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VETERANS HEALTH ADMINISTRATION

Insufficient Mental Health Treatment and Access to Care for a Patient and Review of Administrative Actions in Veterans Integrated Service Network 10

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of VA Secretary Denis McDonough to evaluate concerns regarding Veterans Integrated Service Network (VISN) 10 staff's care and treatment coordination for a patient who died in the fall of 2021.[1] Specifically, the OIG assessed concerns related to VA Ann Arbor Healthcare System (Ann Arbor VA) staff's failure in 2017 to adequately assess the patient for posttraumatic stress disorder (PTSD), toxic exposure, and traumatic brain injury (TBI), and provide the patient adequate mental health treatment.[2]

The OIG identified concerns regarding Battle Creek VA Medical Center (Battle Creek VA) staff's failure to verify the patient's treatment eligibility accurately and to coordinate the patient's transfer for inpatient mental health and residential treatment effectively in 2021. Further, the OIG evaluated the sufficiency of Veterans Health Administration (VHA) leaders' actions prior to and following notification of the patient's death.

Synopsis of the Patient's Care

Ann Arbor VA Care from Fall 2015 through Fall 2017

In fall 2015, the patient, in their mid-thirties at the time, initiated care at the Ann Arbor VA and participated in outpatient mental health treatment until fall 2017.[3] The patient's medical history included military-related head trauma. At the time the patient began care, an Ann Arbor VA staff member assisted the patient with submitting healthcare eligibility paperwork and provided service connection information.

In early 2016, an Ann Arbor VA psychiatrist documented that the patient may have an unspecified depressive disorder, and that medication and therapy were "not indicated" with follow-up "only as-needed." Almost 11 months later in late 2016, the patient had an involuntary admission to a non-VA facility's inpatient mental health unit after experiencing a "psychotic episode" and was transferred to another non-VA facility.

In early 2017, approximately a week after the patient was discharged, the Ann Arbor VA psychiatrist noted the patient was having side effects and wanted to discontinue medications. In early spring 2017, the psychiatrist documented the patient's sporadic noncompliance with taking

[1] VISN 10 serves patients in Indiana, Ohio, northern Kentucky, and Michigan, and is comprised of 10 medical centers, including the VA Ann Arbor Healthcare System, Battle Creek VA Medical Center, and the VA Saginaw Health Care System.

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

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

an antipsychotic medication. Approximately five weeks later, the patient was admitted voluntarily to the Ann Arbor VA inpatient mental health unit "for crisis stabilization, diagnostic clarity, medication management, and maintenence [*sic*] of safety."

Five days after admission, the patient requested a change of outpatient psychiatrist and agreed with the discharge plan that included a new antipsychotic medication, two anxiety medications, and an antidepressant medication. The day after discharge, the patient met with a different outpatient psychiatrist and approximately two weeks later, the patient canceled the next three appointments scheduled with the psychiatrist.

In summer 2017, a social worker documented that the patient would not continue receiving case management given the patient's "sustained stability." In a consultation with a psychologist, the next day, the patient agreed to defer treatment decisions until the patient completed diagnostic assessment to rule out symptoms "of psychosis that may warrant further stabilization and to confirm presence of" PTSD symptoms that would benefit from trauma treatment.

In fall 2017, the patient presented to the Ann Arbor VA Emergency Department and the patient's accompanying friends reported that the patient discontinued mental health medications. An Emergency Department physician documented the patient's "acute psychosis," and initiated a petition for involuntary hospitalization to the inpatient mental health unit due to the severity of the patient's delusions that placed the patient "at increased risk for unintentional harm to self or others," lack of insight, and likelihood of poor medication compliance or outpatient follow-up.

On the inpatient mental health unit, a psychiatrist noted the patient's involuntary admission and documented a differential diagnosis of paranoid schizophrenia, psychosis secondary to medical condition, and delusional disorder.[4] The patient reported wanting to "leave the unit [as soon as possible]." Later that day, another psychiatrist entered orders for a voluntary admission and the patient signed the Michigan state voluntary admission paperwork.[5] The patient refused medication and did "not believe" antipsychotic medication was warranted. The following day, after a psychiatry resident physician, under supervision of an inpatient psychiatrist, documented that the patient "did not meet criteria for involuntary hospitalization/treatment," and the patient was discharged. The discharge summary included an unspecified psychotic disorder diagnosis

[4] A differential diagnosis "is a list of possible conditions that could cause" a patient's symptoms. Through assessment techniques, a provider may "rule out conditions" and finalize a diagnosis. Cleveland Clinic, "Differential Diagnosis," accessed January 4, 2024, https://my.clevelandclinic.org/health/diagnostics/22327-differential-diagnosis.

[5] DCH-0086, Formal Voluntary Admission Application-Adult. Michigan Department of Health and Human Services, April, 2019, accessed June 24, 2024, https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.michigan.gov%2Fmdhhs%2F-%2Fmedia%2FProject%2FWebsites%2Fmdhhs%2FKeeping-Michigan-Healthy%2FMental-Health%2FRecipient-Rights%2FDCH-0086_653546_7.dotx%3Frev%3Daf55059213934fe09d6b65630a579a52%26hash%3D7D331C0C05039512099A2E986508D669&wdOrigin=BROWSELINK.

and noted the patient had impaired insight and "was not interested in starting a medication during this admission."

Approximately a week later, the psychologist and patient discussed treatment for psychotic symptom stabilization four to six months prior to the patient's engagement in trauma-focused treatment. However, the patient declined recommendations for medication management, general anxiety treatment, and the psychiatrist's offer of an appointment every three to four months. Approximately a week later, the patient presented for an appointment and an advanced medical support assistant documented that the patient was "clearly frustrated" when informed of not having an appointment, and "replied I am done with the VA."

OIG Findings

Assessment of PTSD, Toxic Exposure, and TBI

The OIG determined that Ann Arbor VA staff considered a PTSD diagnosis and assessment throughout the patient's care and based on reasonable medical decision-making, planned to assess PTSD symptoms upon stabilization of the patient's acute mental health symptoms. However, the patient discontinued treatment in fall 2017, and a PTSD evaluation was not completed.

Ann Arbor VA staff also screened the patient for toxic exposure and provided the patient with relevant information to proceed with toxic exposure evaluation, as required by VHA.[6] Further, the OIG concluded that Ann Arbor VA providers screened the patient for TBI as required by VHA and adequately considered the patient's history of head trauma in the formulation of the patient's diagnoses and treatment plans.[7]

[6] The OIG was unable to confirm the patient's follow-up due to an absence of electronic health record documentation. VHA Handbook 1303.02, *Gulf War (Including Operation Iraqi Freedom) Registry (GWR) Program (Formerly Persian Gulf (GWR) Program)*, June 5, 2007, rescinded and replaced by VHA Directive 1325, *Gulf War Registry*, June 1, 2017. The 2017 directive was rescinded and replaced by VHA Directive 1308, *Health Outcomes Military Exposures Registry Programs*, March 25, 2022. VHA Handbook 1303.02 and VHA Directive 1325 were in effect during the time of the patient's care. Unless otherwise specified, the 2022 directive contains the same or similar language regarding the Gulf War Registry examination requirements as the 2007 and 2017 documents.

[7] VHA Directive 2010-012, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*, March 8, 2010, rescinded and replaced by VHA Directive 1184, *Screening and Evaluation of Traumatic Brain Injury (TBI) in Operation Enduring Freedom (OEF) Operation Iraqi Freedom (OIF) and Operation New Dawn (OND) Veteran*, April 6, 2017. The 2017 directive was rescinded and replaced by VHA Directive 1184, *Screening and Evaluation of Post-9/11 Veterans for Deployment-Related Traumatic Brain Injury*, January 3, 2022. Unless otherwise specified, the 2022 directive contains the same or similar language regarding TBI screening as the 2010 and 2017 directives.

Insufficient Fall 2017 Inpatient Mental Health Unit Treatment and Discharge Care Coordination

The OIG found that prior to the patient's discharge from the inpatient mental health unit in fall 2017, Ann Arbor VA inpatient mental health unit providers failed to sufficiently assess the patient's mental health needs prior to discharge.

Failure to Sufficiently Assess the Patient's Condition

In fall 2017, the patient presented to the Emergency Department with "increasing erratic behavior" and the patient received an intravenous dosage of a tranquilizer and an oral dose of an antipsychotic medication for agitation. The patient was admitted to the inpatient mental health unit involuntarily and the covering psychiatrist observed the patient to be "better than described by the" Emergency Department physician "probably due to" the administered antipsychotic medication. That evening, approximately 18.5 hours after the patient received the antipsychotic medication, the psychiatrist entered orders for a voluntary admission.

The following day, an inpatient psychiatrist documented that "at this time, there [were] no grounds for involuntary hospitalization." In contrast to the covering psychiatrist's documented assessment, the inpatient psychiatrist told the OIG that the antipsychotic medication was not "making that big of a difference for [the patient]" and "we did not see any evidence that [the patient] was not attending to [activities of daily living]."

Additionally, the inpatient psychiatrist told the OIG that the evaluation occurred in the morning. The OIG determined that the patient was likely benefiting from the antipsychotic medication at the time of the inpatient psychiatrist's evaluation; therefore, the inpatient psychiatrist could not sufficiently evaluate the patient's underlying mental health condition.[8] Given the patient's refusal to take medications, the OIG would have expected a longer monitoring interval to assess the patient's condition when truly free of antipsychotic effects.

The OIG concluded that the inpatient psychiatrist's failure to consider the patient's initial unmedicated presentation that reflected mental health deterioration, potential nutritional insufficiency (discussed below), and probable therapeutic responses to administered medication likely contributed to an underestimation of the severity of the patient's mental health condition and ultimately a failure to treat the patient effectively.

Insufficient Consideration of Abnormal Laboratory Results

When the patient presented to the Emergency Department in fall 2017, the patient's laboratory testing results indicated a possible nutritional insufficiency or a medical problem. Emergency

[8] The OIG was unable to determine the exact time of the inpatient psychiatrist's evaluation because of the absence of this information in the documentation. The OIG team considered 8:00 a.m. to noon as the morning for this estimate and estimated that the patient received the antipsychotic medication between 31 and 35 hours prior to the evaluation.

Department staff administered potassium chloride to the patient to correct the patient's low potassium level and a recheck 25 hours later indicated a low-normal range.

