHA Directive 1166, Patient Record Flags, was published in November 2023. The Directive provides clarity of national expectations and requirements for the management of patients with a high-risk flag. Before the publication of Directive 1166, this content was located within two national directives, a national notice, and several national memoranda.

3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at vacovha10oicoig@va.gov.

(Original signed by:)

Shereef Elnahal, M.D., MBA

[**OIG comment:** The OIG received the above memorandum from VHA on June 24, 2024.]

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

Delays and Deficiencies in the Mental Healthcare of a Patient at the Michael E. DeBakey VA Medical Center in Houston, Texas
MCI #2023-00776-HI-1351

Recommendation 5. The Under Secretary for Health clarifies the expectations and requirements for homeless program staff's completion of suicide risk assessments and updates or reviews of safety plans for high risk for suicide patients.

VHA Comments: Concur

The Homeless Programs Office (HPO) will provide training that clarifies the expectations and requirements for homeless program staff's completion of suicide risk assessments which includes a review of safety planning for high risk for suicide Veterans. HPO will also submit evidence of the wide dissemination of training and additional resources available and note the attendance of homeless program field staff.

Status: In Progress Target Completion Date: December 2024

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 29, 2024

From: Director, South Central VA Health Care Network (10N16)

Subj: Healthcare Inspection—Delays and Deficiencies in the Mental Health Care of a Patient at the Michael E DeBakey VA Medical Center in Houston, Texas

To: Office of the Under Secretary for Health (10)
Director, Office of Healthcare Inspections (54MHP1)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I have reviewed the draft report and concur with the response provided by the facility for the Delays and Deficiencies in the Mental Healthcare of a Patient at the Michael E. DeBakey VA Medical Center draft report.

2. I want to thank the Office of Inspector General for a thorough review of this case, and we will work closely with the facility on actions to ensure the recommendations are appropriately addressed. If you have additional questions, please contact VISN 16 Quality Management Officer (QMO).

(*Original signed by:*)

Skye McDougall, PhD
South Central VA Health Care Network (VISN 16)

[**OIG comment:** The OIG received the above memorandum from VHA on June 24, 2024.]

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 29, 2024

From: Director, Michael E. DeBakey VA Medical Center (580)

Subj: Healthcare Inspection—Delays and Deficiencies in the Mental Health Care of a Patient at the Michael E DeBakey VA Medical Center in Houston, Texas

To: Director, South Central VA Health Care Network (10N16)

1. Thank you for the opportunity to review and respond to the draft report, Delays and Deficiencies in the Mental Health Care of a Patient at the Michael E. DeBakey VAMC in Houston, Texas. I concur with the recommendations contained in the report. Corrective actions have been developed and implemented as delineated in the Director's Comments section.

2. Michael E. DeBakey VA Medical Center is highly committed to High Reliability by providing the highest quality of care, mitigating risks, and ensuring that patient safety is at the forefront of everyday care and interactions with our Veterans.

3. If you have additional questions, please contact the Michael E. DeBakey VA Medical Center Director for Quality and Patient Safety.

(*Original signed by*:)

Francisco Vazquez
Medical Center Director, Michael E. DeBakey VA Medical Center

[**OIG comment:** The OIG received the above memorandum from VHA on June 24, 2024.]

Facility Director Response

Recommendation 1

The VA Houston Health Care System Director evaluates the efficiency of evidence-based psychotherapy consult management procedures; identifies barriers to timely appointment scheduling, including scheduling processes and staffing needs; and takes action as warranted.

_X _Concur.

____Nonconcur.

Target date for completion: July 2024

Director Comments

The VA Houston Health Care System Director recognizes the importance of evaluating the efficiency of evidence-based psychotherapy consult management procedures; identifying barriers to timely appointment scheduling, including scheduling processes and staffing needs; and taking action as warranted.

Recommendation 2

The VA Houston Health Care System Director ensures that administrative support staff document scheduling efforts in patients' electronic health records, as required by the Veterans Health Administration.

_X _Concur.