Based on the patient's mental health condition and the possibility of the patient's diminished ability to effectively perform activities of daily living, such as nutritional intake, the OIG would have expected Ann Arbor VA providers to have addressed these concerns by (1) discussing activities of daily living needs with the patient; (2) considering retaining the patient in inpatient mental health treatment; or at a minimum, (3) alerting outpatient providers of the need for follow-up in these areas.

Inadequate Outpatient Care Plan

Since 2012, VHA requires that patients are assigned a mental health treatment coordinator (MHTC) to promote continuity of care during transitions between levels of care, such as discharge from an inpatient mental health unit to outpatient mental health care, and to foster patients' engagement in treatment.[9] Although the patient's electronic health record (EHR) identified multiple MHTCs over the course of the patient's Ann Arbor VA care, generally staff were unaware of the MHTC assignment.

The OIG found that staff's failure to document information about MHTC assignment using the required EHR note title in spring or fall 2017 may have contributed to staff's lack of awareness of the assignment. Further, the patient's EHR documentation did not include the rationale for changes or confirmation that the patient was involved and informed about the MHTC assignments, as required by VHA.[10]

In fall 2017, inpatient mental health unit staff did not document collaboration with the patient or the outpatient psychiatrist in the development of the outpatient care plan, as encouraged by VHA.[11] Given the patient's refusal to take medications and staff's awareness of the patient's minimal contact and lack of a working relationship with the psychiatrist, the OIG would have expected staff to make efforts to enhance the patient's engagement.

The OIG concluded that Ann Arbor VA staff's failure in late spring and fall 2017 to identify and address barriers to the patient's participation in medication management and to ensure that a staff member was functioning in the MHTC role to foster the patient's engagement in outpatient care

[9] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum to the Network Directors (10N-23), Chief Medical Officer, and VISN Mental Health Liaisons, March 26, 2012.

[10] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

[11] VHA Handbook 1160.06, *Inpatient Mental Health Services,* September 16, 2013. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023. Unless otherwise specified, the guidelines regarding the MHTC coordination during inpatient mental health unit admissions in the 2023 directive contain the same or similar language as the 2013 handbook.

may have contributed to the patient's abrupt cessation of care and staff's lack of follow-up with the patient.

Battle Creek VA Inadequate Transfer Coordination with Non-VA Agencies in 2021

In 2021, multiple staff members from non-VA agencies reached out to the Oscar G. Johnson VA (Iron Mountain VA), Battle Creek VA, and the VA Saginaw Health Care System (Saginaw VA) to verify eligibility and coordinate a transfer of the patient to VA care from non-VA facilities.

Verification of Eligibility

Veterans who served a minimum duration on active duty in the "active military, naval, or air service," are eligible for basic VA healthcare.[12] A veteran may apply to be enrolled in the VA healthcare system by completing an eligibility form.[13] Once enrolled, a patient "may seek care at any VA facility without being required or requested to reestablish eligibility."[14]

In late spring 2021, the patient was admitted involuntarily to a non-VA facility and on the same day during evening hours, a non-VA agency supervisor documented speaking with an unidentified Battle Creek VA staff member who reported "that they cannot assist" because the patient was "not registered." However, in fall of 2015, the patient completed the eligibility form and the next day was deemed eligible for VA healthcare benefits for 10 years based on VHA guidelines.[15]

The OIG was unable to identify any Battle Creek VA staff member who spoke with the non-VA agency supervisor because of the absence of a name or phone number in the non-VA records and a lack of documentation in the patient's EHR and administrative officer of the day log. The OIG

[12] VHA Directive 2010-038, *Enrolled Veterans Intake and Registration*, August 30, 2010. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1601A.01(2), *Registration and Enrollment*, July 7, 2020, amended June 6, 2023, and April 4, 2024, and VHA Directive 1601A.02(6), *Eligibility Determination*, July 6, 2020, amended March 6, 2024. Unless otherwise specified, the 2024 directives contain the same or similar language regarding placement of enrolled patients seeking care at any VA facility as the rescinded 2010 directive; 38 C.F.R. § 17.31 (2017).

[13] VHA Directive 2004-041, *Implementation of the VA Form 10-10EZ, Revised Application for Health Benefits*, and VA Form 10-10EZR, *Health Benefits Renewal Form*, August 4, 2004.

[14] VHA Directive 2010-038.

[15] The patient was considered to be in priority Group 6, which includes patients who were "toxic-exposed," "Vietnam-era herbicide-exposed" patients, "Radiation-exposed" patients, patients that served in "Southwest Asia during the Persian Gulf War," and "Combat Veterans who served in a theater of combat operations after the Persian Gulf War and those Veterans who served in combat against a hostile force during a period of hostilities after November 11, 1998," VHA Directive 2010-038; VHA Directive 1601A.01(2). VHA Directive 1601A.01(2) provides information on priority group placement; In 2020, as noted in VHA Directive 1601A.02(6), VHA extended the eligibility period for Combat Veterans from five to ten years after the date of active duty discharge; 38 C.F.R. § 17.36 (2015).

found that Battle Creek VA leaders likely did not have knowledge of the non-VA agency supervisor's call because of the absence of Battle Creek VA documentation.

Additionally, as discussed below, the OIG determined that in early fall 2021, the Battle Creek VA mental health residential rehabilitation treatment program (MH RRTP) screening coordinator's (screening coordinator's) failure to recognize the patient's eligibility for VA care may have contributed to barriers for non-VA staff to submit a referral for the patient, resulting in a delay of consideration of the patient's suitability for MH RRTP care.[16]

Inadequate Inpatient Mental Health Unit Bed Management

In early fall 2021, a non-VA mental health agency social worker informed a Battle Creek VA transfer coordinator (transfer coordinator) that the patient was admitted to a non-VA facility for over two weeks with diagnoses of PTSD and delusional disorder, and requested the patient's transfer to the Battle Creek VA inpatient mental health unit or MH RRTP.

The OIG found that although Battle Creek VA staff were responsive to non-VA staff inquiries about transferring the patient to the inpatient mental health unit, the patient was not considered for transfer due to a critical bed status rendering beds unavailable at the time of the transfer request. As a result of an internal review conducted by Battle Creek VA leaders in January 2022, the use of critical bed status was discontinued in April 2023. The OIG found that from February 2022 until January 2024, Battle Creek VA leaders did not establish written guidance regarding interfacility transfers as was required by VHA during that time.[17]

Inaccurate and Inadequate MH RRTP Referral Procedures

The OIG found that the Battle Creek VA August 2021 MH RRTP standard operating procedure prohibited veterans to self-refer or be referred from non-VA agencies, inconsistent with VHA requirements.[18] The Battle Creek VA chief, Psychology Service acknowledged becoming aware of the inconsistency between the VHA directive and the standard operating procedure when the OIG inquired about the discrepancy. The Battle Creek VA chief, Psychology Service updated the standard operating procedure to be consistent with the VHA directive and provided RRTP staff with the updated standard operating procedure.

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[16] VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019. In 2010, VHA established MH RRTPs to provide treatment and rehabilitative services for a range of needs, including patients with mental health and substance use disorders and psychosocial challenges, such as employment and housing, in a 24-hour-per-day, 7-day-per-week staffed setting.

[17] VHA Directive 1094, *Inter-Facility Transfer*, January 11, 2017. This directive was in place during the time of the events discussed in this report. It was updated and replaced with VHA Directive 1094, *Interfacility Transfer*, January 20, 2022. The January 2022 directive was removed on February 24, 2022, and replaced with the 2017 directive.

[18] Battle Creek VA Standard Operating Procedure 116B-5, "Mental Health Residential Rehabilitation Treatment Programs (MH RRTP*),"* August 9, 2021; VHA Directive 1162.02.

Battle Creek VA MH RRTP staff's lack of awareness of both the patient's enrollment status and the VHA requirement to consider non-VA agency referrals likely created barriers for non-VA staff to submit a referral for the patient, resulting in a delay of consideration of the patient's suitability for MH RRTP care.

In early fall 2021, a case manager "reported interest in" MH RRTP for the patient, and the transfer coordinator provided MH RRTP staff contact information. The transfer coordinator alerted the Battle Creek VA MH RRTP screening coordinator. The OIG found that the screening coordinator inaccurately communicated that the patient was not able to be referred from a non-VA agency at the time of the referral; however, the screening coordinator was knowledgeable about the VHA non-VA referral requirement in a 2023 interview with the OIG.

Also in early fall 2021, a non-VA short-term residential crisis unit provider documented that the non-VA agency staff was trying to get the patient "set up for services" with the Saginaw VA. Saginaw VA staff also provided the case manager with requested MH RRTP referral information and contacted the screening coordinator about the patient's "possible placement." A Saginaw VA Veterans Justice Outreach (VJO) social worker documented a plan to submit a Battle Creek VA MH RRTP consult for the patient after the patient was "settled."[19]

In mid-fall 2021, the Director, VHA Continuum Care and General Mental Health received an email from a professional acquaintance who reported that the patient was "in need of urgent medical care," and requested assistance in accessing VA care for the patient. The Director, VHA Continuum Care and General Mental Health also notified the VISN 10 Chief Mental Health Officer (VISN 10 CMHO), and the then-Executive Director and Chief of Staff, Office of Mental Health and Suicide Prevention, about the request.[20]

The next morning, the Battle Creek VA associate chief of staff for mental health (ACOS) provided the VISN 10 CMHO with information about the outreach for the patient's transfer and the transfer coordinator's plan to reach out to the non-VA mental health agency. Later the same day, the ACOS contacted a family member "to determine if the Veteran had any current needs or if transfer to the VA was needed at this time." The ACOS documented learning that the patient died that morning from sudden cardiac death in schizophrenia.

[19] The VJO Program staff identifies "identify justice-involved Veterans and contact them through outreach, in order to facilitate access to VA services at the earliest possible point." VHA, "Veterans Justice Outreach Program," accessed October 31, 2023, https://www.va.gov/HOMELESS/VJO.asp.

[20] The VISN 10 CMHO at the time of the outreach regarding the patient's transfer to VA care reported being detailed to the position of Executive Director, Office of Mental Health and Suicide Prevention on May 1, 2022, and was officially appointed to the position on December 4, 2022. For purposes of this report, the OIG will refer to this leader as the VISN 10 CMHO given that this was the position held from May 2021 through the time of the patient's death. The Executive Director, Office of Mental Health and Suicide Prevention, who was in the position at the time of the outreach regarding the patient's transfer to VA care, was in the position from January 2015 until April 2022.

In mid-fall 2021, the patient was discharged to a non-VA adult foster care home.[21] A week after providing a veteran liaison with the Battle Creek VA MH RRTP contact information, the transfer coordinator contacted the liaison and asked if an MH RRTP admission was needed. The liaison noted a plan to check on the patient's status and notify the transfer coordinator. That day, the associate chief of staff learned the patient died that morning.

VHA Leaders' Actions Following the Patient's Death

In January 2022, the Battle Creek VA Director chartered a Rapid Process Improvement Workgroup (RPIW) to address concerns about inadequate transfer coordination for the patient and the absence of a "standard process" for acceptance of transfers from community partners that was "creating frustration with our community partners . . . and ultimately leaving Veterans in inappropriate levels of care."[22]

As a result of the RPIW, a workgroup was organized in January 2022 to establish a Transfer and Admission Coordination (TAC) Office with the goal of centralizing the management of the transfer and admission process. In January 2024, the chief, quality resource service reported that most of the actions to establish the TAC Office had been implemented. The OIG concluded that Battle Creek VA leaders implemented recommendations from the RPIW to improve the transfer coordination processes.

Interagency Reconciliation Council

In spring 2022, Senator Gary Peters sent a letter to the VA Secretary asking if the VA was investigating the patient's death and what actions the VA was taking "to ensure that servicemembers struggling with a mental health crisis" are able to obtain VA services. In mid-summer 2022, the VISN 10 Director responded that the circumstances of the patient's death were reviewed and reported a plan to create the Interagency Reconciliation Council (IRC). In July 2022, VISN 10 leaders and the Michigan Veterans Affairs Agency implemented the IRC, a pilot program to improve communication regarding needs and resources, including care transitions, for reservists, national guard members, transitioning service members, and their families in Michigan.

The OIG found that since initiation in July 2022, the IRC has not identified or taken steps beyond information sharing to improve communication regarding the needs and resources as intended. The OIG concluded that the IRC's lack of clearly defined objectives and processes to

[21] Mich. Comp. Laws Ann. § 400.703(4) (2019). An adult foster care home provides care for adults "who are aged, mentally ill, developmentally disabled, or physically disabled who require supervision on an ongoing basis but who do not require continuous nursing care."

[22] The RPIW convened for three days in January 2022.

monitor progress and address identified barriers may hinder the IRC's success in meeting the intended outcomes.

Recommendations

The OIG made one recommendation to the Ann Arbor VA Medical Center Director related to a review of the patient's spring to fall 2017 mental health care to identify quality of care improvement opportunities; four recommendations to the Battle Creek VA Medical Center Director related to eligibility verification procedures, the full implementation of the TAC Office, expediting the completion and implementation of the interfacility transfers standard operating procedure, and alignment of the MH RRTP standard operating procedure with VHA requirements; and one recommendation to the VISN 10 Director related to the IRC's identification of clearly defined objectives and processes to monitor progress.

VA Comments

The VISN 10, Ann Arbor VA, and Battle Creek VA Directors concurred with the findings and 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

AOD	administrative officer of the day
ACOS	associate chief of staff
CMHO	chief mental health officer
EHR	electronic health record
IRC	Interagency Reconciliation Council
MH RRTP	mental health residential rehabilitation treatment program
MHTC	mental health treatment coordinator
OIG	Office of Inspector General
PTSD	posttraumatic stress disorder
RPIW	rapid process improvement workgroup
TAC	Transfer and Admission Coordination
TBI	traumatic brain injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VJO	Veterans Justice Outreach

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of VA Secretary Denis McDonough to evaluate concerns regarding Veterans Integrated Service Network (VISN) 10 staff's care and treatment coordination for a patient who died in mid-fall 2021. Specifically, the OIG assessed concerns related to VA Ann Arbor Healthcare System (Ann Arbor VA) staff's failure in 2017 to adequately assess the patient for posttraumatic stress disorder (PTSD), toxic exposure, and traumatic brain injury (TBI), and provide the patient adequate mental health treatment.[1] Further, the OIG identified concerns regarding Battle Creek VA Medical Center (Battle Creek VA) staff's failure to verify the patient's treatment eligibility accurately and to coordinate the patient's transfer for inpatient mental health and residential treatment effectively in fall 2021. The OIG also evaluated the sufficiency of Veterans Health Administration (VHA) leaders' actions following the notification of the patient's death.

Background

VISN 10 serves patients in Indiana, Ohio, northern Kentucky, and Michigan and is comprised of 10 medical centers, including the Ann Arbor VA, Battle Creek VA, and the VA Saginaw Health Care System (Saginaw VA). The Ann Arbor VA serves veterans residing in southeastern Michigan and northwestern Ohio and provides inpatient beds in medicine and psychiatry and outpatient mental health services. The Battle Creek VA provides veterans in the western and lower peninsula of Michigan with medical and mental health care that includes 55 inpatient mental health beds and 101 mental health residential rehabilitation treatment program (MH RRTP) beds for substance use disorder and PTSD treatment and psychosocial rehabilitation.[2] The Saginaw VA provides Central and Northern Michigan's Lower Peninsula veterans with outpatient primary care and mental health services including homeless services and transition and care management to post-9/11 era patients.

Concerns

In early 2023, VA Secretary Denis McDonough requested that the OIG provide an independent oversight inspection regarding the patient's care and related administrative actions. The OIG reviewed the following concerns.

[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] VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019. In 2010. VHA established MH RRTPs to provide treatment and rehabilitative services for a range of needs, including patients with mental health and substance use disorders, and psychosocial challenges, such as employment and housing in a 24-hour-per-day, 7-day-per-week staffed setting.

1. Ann Arbor VA staff failed to adequately assess the patient for PTSD, toxic exposure, or TBI during the patient's outpatient care from fall 2015 through mid-fall 2017.
2. Ann Arbor VA staff failed to provide the patient sufficient inpatient mental health treatment in 2017.
3. Battle Creek VA staff failed to verify the patient's treatment eligibility accurately and to coordinate the patient's transfer for inpatient mental health care and residential rehabilitation treatment in 2021.

The OIG also evaluated the sufficiency of VA leaders' actions prior to and following notification of the patient's death, including initiation of a Rapid Process Improvement Workgroup (RPIW) and establishment of the Interagency Reconciliation Council (IRC).[3]

Scope and Methodology

The OIG initiated the inspection on April 19, 2023, and conducted virtual site visits from May 8 –19, 2023, and June 6–8, 2023.

The OIG team interviewed the patient's family members; the former VISN 10 Chief Mental Health Officer (VISN 10 CMHO); Director, VHA Continuum Care and General Mental Health (Director), Office of Mental Health and Suicide Prevention; and VISN 10 leaders; Ann Arbor VA, Saginaw VA, and Battle Creek VA leaders and staff familiar with the patient's care and relevant processes.[4] The OIG also interviewed non-VA staff involved in communication with VHA staff regarding the patient. The OIG reviewed relevant VHA directives, handbooks, and memoranda; relevant VISN 10 medical center policies, standard operating procedures, and organizational charts. The OIG team also reviewed the patient's electronic health record (EHR) and non-VA medical records.

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).

[3] The IRC is a VISN 10 pilot program to improve communication regarding needs and resources for reservists, national guard members, transitioning service members, and their families in Michigan. VHA requires medical center leaders to establish a program for the continuous "improvement of services through the evaluation, monitoring, and implementation of process changes." In January 2022, the Battle Creek VA Director chartered a Rapid Process Improvement Work Group. VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program,* December 12, 2019.

[4] The VISN 10 CMHO at the time of the outreach regarding the patient's transfer to VA care reported being detailed to the position of Executive Director, Office of Mental Health and Suicide Prevention on May 1, 2022, and was officially appointed to the position on December 4, 2022. For purposes of this report, the OIG will refer to this leader as the VISN 10 CMHO given that this was the position held from May 2021 through the time of the patient's death.

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 within a specified scope and methodology and makes recommendations to VA leaders, if warranted. 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

In fall 2015, the patient, in their mid-thirties at the time, initiated care at the Ann Arbor VA and participated in outpatient mental health treatment until fall 2017.[5] The patient's medical history included military-related head trauma.

While receiving care at the Ann Arbor VA, the patient was diagnosed with various mood and psychotic disorders and rule out disorders, including rule out PTSD.[6] Beginning in 2016, providers prescribed mental health medications to manage the patient's symptoms, and reported side effects and concerns. Medications included four different antipsychotic medications (antipsychotic medications 1, 2, 3, and 4), a mood stabilizer, a medication for sleep, an anxiety medication, and an antidepressant medication. Over the course of treatment, the patient took the medications inconsistently. The patient was admitted to inpatient mental health units for psychotic symptoms three times—an involuntary admission to a non-VA facility in late 2016, then a voluntary admission to the Ann Arbor VA in spring 2017, and an involuntary admission in fall 2017. Following the fall 2017 admission, the patient discontinued care at the Ann Arbor VA.

Starting in late spring through mid-fall 2021, multiple staff members from non-VA agencies reached out to the Battle Creek VA, the Saginaw VA, and the Oscar G. Johnson VA (Iron Mountain VA) staff in consideration of transfer of the patient's care. [7] After a late summer 2021 non-VA facility inpatient mental health unit admission, the patient was discharged to a non-VA short-term residential unit for crisis stabilization (non-VA residential crisis unit) with diagnoses of paranoid schizophrenia and PTSD. In mid-fall 2021, the patient was discharged to a non-VA adult foster care home (adult foster care home).[8] Eleven days later, the patient died at the adult foster care home from sudden cardiac death in schizophrenia.

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

[6] A provider may document a rule-out diagnosis when a patient presents with symptoms or signs suggesting a disorder and additional information is needed to confirm the diagnosis.

[7] Iron Mountain VA is a VISN 12 medical center located in Michigan.

[8] An adult foster care home provides care for adults "who are aged, mentally ill, developmentally disabled, or physically disabled who require supervision on an ongoing basis but who do not require continuous nursing care." Mich. Comp. Laws Ann. § 400.703(4) (2019).

Ann Arbor VA Care from Fall 2015 through Summer 2017

2015

In fall 2015, an Ann Arbor VA staff member assisted the patient with submitting healthcare eligibility paperwork, provided service connection information, and placed a primary care consult to "connect [patient] to care." Nine days later, the patient attended a primary care appointment to establish care. A primary care resident physician documented the patient's head trauma history, negative TBI screen, and the patient's "spectrum of complaints," including "possible" mental health, cardiovascular, and neurological diagnoses. The primary care resident physician submitted a mental health consult to address the patient's "neurologic symptoms including tinnitus, headache, numbness/tingling in non-physiologic pattern" and "multiple stressful" military experiences.