____Nonconcur.

Target date for completion: July 2024

Director Comments

The VA Houston Health Care System Director has ensured that administrative support staff document scheduling efforts in patients' electronic health records, as required by the Veterans Health Administration. In January 2024, Administrative supervisors initiated weekly audits of a minimum of 5 randomly selected evidence-based psychotherapy (EBP) appointments per scheduler. A formal checklist, based on the Standard Operating Procedure (SOP) from the schedulers, has been developed to track compliant documentation and will be implemented as part of a monitoring plan. Results of these reviews will be reported to Mental Health leadership and if results are below the benchmark, education and reinforcement of requirements will be reviewed with associated individuals.

Recommendation 3

The VA Houston Health Care System Director ensures that staff document offering VA-issued devices for participation in virtual mental health appointments in patients' electronic health records.

_X _Concur.

____Nonconcur.

Target date for completion: July 2024

Director Comments

The VA Houston Health Care System has initiated a two-pronged approach to ensure that staff document offering VA-issued devices for participation in virtual mental health appointments in patients' electronic health records. Clinicians conducting Therapy Treatment Planning (TTP) sessions use a template that includes a query as to patient's preferred participation modality. If a patient's preference is for virtual care, the patient's response is documented, and the clinician confirms that the patient has the required technology and connectivity to participate. If not, a Digital Divide Consult is placed.

When the scheduler contacts the patient to arrange an initial virtual evidence-based psychotherapy (EBP) appointment, the scheduler confirms whether the patient has their own device and connectivity. If the patient does not, the scheduler will check to see if a Digital Divide Consult was entered, and if so, whether a device was received. If no device was received, or no Digital Divide Consult placed, the scheduler informs the clinician. Both clinician and scheduler advise patient to contact the clinic if a device is not received 1 week prior to initiating EBP. Adherence to this process by clinicians and schedulers will be included on the formal checklist developed for scheduling audits.

Recommendation 4

The VA Houston Health Care System Director conducts a review of providers' lethal means safety assessment and planning with the patient, identifies barriers to effective lethal means safety discussions, and takes action as warranted.

_X _Concur.

____Nonconcur.

Target date for completion: June 2024

Director Comments

The VA Houston Health Care System Director ensures that Mental Health Leadership conduct a review of providers' lethal means safety assessment and planning with the patient, identifies barriers to effective lethal means safety discussions, and takes action as warranted. The Suicide Prevention Team reviews the Safety Plans, which include lethal means, of all Veterans recently identified as high risk for suicide. This process will be expanded to include the Suicide Prevention Team conducting weekly reviews of notes through use of a High Risk for Suicide checklist for all admissions for a lethal means safety assessment and planning with the patient. The review will also include the identification of barriers to effective lethal means safety discussions, and clinical documentation. An action plan and evidence of follow-up will be documented if the review indicates the need. The results of the review will be reported to the Suicide Prevention Team and through the QPS Committee.

OIG Comments

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

Recommendation 6

The VA Houston Health Care System Director reviews staff's compliance with high-risk flag patient care requirements, to include updating and reviewing safety plans, following up on failed contacts, and completing suicide risk assessments.

_X _Concur.

____Nonconcur.

Target date for completion: June 2024

Director Comments

The VA Houston Health Care System Director has ensured that the Mental Health Care Line Executive reviews staff compliance with high-risk flag patient care requirements, to include updating and reviewing safety plans, following up on failed contacts, and completing suicide risk assessments. The Suicide Prevention Team's weekly formal review will be expanded to include the high-risk flag patient care requirements, specifically, whether the Safety Plan has patient-specific strategies relevant to the Veteran's history of suicidal ideation, plans, and attempts. The review will also include when a Veteran is lost to contact or unable to be reached, additionally, it will capture when the assigned team solicits consultation from another clinician, a supervisor, or a suicide prevention coordinator, and documentation of suicide risk assessment at every encounter. The results of the reviews will be reported to the Suicide Prevention Committee and the Mental Health Care Line Executive and Mental Health Leadership Team, to include a drill

down for follow up action and resolution of non-compliance. Further, to ensure compliance, 5 randomly selected high-risk cases will be reviewed by the supervisor, the results of which will be reported to the Mental Health Care Line Executive monthly and reported to the QPS Committee for tracking.