Approximately two weeks later, in a post-9/11 transition and case management needs assessment by telephone, the patient expressed concern about environmental exposure and a social work intern provided information about VA benefits and how the patient could self-refer for a registry examination.[9] The social work intern planned "to send exposure registry information" to the patient. The patient did "not feel the need for ongoing case management services" and the social work intern agreed "with this decision."

2016

In an early 2016 psychiatric evaluation, a social worker documented the patient's report of "poor sleep" and hand and feet pain for approximately eight years. The patient also reported six "sessions" with a non-VA psychiatrist in summer 2015 and denied being diagnosed with a mental health condition. The social worker conducted a diagnostic interview in which the patient "did not endorse symptoms" of specific mental health conditions, including major depressive episodes, manic episodes, PTSD, and psychotic disorders.

About a month later, a psychiatrist (psychiatrist 1) noted reviewing the social worker's evaluation, completed the psychiatric evaluation with the patient and documented the patient's current "mild depressive symptoms," report of head trauma in the military, and "ruminative and perseverative" thought process "about perceived failures of military leadership." Psychiatrist 1 also documented that the patient's adjustment disorder was resolved and that the patient may have an unspecified depressive disorder. Psychiatrist 1 noted being the patient's mental health

[9] Transition and Case Management is a VHA program that assists veterans transitioning "from military to civilian life." "Post-9/11 Transition and Case Management" (web page), VA, accessed October 19, 2023, https://www.va.gov/POST911VETERANS/About_Post_911_TCM.asp.

treatment coordinator (MHTC), and that medication and therapy was "not indicated" with follow-up "only as-needed."[10]

Almost 11 months later in late 2016, the patient's family member (family member 1) contacted an Ann Arbor VA advanced medical support assistant and reported that the patient presented to a non-VA facility (non-VA facility 1) after experiencing a "psychotic episode." An Ann Arbor VA nurse (nurse 1) documented speaking with a non-VA facility 1 staff member, and that the patient's family "was hopeful to transfer patient to VA" and that the patient did not meet "criteria for VA to authorize emergency care." The next day, a different nurse (nurse 2) documented that another family member (family member 2) reported that the patient was admitted voluntarily to another non-VA facility (non-VA facility 2) and requested the patient be transferred to the Ann Arbor VA. The following day, another nurse (nurse 3) documented that a non-VA facility 2 social worker reported the patient was "non violent but paranoid" and under "involuntary" admission. Nurse 3 documented sending transfer information to the non-VA social worker. Nurse 3 documented not receiving the necessary transfer information from non-VA facility 2 and later that morning, the non-VA social worker told nurse 3 that the patient declined transfer to the Ann Arbor VA.

2017

In early 2017, psychiatrist 1 noted that the non-VA facility 2 medical records specified that the patient was "extremely paranoid" about the government and that the patient responded to internal stimuli and communicated using different accents. Psychiatrist 1 documented that during that admission, the patient was prescribed an antipsychotic medication (antipsychotic medication 1) and medications for mood stabilization and sleep. A non-VA facility 2 provider diagnosed the patient with an unspecified psychotic disorder. The same day, psychiatrist 1 documented that the patient was accompanied by family member 2 and presented with "vague paranoid thoughts," "persecutory themes," and limited insight. The patient and family member 2 reported that the patient's primary problems were "related to 'PTSD.'" Psychiatrist 1 did not make medication changes, referred the patient to a case manager, documented that the patient signed a release of information for family member 2, and scheduled a follow-up appointment in two weeks or sooner as needed.

A week later, in an initial case management appointment, a social worker (social worker 1) documented that the patient, accompanied by family member 2, reported decreased paranoid ideation and symptom improvements with medication. On the same day, the patient and family

[10] Since 2012, VHA has required that patients receiving mental health services are assigned an MHTC to promote continuity of care during transitions between levels of care, and to foster patients' engagement in treatment. Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum to the Network Directors, Chief Medical Officer, and VISN Mental Health Liaisons, March 26, 2012.

member 2 met with psychiatrist 1 who documented a discussion of the patient's possible diagnoses including "showing" the patient the diagnostic criteria for brief psychotic disorder and other psychotic disorders. The patient reported improved sleep, an inability to concentrate, and a desire to discontinue medications. Psychiatrist 1 continued medication for mood stabilization with the plan to "consider tapering and stopping, . . . and that [the patient] is having [side effects] to the medication." Psychiatrist 1 obtained a release of information for a non-VA therapist that the patient reported having "started seeing."

The next day, the non-VA therapist contacted psychiatrist 1 and reported that the patient "may need to transfer" to another therapist due to the patient's loss of insurance. Psychiatrist 1 documented a plan to discuss receiving psychotherapy at the Ann Arbor VA with the patient at the "next meeting."

That same month, social worker 1 met with the patient and family member 1, and documented that the patient reported improved mood, decreased paranoid ideation, and medication side effects. Psychiatrist 1 contacted the patient to discuss medications and documented that the patient expressed concerns about "grey matter damage" to the brain that "can potentially happen" as a result of "long-term medication treatment," and that the patient "read about brief psychotic disorder and feels it may fit" the patient's symptoms. The patient agreed to discontinue antipsychotic medication 1, start a different antipsychotic medication (antipsychotic medication 2), and taper off the mood stabilizer medication "as this is likely a cause for [the patient's] cognitive problems."

About three weeks later, psychiatrist 1 documented that the patient started antipsychotic medication 2, reported "low energy and mental slowing on it," and requested to reduce the dosage. Psychiatrist 1 decreased the dosage and recommended "longer-term pharmacotherapy." The patient reported a plan to discontinue medications in a few months and signed a release of information for another non-VA therapist. In early spring 2017, psychiatrist 1 documented the patient's sporadic noncompliance with taking antipsychotic medication 2. Psychiatrist 1 also noted the patient's report of "depressive feelings over several weeks, [with] low energy, increased sleep, which seem to be improving now."

Approximately five weeks later, in mid-spring 2017, the patient contacted the Ann Arbor VA call center and requested a new psychiatric provider and reported canceling a late spring 2017 appointment with psychiatrist 1. This same day, the patient met with a clinical pharmacist and reported not taking any medication currently, complained of anxiety and being misdiagnosed and having PTSD, requested a new provider, expressed interest in psychotherapy, and agreed to "any classes that may help." The clinical pharmacist explained the provider change process. The clinical pharmacist added psychiatrist 1 as an additional signer to the note and recommended a medication for anxiety (anxiety medication 1) and a group psychotherapy referral. In response to the patient's request to a medical support assistant for "an urgent appointment" with psychiatrist 1, psychiatrist 1 called the patient and noted the patient's paranoid ideation, declination of an

antipsychotic medication, and request to change providers. Psychiatrist 1 prescribed the recommended anxiety medication 1. The same day, in a meeting with social worker 1, the patient complained of anxiety symptoms including ruminative thoughts, flushing of the face, and an "elevated respiratory rate." Social worker 1 submitted a consult for a therapy group for depression, and 16 days later, staff discontinued the consult because the "patient did not respond" to the scheduling effort.[11]

The day after the patient contacted the call center, the patient securely messaged psychiatrist 1, "I would like to retain you as my primary psychiatrist." The same day, the patient and a family member (family member 3) presented to the Ann Arbor VA Emergency Department. The patient reported paranoid ideation and anxiety, discontinuation of mental health medication two months prior, initiation of the medication for anxiety the day prior, and reluctance to continue antipsychotic medications. A psychiatry resident physician (psychiatry resident physician 1) documented the patient's voluntary admission to the inpatient mental health unit "for crisis stabilization, diagnostic clarity, medication management, and maintenence [*sic*] of safety."

The next day, an inpatient psychiatrist (inpatient psychiatrist 1) documented initiation of an antipsychotic medication (antipsychotic medication 3). Also on this day, the patient signed a release of information for family members 1 and 3, and a friend. The next day, a social worker submitted a military sexual trauma consult. In response, a military sexual trauma coordinator (psychologist) consulted with psychiatrist 1 and a psychiatry resident physician (psychiatry resident physician 2) and documented that the patient's paranoid ideation should be stabilized prior to trauma-specific assessments and treatment.

Five days after admission, psychiatry resident physician 2 documented that the patient reported "clear" thinking, denied paranoid ideation, and would like to be discharged. Psychiatry resident 2 also documented that the patient requested an outpatient provider change, and agreed to restart anxiety medication 1 rather than continue another anxiety medication (anxiety medication 2) started during the admission, continue antipsychotic medication 3, and start an antidepressant medication.

The next day, the patient was discharged to home with scheduled appointments for outpatient psychiatry, case management, and group therapy. The patient was discharged with prescriptions for antipsychotic medication 3, anxiety medications 1 and 2, and the antidepressant medication. A social worker informed the patient about being assigned to another psychiatrist (psychiatrist 2) for outpatient care and about being scheduled for the next "Intro to Therapy" group beginning 14 days after discharge. The patient's discharge instructions identified both psychiatrist 2 and social worker 1 as the patient's MHTC. Psychiatry resident physician 2 entered the discharge summary

[11] Ann Arbor VA staff alternately refer to group treatment planning meetings as class and group. For purposes of this report, the OIG will use the term *identified* in the applicable documentation.

approximately three weeks after the patient's discharge and diagnosed the patient with unspecified schizophrenia spectrum and other psychotic disorder.

The day after discharge from the inpatient mental health unit, psychiatrist 2 met with the patient and documented a history of "unspecified psychotic disorder, [rule out] PTSD," and that the patient was continuing mental health medications and meeting with a non-VA therapist.[12] Approximately two weeks later, the patient canceled an appointment with psychiatrist 2. That same day psychiatrist 2 submitted a military sexual trauma consult and a Mental Health Clinic consult for a diagnostic assessment and treatment recommendations.[13] The patient canceled the next two scheduled appointments with psychiatrist 2, approximately one month and three months later, respectively.[14]

The patient attended three case management appointments with social worker 1 in spring 2017, and then in summer 2017, social worker 1 documented that the patient will not continue receiving case management given the patient's "sustained stability." In a military sexual trauma consultation the next day, a psychologist reviewed treatment "options that may be beneficial following" military sexual trauma. The psychologist and the patient agreed to defer treatment decisions until the patient completed diagnostic assessment to rule out symptoms "of psychosis that may warrant further stabilization and to confirm presence of" PTSD symptoms that would benefit from trauma treatment. A psychology intern completed a diagnostic assessment and recommended the patient continue medication management and participate in anxiety psychotherapy prior to engaging in intensive, trauma-focused treatment.[15] The psychology intern referred the patient to cognitive behavioral therapy for anxiety.

A social worker documented that the patient was scheduled for a treatment-planning class approximately a month later.[16] A PTSD social worker attempted to contact the patient twice in late summer 2017 to offer case management in the PTSD outpatient clinic, was unable to leave a voicemail message, and sent a letter.

Fall 2017

In late summer and fall 2017, the patient attended two treatment-planning group sessions. The treatment-planning group social worker submitted a therapy consult, and a program analyst was unable to contact the patient to schedule an appointment. The patient contacted the psychologist

[12] A provider may document a rule-out diagnosis when a patient presents with symptoms or signs suggesting a disorder and additional information is needed to confirm the diagnosis.

[13] In an interview with the OIG, psychiatrist 2 did not recall the circumstances for the consult submission.

[14] EHR documentation notes that the patient "cx [canceled] and will rs [reschedule]" the latter appointment.

[15] For licensure, doctoral psychology students are required to complete an internship program that provides "high-quality training in clinical practice and specialties." American Psychological Association, "Doctoral Internships," accessed December 11, 2023, https://www.apa.org/education-career/grad/internship.

[16] The patient's EHR documentation did not provide information about why the treatment planning group appointment was scheduled for approximately a month later.

and described "intense experiences related to speaking with [the patient's] doctor and friends/family about [the patient's] traumas," and an improved mood. The patient reported not taking "most" psychiatric medications. The patient agreed to complete further testing for diagnostic assessment and the psychologist "established a check-in session with Veteran in ~ [approximately] 2 weeks."

Four days after contacting the psychologist, the patient presented to the Ann Arbor VA Emergency Department with friends, and the patient reported being "emotionally abused" by a government agency. The patient's friends reported that the patient discontinued mental health medications and noticed worsened behavior in the last 30 minutes prior to arriving at the Emergency Department. Emergency Department staff administered an intravenous dose of a tranquilizer and an oral dose of an antipsychotic medication (antipsychotic medication 4) to the patient at 12:45 a.m. for agitation. A psychiatry resident physician (psychiatry resident physician 3) documented that the patient expressed paranoia related to the government agency, was "quite guarded," and "seemed to be minimizing symptoms." The patient's laboratory results indicated abnormalities that included low potassium and elevated creatinine, and staff administered potassium chloride in the Emergency Department.

An Emergency Department physician documented the patient's "acute psychosis," and initiated a petition for involuntary hospitalization to the inpatient mental health unit. Psychiatry resident physician 3 completed a clinical certificate and documented that the patient was involuntarily admitted due to the severity of the patient's delusions that placed the patient "at increased risk for unintentional harm to self or others," lack of insight, and likelihood of poor medication compliance or outpatient follow-up.[17]

The covering psychiatrist documented awareness of the patient's involuntary hospitalization and a differential diagnosis of paranoid schizophrenia, psychosis secondary to medical condition, and delusional disorder.[18] The patient reported "feeling well" and wanting to "leave the unit [as soon as possible]."

The following day, another psychiatry resident physician (psychiatry resident physician 4), under supervision of an inpatient psychiatrist (inpatient psychiatrist 2), documented that the patient "did not meet criteria for involuntary hospitalization/treatment and requested to be discharged."[19]

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[17] A clinical certificate is a "written conclusion and statements of a physician or a licensed psychologist that an individual is a person requiring treatment" that includes information and opinions that support the conclusion. Michigan Mental Health Code § 330.1400, 330.1430, and 330.1431.

[18] Cleveland Clinic, "Differential Diagnosis," accessed January 4, 2024, https://my.clevelandclinic.org/health/diagnostics/22327-differential-diagnosis. A differential diagnosis "is a list of possible conditions that could cause" a patient's symptoms. Through assessment techniques, a provider may "rule out conditions" and finalize a diagnosis.

[19] The documentation indicated that psychiatry resident physician 4 dictated the information the day after the patient's admission, the dictation was entered into the EHR six days later, and inpatient psychiatrist 2 signed the documentation for psychiatry resident physician 4 the following day.

In the discharge summary, psychiatry resident physician 4 diagnosed the patient with unspecified psychotic disorder and noted that the patient acknowledged "paranoid thoughts about people trying to assess [the patient]," had impaired insight, "was not interested in starting a medication during this admission," and was interested in following up with the psychologist for therapy.

In a treatment-planning group the day after discharge, the patient reported PTSD treatment as the "first step" to address "struggles currently." The next day, the patient did not present to a scheduled appointment with a social worker (social worker 2). That day, social worker 2 was unsuccessful in reaching the patient by phone and the following day, an administrative staff member sent the patient a letter.

Approximately a week later, the psychologist and patient discussed completion of diagnostic testing and four to six months of psychotic symptom stabilization prior to the patient's engagement in trauma-focused treatment. The patient declined the psychologist's recommendations for medication management, general anxiety treatment, and a follow-up psychology appointment. The patient agreed to continue meeting with social worker 1 "to monitor discharge functioning." After the patient canceled an appointment, psychiatrist 2 called the patient to inquire about the cancellation and the patient's plan to not take medications. The patient reported feeling "much better" and declined psychiatrist 2's offer for an appointment every three to four months.

Social worker 1 called the patient after the patient missed an appointment and the patient declined further sessions and reported only wanting to attend appointments with the "medication provider." A medical support assistant unsuccessfully attempted to contact the patient to reschedule the appointment with social worker 1. The same day, a Mental Health Clinic administrative staff member sent the patient a letter regarding the change of MHTC from psychiatrist 2 to social worker 1. Later that week, the patient presented for an appointment and an advanced medical support assistant documented that the patient was "clearly frustrated" when informed of not having an appointment. When asked for the name of the provider, the patient "replied I am done with the VA," and left the clinic after the advanced medical support assistant offered to provide assistance. The following day, social worker 1 left the patient a voicemail message.

2021

The next EHR documentation entry occurred in winter 2021. An Ann Arbor VA suicide prevention coordinator documented an unsuccessful phone contact attempt and sent the patient a letter that stated, "we noticed that it's been some time since you were involved in VA Mental

Health Care" and the suicide prevention team was "available if you are in need of additional support."[20]

VHA Care Coordination with Non-VA Agencies Late Spring through Mid-Fall 2021

In late spring 2021, a veteran services officer informed an Iron Mountain VA social worker that the patient's family filed a petition "for evaluation of need for acute inpatient psychiatric care" at a non-VA hospital.[21] The veteran services officer reported that the patient was "not on medications" and exhibited psychotic symptoms, such as believing a government agency was "'controlling [the patient] electronically.'" The veteran services officer stated that the patient "will not have anything to do with anyone from the VA," and was admitted to the non-VA hospital involuntarily. The Iron Mountain VA social worker verified that the patient was eligible for VA care and informed the veteran services officer that the patient "will be covered."

On day 1 in early fall 2021, a non-VA mental health agency social worker (non-VA social worker 1) informed a Battle Creek VA transfer coordinator (transfer coordinator) that the patient was admitted to a non-VA behavioral center for over two weeks with diagnoses of PTSD and delusional disorder and requested the patient be transferred to the inpatient mental health unit or MH RRTP. During the admission, the patient was prescribed another antipsychotic (antipsychotic medication 5) in a monthly injection and oral dose. A social worker at the non-VA behavioral center (non-VA social worker 2) told the transfer coordinator that the patient was not on one-to-one observation, and the transfer coordinator faxed a transfer packet.

On day 5, the patient was admitted to a non-VA residential crisis unit for crisis stabilization. Three days later, the transfer coordinator contacted a non-VA mental health agency case manager (case manager) who reported that the patient was "not currently in need of acute [level of care]." The case manager "reported interest in" RRTP for the patient, and the transfer coordinator provided contact information. On day 11, a non-VA residential crisis unit provider documented that the non-VA agency staff was trying to get the patient "set up for services with the VA in Saginaw. The goal is to get help with housing and set up with VA medical/psychological services."

On day 13, a Saginaw VA social worker explained to a non-VA residential crisis social worker intern what the patient would need to provide to establish eligibility for VA services. The same day, a Saginaw VA medical support assistant scanned the patient's military discharge papers and the VA application for health care form in the patient's EHR. The Saginaw VA social worker

[20] In an interview with the OIG, the suicide prevention coordinator reported that this contact attempt was part of an outreach pilot program to patients who had discontinued mental health treatment.

[21] Veteran services office staff assist veterans in submitting claims for benefits.

contacted the patient and then sent the patient's information "to eligibility to ascertain the Veteran [*sic*] current eligibility status."

The Saginaw VA social worker notified the patient of VA care eligibility and noted that the patient "was calm, cooperative but appeared to be confused and depressed." When asked about legal status and housing, the patient suggested that the Saginaw VA social worker speak with a non-VA residential crisis unit staff member "and handed the phone to a staff person." The non-VA residential crisis unit staff member explained the patient's alternative treatment order and "that they were not clear on where the Veteran could reside or what other things that they [*sic*] court had ordered."[22]

The Saginaw VA social worker requested that a Saginaw VA Veterans Justice Outreach (VJO) social worker (Saginaw VA VJO social worker) "meet with the Veteran to have the necessary releases of information signed" and to "figure out what to [do] next to assist the Veteran." The Saginaw VA social worker included the Saginaw VA VJO social worker as an additional signer on the note.[23] The Saginaw VA VJO social worker scheduled an appointment with the patient for the next day (day 14) at the non-VA residential crisis unit.

Additionally on day 13, the case manager contacted the Saginaw VA social worker and requested that the patient "be enrolled in services with" the Saginaw VA and "woud [*sic*] like the Veteran to go to the Battle Creek" VA RRTP. The Saginaw VA social worker explained the RRTP referral process and that the Battle Creek VA RRTP staff would complete an assessment to determine RRTP appropriateness.