OIG Comments

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

Glossary

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

antipsychotic medication. Prescribed to manage symptoms of psychosis including delusions ("fixed, false, and idiosyncratic" beliefs) and hallucinations. May also be prescribed to treat mood disorders.[1]

auditory hallucinations. Perception of hearing voices or noises that do not exist in reality.[2]

comprehensive suicide risk evaluation. Required documentation following a patient's positive suicide risk screening that includes the patient's suicidal behavior history, preparatory behavior, warning signs, risk and protective factors, and risk mitigation strategies.[3]

COVID-19 pandemic. A disease outbreak over a wide geographic area that affects most of the population caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).[4]

high risk for suicide patient record flag. An alert in a patient's EHR to "communicate to VA staff members that a patient has been identified as high acute risk for suicide."[5]

human immunodeficiency virus. "Attacks cells that help the body fight infection, making a person more vulnerable to other infections and diseases."[6]

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[1] National Institute of Mental Health, "Mental Health Medications," accessed November 30, 2023, https://www.nimh.nih.gov/health/topics/mental-health-medications#part_2362; Johns Hopkins Psychiatry Guide, "Delusions," accessed April 3, 2024, https://www.hopkinsguides.com/hopkins/view/Johns_Hopkins_Psychiatry_Guide.

[2] Cleveland Clinic, "Auditory Hallucinations," accessed March 5, 2024, https://my.clevelandclinic.org/health/symptoms/23233-auditory-hallucinations.

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

[4] World Health Organization, "Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It," accessed January 8, 2024, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it; *Merriam-Webster.com Dictionary*, "pandemic," accessed January 8, 2024, https://www.merriam-webster.com/dictionary/pandemic; "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19," World Health Organization, accessed October 12, 2023, https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

[5] VHA Directive 1166.

[6] "What are HIV and AIDS?" US Department of Health & Human Services, accessed March 5, 2024, https://www.hiv.gov/hiv-basics/overview/about-hiv-and-aids/what-are-hiv-and-aids.

lethal means safety. An evidence-based suicide prevention practice focused on decreasing an individual's access to objects such as medications, firearms, or sharp items that can be used in suicide attempts or other self-directed violence.[7]

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. Other symptoms include changes in sleeping patterns, appetite, energy level, and weight; "psychomotor agitation;" feelings of worthlessness and guilt; poor concentration; and thoughts of death.[8]

melanoma. A "serious type of skin cancer" that forms in the melanin-producing cells that create skin color.[9]

passive suicidal ideation. A "desire to die" without a specific plan or intent for self-harm.[10]

safety plan. A written list of coping strategies and sources of support for patients who are at high risk for suicide to use before or during a crisis.[11]

suicide behavior and overdose report. A "national note template designed to standardize and streamline the process of reporting any suicidal self-directed violence behavior or overdose event among VA patients."[12]

[7] "Lethal Means Safety & Suicide Prevention," VA Mental Illness Research, Education, and Clinical Center, Center of Excellence, accessed January 22, 2024, https://www.mirecc.va.gov/lethalmeanssafety/.

[8] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition – Text Revision* (DSM-5-TR), "Major Depressive Disorder," accessed November 30, 2023, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x04_Depressive_Disorders.

[9] "Melanoma," Mayo Clinic, accessed November 30, 2023, https://www.mayoclinic.org/diseases-conditions/melanoma/symptoms-causes/syc-20374884.

[10] Christine N. May et al., "Passive suicidal ideation: A clinically relevant risk factor for suicide in treatment-seeking veterans," *Illness, Crisis, & Loss* 23, no. 3 (July 2015): 261–277, https://doi.org/10.1177/1054137315585422.

[11] VA, Safety Plan Quick Guide for Clinicians, March 2012.

[12] VA, "Suicide Behavior and Overdose Report (SBOR): Frequently Asked Questions," July 13, 2022.

OIG Contact and Staff Acknowledgments

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