Over the next two days (days 14 and 15), the Saginaw VA VJO social worker completed an assessment of the patient, requested the police referral and court order from the county court, and unsuccessfully attempted to contact staff at the non-VA mental health agency and the non-VA residential crisis unit. On day 18, the case manager told the Saginaw VA VJO social worker that the patient's care was court ordered and that the non-VA mental health "agency's preferred

[22] Michigan's alternate treatment order is a petition filed on behalf of a patient that orders an alternative to incarceration, including hospitalization or outpatient care, that meets the patient's mental health treatment needs. An agency or mental health professional supervises the "individual's assisted outpatient treatment program." If the patient refuses to comply with the court order, a police officer can intervene and transport the patient to a hospital. Michigan law was amended effective 2019 to delete alternative treatment orders, replaced by initial orders of various lengths of time providing hospitalization not exceeding 60 days, assisted outpatient treatment not exceeding 180 days, or a combination of hospitalization and assisted outpatient treatment not exceeding 180 days. Michigan Mental Health Code § 330.1472(a).

[23] The VJO Program staff identifies "identify justice-involved Veterans and contact them through outreach, in order to facilitate access to VA services at the earliest possible point." VHA, "Veterans Justice Outreach Program," accessed October 31, 2023, https://www.va.gov/HOMELESS/VJO.asp.

direction" was for the patient to have a VA psychiatric evaluation and be referred to the Battle Creek VA PTSD Residential Rehabilitation Treatment Program (PTSD RRTP).[24]

On day 21, the Saginaw VA VJO social worker and the patient discussed the non-VA agency's legal authority for the patient's care and the recommendation for the patient to receive inpatient mental health treatment. The patient agreed to a Battle Creek VA PTSD RRTP referral with the understanding that if the patient was not accepted or "did not wish to enter, then [VA] would need to work with the" non-VA agency "to determine if alternate planning, such as outpatient therapy, may be acceptable." The Saginaw VA VJO social worker updated the case manager regarding "referral to Battle Creek, as well as possible outpatient options in [the] event Battle Creek is not able to accept [the] Veteran at this time."

On day 27, the Saginaw VA VJO social worker informed the case manager that the Battle Creek VA RRTP staff had concerns that the patient "did not yet have a diagnosis of PTSD," and the case manager provided a report that included the non-VA mental health agency social worker's evaluation of the patient that included a PTSD diagnosis and noted that the patient "would appear to meet criteria for PTSD although [the patient] did answer in the negative for all 5 PTSD screening questions."

On day 32, the Saginaw VA VJO social worker was unable to reach the case manager or the case manager's supervisor (non-VA agency supervisor). The Saginaw VA VJO social worker contacted the non-VA residential crisis unit staff member "to determine if [the]Veteran would be moved to a different location or not." The non-VA residential crisis unit staff member reported being unable to reach the case manager as well and that the patient might be moved to an adult foster care home. On day 39, the patient was admitted to the adult foster care home.

The following week, on day 41, the Battle Creek VA transfer coordinator received an inpatient mental health transfer request from a Michigan state veteran liaison.[25] The transfer coordinator explained the transfer process, provided the MH RRTP contact information, and requested notification if an inpatient mental health transfer was warranted. On the same day, a Michigan state veteran navigator contacted the transfer coordinator to inquire about inpatient mental health transfer.[26] The transfer coordinator explained that the patient would need to be assessed to determine the medical necessity and the patient's medical stability for an inpatient mental health

[24] PTSD RTTPs are specialized MH RRTPs that "provide a safe, supportive, and structured environment for Veterans diagnosed with PTSD and co-occurring disorders." VHA Directive 1162.02.

[25] The veteran liaison worked for the Michigan Department of Health & Human Services, Behavioral Health and Developmental Disabilities Administration.

[26] Michigan Department of Health and Human Services veteran navigators assist veterans and their families in connecting to resources to address needs including mental health, substance abuse, and housing. "Veteran Navigators," (webpage) Michigan Department of Health and Human Services, accessed October 26, 2023, https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/veteran-navigators.

admission. The veteran navigator was "unsure when/if this would be completed," and planned to contact the case manager and notify the transfer coordinator of the "outcome."

Two days later, on day 43, a Battle Creek VA community care nurse (community care nurse) received a call from the veteran navigator "requesting a PTSD bed" for the patient, who was placed in a temporary adult foster care home. The community care nurse notified a Battle Creek VA MH RRTP social worker (MH RRTP social worker) with contact information for the veteran navigator and the adult foster care home. That day, the MH RRTP social worker provided the veteran navigator with information on the MH RRTP referral process.

On the same day, the Saginaw VA VJO social worker provided the patient's background information to a Battle Creek VA VJO social worker and requested the patient be referred to the Battle Creek VA PTSD RRTP. The Saginaw VA VJO social worker also requested the Battle Creek VA VJO social worker assume "VJO Case Management to ensure continued advocacy for Veteran's needs." The Battle Creek VA VJO social worker documented being unable to place an MH RRTP consult because "there is no criminal legal issue and no established VA care" and having "reached out to residential care screening team to inquire further as it appears there was already contact made regarding this Veteran and residential care."

A week later on day 50, the transfer coordinator unsuccessfully attempted to contact the veteran navigator regarding the status of the transfer request. The transfer coordinator notified the non-VA agency supervisor that the patient "would need to be assessed either at a VA, or at another hospital to determine medical necessity" and medical stability for inpatient mental health admission or "lower level of care." The non-VA agency supervisor agreed to "check on status of veteran" and notify the transfer coordinator. The transfer coordinator also reached out to the veteran liaison, who planned to check on the patient's status and notify the transfer coordinator.

Later on day 50, the Battle Creek VA associate chief of staff for mental health (ACOS) contacted family member 3 "to determine if the Veteran had any current needs or if transfer to the VA was needed at this time." The Battle Creek VA ACOS documented in the patient's EHR that family member 3 reported that the patient died that morning from cardiac arrest.

EHR Documentation Following the Patient's Death

Ten days after the patient's death, a Saginaw VA administrative staff member scanned non-VA agency mental health report and court records into the patient's EHR. Four days later, on day 64, a VISN 12 medical administrative specialist documented that family member 1 provided notification that the patient died on day 50. On day 82, the Saginaw VA social worker documented receiving a call from a non-VA residential crisis unit staff member who "was still working on benefits for the Veteran" and the patient's family. The Saginaw VA social worker documented being able to "neither confirm nor deny anything in regards [*sic*] to the Veteran at this time."

Approximately three months later, a Battle Creek VA advanced medical support assistant documented receiving notification that the patient was deceased.

In early fall 2022, a Saginaw VA psychologist reviewed the patient's medical records and completed a compensation and pension examination. The Saginaw VA psychologist diagnosed the patient with PTSD, unspecified schizophrenia spectrum and other psychotic disorder, and undiagnosed history of traumatic brain injury by self-report. The Saginaw VA psychologist concluded that the patient's PTSD was likely "incurred in or caused by the claimed in-service injury, event, or illness" that the patient experienced during military service.

Inspection Results

1. Assessments of PTSD, Toxic Exposure, and TBI

PTSD Assessment

The OIG determined that Ann Arbor VA staff considered a PTSD diagnosis and assessment throughout the patient's care and based on reasonable medical decision-making, planned to assess PTSD symptoms upon stabilization of the patient's psychotic symptoms. However, the patient discontinued treatment in fall 2017 and a PTSD evaluation was not completed.

Since 2004, VHA requires a detailed assessment of symptoms when patients are "presumed to have symptoms of PTSD" or screen positive for PTSD.[27] At the patient's initial mid-fall 2015 primary care appointment the patient screened negative for PTSD. In an early 2016 diagnostic interview, the patient denied symptoms of PTSD. Psychiatrist 1 diagnosed the patient with a "resolved" adjustment disorder and "[rule out] unspecified depressive disorder," and planned follow-up "only as-needed."

Approximately one year later in early 2017, the patient and family member 2 told psychiatrist 1 about problems the patient "was experiencing related to 'PTSD'." In an interview with the OIG, psychiatrist 1 reported that the treatment goals were to stabilize the patient's psychotic symptoms and continue assessing for PTSD. Psychiatrist 1 told the OIG that "The goal was to stabilize [the patient's] psychosis with antipsychotics and then keep assessing [the patient] in terms of PTSD symptoms, other symptoms, but I thought that the psychosis was the most pressing concern at that point."

[27] VA/DoD, *Clinical Practice Guideline for the Management of Post-Traumatic Stress*, January 2004; The 2004 guidelines were built on by VA/DoD, *Clinical Practice Guideline for the Management of Post-Traumatic Stress*, October 2010. The 2010 guidelines were replaced by VA/DoD, *Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder*, June 2017. The 2017 document was replaced by VA/DoD, *Clinical Practice Guideline for Management of Posttraumatic Stress Disorder and Acute Stress Disorder*, June 2023. Unless otherwise specified, the 2017and 2023 guidelines contain the same or similar language regarding the assessment of PTSD symptoms as the 2004 and 2010 guidelines.

In spring 2017, the patient and family member 3 presented to the Ann Arbor VA Emergency Department with concerns about the patient's "paranoia and anxiety," and reported discontinuation of mental health medications and reluctance to continue antipsychotic medications. Psychiatry resident physician 1 documented the patient's voluntary admission to the inpatient mental health unit with a diagnosis of rule out PTSD. The psychologist documented that psychiatrist 1 recommended "stabilization of paranoia prior to consideration of trauma-specific evaluation/services." Inpatient psychiatrist 1 documented that the patient's discontinuation of antipsychotic medication may have contributed to the symptom relapse. Inpatient psychiatrist 1 told the OIG that the patient's diagnosis was unclear and that the focus of treatment was "stabilizing the acute anxiety and paranoia, so [the patient] could sleep and so [the patient] could function."

While admitted, the patient requested a change of psychiatric provider and psychiatrist 2 was assigned. In the patient's first outpatient appointment following discharge, psychiatrist 2 documented the patient's history of "unspecified psychotic disorder, [rule out] PTSD," and a plan for the patient to continue taking medications, attending non-VA psychotherapy, and returning to the clinic in one month or sooner as needed.

Approximately two weeks later, psychiatrist 2 documented the patient's "significant trauma history and worsening paranoia," and submitted a consult for a diagnostic assessment. Psychiatrist 2 diagnosed the patient as "delusional disorder versus schizophrenia," and noted that the "veracity of reported trauma" complicated the diagnosis. A psychology intern documented, "Although PTSD was not fully assessed in this evaluation," the patient reported distress related to sexual trauma. The psychologist documented that PTSD assessment was not completed based on the patient's "complicated clinical presentation and recent hospitalization" and recommended that trauma symptoms be assessed following treatment to manage anxiety and emotional distress.

In fall 2017, the psychologist documented a plan for the psychology intern to contact the patient to schedule further PTSD assessment. Four days later, the patient was readmitted to the mental health unit with a diagnosis of unspecified psychotic disorder. Following discharge, the patient attended an individual PTSD therapy session and the psychologist documented discussing completion of diagnostic testing for PTSD and four to six months of psychotic symptom stabilization prior to the patient's engagement in trauma-focused treatment. The patient declined follow-up treatment with the psychologist, psychiatrist 2, and social worker 1 and did not re-engage in Ann Arbor VA care.

The OIG determined that given the patient's psychotic symptoms and impaired functioning, Ann Arbor VA providers appropriately focused on stabilization and management prior to completing further PTSD assessment.

Toxic Exposure Screening

The OIG found that Ann Arbor VA staff screened the patient for toxic exposure and provided the patient with relevant information to proceed with toxic exposure evaluation as required by VHA.[28]

VHA recognizes that exposure to a range of environmental and chemical hazards (toxic exposure) during military service has "the potential to produce adverse health effects, either alone or in combination."[29] Exposure to environmental hazards such as sand, dust, smoke, and fumes can cause respiratory and other illnesses.[30] The VHA Office of Health Outcomes Military Exposures manages registry programs that provide eligible veterans the opportunity to report toxic exposures and health problems.[31] In the early 1990s, VA created an official electronic record of Gulf War veterans to evaluate potential health problems related to toxic exposure and to improve veterans' health care.[32] Since 2007, VHA requires staff to encourage eligible veterans seeking VHA treatment to complete an initial registry examination.[33]

In late fall 2015, a social work intern completed a post-9/11 transition and case management needs assessment by telephone with the patient. When the social work intern screened the patient for environmental exposure, the patient expressed concern about exposure during deployment. The social work intern "discussed and educated" the patient regarding the registry, how to self-refer for a registry examination, and provided the registry examination contact information.[34]

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[28] VHA Handbook 1303.02, *Gulf War (Including Operation Iraqi Freedom) Registry (GWR) Program (Formerly Persian Gulf (GWR) Program)*, June 5, 2007, rescinded and replaced by VHA Directive 1325, *Gulf War Registry*, June 1, 2017. The 2017 directive was rescinded and replaced by VHA Directive 1308, *Health Outcomes Military Exposures Registry Programs*, March 25, 2022. VHA Handbook 1303.02 and VHA Directive 1325 were in effect during the time of the patient's care. Unless otherwise specified, the 2022 directive contains the same or similar language regarding the Gulf War Registry examination requirements as the 2007 and 2017 documents.

[29] VHA Handbook 1303.02; VHA uses the term "military exposure" and notes that "Military exposure is sometimes called toxic exposure." Toxic agents may include nuclear, biological, chemical and non-ionizing radiation and other waves (e.g., sound, electromagnetic waves of various frequencies.); "Iraq War Exposures" (web page), VA, accessed August 29, 2023, https://www.publichealth.va.gov/exposures/wars-operations/iraq-war.asp.

[30] "Airborne Hazards and Burn Pit Exposures" (web page), U.S. Department of Veterans Affairs, accessed August 29, 2023, https://www.publichealth.va.gov/exposures/burnpits/index.asp.

[31] VHA Handbook 1303.02; VHA Directive 1325; VHA Directive 1308; VHA Directive 1308 establishes the Office of Health Outcomes Military Exposures within the Office of Patient Care Services; "About Health Outcomes Military Exposures" (website), U.S Department of Veterans Affairs, accessed April 6, 2023, https://vaww.publichealth.va.gov/about/post-deployment/index.asp. (This website is not publicly accessible.)

[32] VHA Handbook 1303.02; VHA Directive 1325; VHA Directive 1308; "About Health Outcomes Military Exposures" (website), VA.

[33] VHA Handbook 1303.02; VHA Directive 1325; VHA Directive 1308.

[34] The OIG was unable to confirm the patient's follow-up due to an absence of EHR documentation.

The OIG concluded that Ann Arbor VA providers screened the patient for toxic exposure and encouraged the patient to report concerns and provide contact information, as required by VHA.[35]

TBI Assessment

The OIG found that Ann Arbor VA staff screened the patient for TBI as required by VHA, and the TBI screen was negative.[36] Further, psychiatrists 1 and 2 did not consider TBI to be a critical component of the patient's clinical presentation and, therefore, did not include further TBI evaluation or treatment in the patient's care.

Since 2007, VHA requires "post 9/11" veterans to be screened for TBI to ensure provision of "appropriate treatments and services" upon entry into VA health care.[37] VHA also requires TBI screening for patients having served in combat operations and whose "date of separation from military duty or active duty status occurred after September 11, 2001" with further evaluation for patients who screen positive.[38]

In fall 2015, during an initial primary care appointment, the patient reported multiple head traumas during military service that resulted in "being dazed, confused" immediately following the injury, and subsequent headaches and sleep problems. The patient denied current related symptoms and the TBI screen result was negative. The primary care resident physician documented that the patient was at "low threshold for neurology evaluation for TBI" and placed a mental health consult for evaluation and treatment of "multiple stressful exposures."

In mid-winter 2016, psychiatrist 1 documented the patient's report of multiple head traumas during military service. In an interview with the OIG, psychiatrist 1 described considering the patient's reported history of head trauma, the patient's presentation, and achievements and concluded that the head injury did not contribute to the patient's clinical presentation. Psychiatrist 2, who met with the patient in mid-spring 2017, told the OIG that TBI was not part

[35] VHA Handbook 1303.02; VHA Directive 1325; VHA Directive 1308.

[36] VHA Directive 2010-012, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*, March 8, 2010, rescinded and replaced by VHA Directive 1184, *Screening and Evaluation of Traumatic Brain Injury (TBI) in Operation Enduring Freedom (OEF) Operation Iraqi Freedom (OIF) and Operation New Dawn (OND) Veteran*, April 6, 2017. The 2017 directive was rescinded and replaced by VHA Directive 1184, *Screening and Evaluation of Post-9/11 Veterans for Deployment-Related Traumatic Brain Injury*, January 3, 2022. Unless otherwise specified, the 2022 directive contains the same or similar language regarding TBI screening as the 2010, and 2017 directives.

[37] VHA Directive 2007-013, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans, April 13, 2007*; VHA Directive 2010-012; VHA Directive 1184 (2017); VHA Directive 1184 (2022). The 2022 directive reflects the change to "post-9/11" veterans from Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn veterans.

[38] VHA Directive 2010-012; VHA Directive 1184.

of the patient's "diagnostic picture." In early summer 2017, the psychology intern noted that the patient denied a history of TBI.

The OIG concluded that Ann Arbor VA providers screened the patient for TBI as required by VHA and adequately considered the patient's history of head trauma in the formulation of the patient's diagnoses and treatment plans.[39]

2. Insufficient Fall 2017 Inpatient Mental Health Unit Treatment and Discharge Care Coordination

The OIG found that prior to the patient's discharge from the inpatient mental health unit in fall 2017, Ann Arbor VA inpatient mental health unit providers failed to sufficiently

- assess the severity of the patient's mental health condition and treatment needs prior to discharge,
- consider the ongoing therapeutic effect of medication administered in the Emergency Department and inpatient structured environment on the patient's clinical presentation,
- address the patient's laboratory testing abnormalities, and
- facilitate post-discharge care coordination with outpatient providers.

Failure to Sufficiently Assess the Patient's Condition

For a voluntary inpatient mental health unit admission in Michigan, a physician documents that the patient is "clinically suitable for formal voluntary admission," and the patient signs a statement that specifies the patient's understanding that the patient may be kept there for up to three days, excluding Sundays and holidays, after the patient provides written notice of intention to leave the hospital.[40]

VHA requires providers to manage involuntary mental health admissions (involuntary admission) in accordance with state law and to conduct ongoing evaluation of continued need for involuntary status for admitted patients for treatment purposes.[41] Ann Arbor VA policy specifies involuntary admission for a patient who

[39] VHA Directive 2010-012; VHA Directive 1184, April 6, 2017.

[40] Mich. Admin. Code § R. 330.4077(1)(b) and (2) (AACS 2017).

[41] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language regarding involuntary mental health admissions as the 2013 handbook. The 2013 handbook requirements regarding ongoing evaluations related to involuntary mental health admissions is not included in the 2023 directive, and instead instructs VHA medical centers to develop clear guidelines for involuntary hospitalization.

- "can be reasonably expected within the near future to intentionally or unintentionally seriously injure" self or others;
- "is unable to attend to those of his basic physical needs such as food, clothing, or shelter, that must be attended to in order . . . to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic needs"; and
- is unable to understand the need for treatment and "whose continued behavior as a result of this mental illness can be reasonably expected . . . to result in significant physical harm" to self or others.[42]

In Michigan, to admit a patient involuntarily, a provider must complete a petition to the state probate court and a clinical certificate.[43] Further, another psychiatrist must examine the patient within 24 hours of admission, excluding legal holidays, and complete a second clinical certificate.[44]

In fall 2017, approximately five months after the patient's spring 2017 inpatient mental health unit admission, friends accompanied the patient to the Emergency Department around midnight of a legal holiday due to "increasing erratic behavior" and statements about being monitored by a government agency. Emergency Department staff administered an intravenous dose of a tranquilizer and an oral dose of antipsychotic medication 4 to the patient at 12:45 a.m. for agitation. An Emergency Department physician noted "significant concern" that the patient posed a safety risk and would not be able to "recognize a dangerous situation such as walking into traffic." At 3:42 a.m., the Emergency Department physician initiated a petition for the patient's involuntary hospitalization based on the patient's "significant delusions, unable to follow safety instructions" and "in current mental state, unable to perform basic [activities of daily living], reliably take psychiatric meds, or ensure basic safety." Psychiatry resident physician 3 completed a clinical certificate and noted that the patient was at risk of unintentional harm to self and others due to paranoid delusions and psychosis.

The patient was then admitted to the inpatient mental health unit involuntarily and later that morning told a psychiatrist covering the inpatient mental health unit on the holiday (covering

[42] Ann Arbor VA Policy Memorandum 116-03, *Involuntary Hospitalization/Treatment of Patients with Mental Illness/Disorder,* June 29, 2016. This policy memorandum was in place during the time of the events discussed in this report. It was rescinded and replaced by Ann Arbor VA Policy Memorandum 116-03, *Involuntary Hospitalization/Treatment of Patients with Mental Illness/Disorder,* August 7, 2019. Unless otherwise specified, the 2019 policy memorandum guidelines contains the same or similar language regarding involuntary mental health hospitalization legal requirements as the 2016 version.

[43] A clinical certificate is a "written conclusion and statements of a physician or a licensed psychologist that an individual is a person requiring treatment" that includes information and opinions that support the conclusion. Michigan Mental Health Code § 330.1400 Definitions.

[44] Michigan Mental Health Code § 330.1430.

psychiatrist) about wanting to the leave the unit as soon as possible.[45] The covering psychiatrist noted that the patient was on an involuntary admission and that the patient was paranoid and delusional but appeared "better than described by the" Emergency Department physician "probably due to" antipsychotic medication 4 administered in the Emergency Department. That evening, approximately 18.5 hours after the patient received antipsychotic medication 4, another psychiatrist entered orders for a voluntary admission and the patient signed the Michigan state voluntary admission paperwork.[46] The patient refused antipsychotic medication 4 that evening.

The following day, inpatient psychiatrist 2 evaluated the patient with psychiatry resident physician 4 and documented that the patient was "quite averse" to taking medication and that, "at this time, there [were] no grounds for involuntary hospitalization." Inpatient psychiatrist 2 documented that the patient's judgment was "fair" based on the patient's willingness to come to the VA and to be admitted voluntarily and noted "However, patient does not believe" antipsychotic medication was warranted. Inpatient psychiatrist 2 documented discussing "with patient [the treatment team's] belief that medication could be helpful" and that the patient appeared to be functioning at a "high level."

Inpatient psychiatrist 2 noted that the patient denied hallucinations and delusions and that the patient's "risk factors for suicide" included paranoid delusions and medication noncompliance that "are best addressed by the patient's participation in outpatient care." Inpatient psychiatrist 2 documented that the patient "did not meet criteria for involuntary hospitalization" and was "appropriate for discharge."

In contrast to the covering psychiatrist's documented assessment, inpatient psychiatrist 2 told the OIG about not feeling that antipsychotic medication 4 "was making that big of a difference for [the patient]" and "we did not see any evidence that [the patient] was not attending to [activities of daily living]." Inpatient psychiatrist 2 told the OIG that the Emergency Department physician was "infamous . . . for over-sedating people," and therefore, inpatient psychiatrist 2 considered the assessment of the patient as "un-directable and agitated" in the Emergency Department prior to medication administration, "very much with a grain of salt." Inpatient psychiatrist 2 acknowledged that the patient's insight at the time of discharge was "not particularly good" and that the patient "would be better off with medications," though the patient "didn't see that." The OIG found that inpatient psychiatrist 2's disregard of the Emergency Department physician's observations and assessment of the severity of the patient's unmedicated presentation, that met

[45] Inpatient psychiatrist 2 told the OIG that the covering psychiatrist provided coverage on the legal holiday.

[46] DCH-0086, Formal Voluntary Admission Application-Adult. Michigan Department of Health and Human Services, April, 2019, accessed June 24, 2024, https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.michigan.gov%2Fmdhhs%2F-%2Fmedia%2FProject%2FWebsites%2Fmdhhs%2FKeeping-Michigan-Healthy%2FMental-Health%2FRecipient-Rights%2FDCH-0086_653546_7.dotx%3Frev%3Daf55059213934fe09d6b65630a579a52%26hash%3D7D331C0C05039512099A2E986508D669&wdOrigin=BROWSELINK.

involuntary admission criteria, contributed to inpatient psychiatrist 2's failure to accurately understand the patient's underlying condition.

Additionally, inpatient psychiatrist 2 told the OIG that the evaluation occurred in the morning. The OIG estimated that the patient received antipsychotic medication 4 between 31 and 35 hours prior.[47] The amount of time for half of the antipsychotic medication 4 dose to be eliminated from the blood ranges from 21 to 54 hours and tends to be longer for non-smokers such as this patient. In addition, elimination of the medication from the brain would be somewhat delayed compared to elimination from the blood leading to a longer continuation of therapeutic effect.

Based on these factors, the OIG determined that the patient was likely benefiting from antipsychotic medication 4 at the time of inpatient psychiatrist 2's evaluation; therefore, inpatient psychiatrist 2 could not sufficiently evaluate the patient's underlying mental health condition. Given the patient's refusal to take medications, the OIG would have expected a longer monitoring interval to assess the patient's condition when truly free of antipsychotic effects.

Inpatient psychiatrist 2 did not document considering the therapeutic influence of the inpatient mental health unit environment that provided an organized structure for activities of daily living such as eating and sleeping and did not require the patient's independent actions such as shopping and cooking to ensure basic nutritional needs. These considerations were especially critical given the patient's abnormal laboratory test results that suggested a long-term neglect of nutritional needs as discussed below.

When asked by the OIG about consideration of admitting the patient involuntarily, inpatient psychiatrist 2 stated that, ". . . in light of the criteria under Michigan law, there was no evidence that [the patient] was thinking of harming" self and others, and the patient "was attending to" activities of daily living. However, the OIG determined that at the time of discharge, the patient could have been retained legally on the voluntary admission for an additional 50 hours, and therefore the inpatient mental health unit providers did not have an immediate need for consideration of involuntary admission.[48]

The OIG concluded that inpatient psychiatrist 2's failure to consider the patient's initial unmedicated presentation that reflected mental health deterioration, probable therapeutic responses to administered medication, and the inpatient mental health unit structured environment, likely contributed to an underestimation of the severity of the patient's mental health condition and ultimately a failure to treat the patient effectively.

[47] The OIG was unable to determine the exact time of inpatient psychiatrist 2's evaluation because of the absence of this information in the documentation. The OIG team considered 8:00 a.m. to noon as the morning for this estimate.

[48] The patient was initially on an involuntary admission status for a little more than 15 hours. The patient then remained on a voluntary admission status for 22 hours and could have been retained for up to 72 hours on the voluntary admission status.

Discharge Care Coordination Deficiencies

Insufficient Consideration of Abnormal Laboratory Results

At the time of the patient's 2017 care, VHA required that medical needs of patients on an inpatient mental health unit were "addressed in a timely fashion and that follow-up medical care is coordinated upon discharge."[49]

When the patient presented to the Emergency Department in fall 2017, the patient's laboratory testing results indicated low potassium, sodium, chloride; elevated blood urea nitrogen, bilirubin, and creatinine; and ketones in the urine that might indicate nutritional insufficiency or a medical problem. Also, low potassium could lead to a cardiac rhythm disturbance or mental confusion. Emergency Department staff administered potassium chloride to the patient to correct the low level. The patient's potassium level was rechecked approximately 7 and 25 hours after the initial laboratory testing and results were in the low-normal range. Further, the patient's white blood cell count was elevated upon admission and discharge and could have indicated an infection or an underlying medical condition.

The OIG found that providers did not address the potential causes of the laboratory result abnormalities and did not include monitoring of the patient's potassium level, other indicators of metabolic disturbance, and white blood cell count in the discharge plan. Based on the patient's mental health condition and the possibility of the patient's diminished ability to effectively perform activities of daily living, such as nutritional intake, the OIG would have expected Ann Arbor VA providers to have addressed these concerns by (1) discussing activities of daily living needs with the patient; (2) considering retaining the patient in inpatient mental health treatment to adequately address these problems; or at a minimum, (3) alerting outpatient providers of the need for follow-up in these areas.

Inadequate Outpatient Care Plan

At the time of the patient's care, VHA advised that for outpatient care planning "it is preferable for the patient to meet the outpatient provider prior to discharge" from an inpatient mental health unit to "provide a linkage with outpatient care, and actively involve the patient in planning the follow-up appointment in order to support the patient to engage in continued care after discharge."[50]

Since 2012, VHA requires that patients are assigned a MHTC to promote continuity of care during transitions between levels of care, such as discharge from an inpatient mental health unit

[49] VHA Handbook 1160.06, September 16, 2013; VHA Directive 1160.06, September 27, 2023. The 2023 directive does not include the requirement for attention to patients' medical needs.

[50] VHA Handbook 1160.06, September 16, 2013; VHA Directive 1160.06, September 27, 2023. The 2023 directive requires the inpatient mental health unit team to coordinate care with outpatient providers and does not advise the outpatient provider to meet with the patient prior to discharge to support the patient in transition.

to outpatient mental health care, and to foster patients' engagement in treatment.[51] VHA requires staff to coordinate patients' inpatient mental health unit discharges with the assigned MHTC.[52]

MHTCs serve as patient's point of contact and must ensure

- regular contact with patients as clinically indicated,
- communication with patients about problems or concerns with treatment, and
- continual awareness of patients' mental health treatment goals.[53]

VHA requires staff to document MHTC assignments and reassignments in a patient's EHR using the note title "MHTC Assignment/Reassignment Note." Further, staff must document the rationale for changes in MHTC assignments and confirmation that the patient was "involved and informed" to "ensure a successful handoff."[54]

The OIG found that, although included as the patient's MHTCs in discharge instructions, psychiatrist 2 and social worker 1 did not assume the responsibilities of the MHTC and failed to foster the patient's continuity of care. During the late spring 2017 inpatient mental health unit admission, the patient requested a provider change and was transferred from psychiatrist 1 to psychiatrist 2.[55] The patient's discharge instructions identified both psychiatrist 2 and social worker 1 as the patient's MHTC. The day after discharge, the patient met with psychiatrist 2 who continued the same medications and planned for the patient to return in one month. Within the next four months, the patient canceled three scheduled appointments with psychiatrist 2.

The patient met with social worker 1 for case management twice during the month of discharge and then in a visit two months later, at which time the patient agreed to discontinue case management based on the patient's "sustained stability." In the final visit note, social worker 1 wrote that the patient attributed doing well to medication management and the plan included meeting with psychiatrist 2 for medication management.

The OIG found that during the following three months, the patient did not refill medications to maintain compliance. The patient participated in sessions with the psychologist during that time. However, the OIG found that the psychologist did not document the patient's medication compliance and the lack of follow-up with psychiatrist 2. The psychologist told the OIG that

[51] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

[52] VHA Handbook 1160.06, September 16, 2013; VHA Directive 1160.06 September 27, 2023; Unless otherwise specified, the guidelines regarding the MHTC coordination during inpatient mental health unit admissions in the 2023 directive contain the same or similar language as the 2013 handbook.

[53] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum, attachment A.

[54] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

[55] In winter 2016, psychiatrist 1 documented being the patient's assigned MHTC in a progress note.

medication issues were discussed with the patient and that the patient sometimes reported wanting medication and at other times did not.

In fall 2017, the patient told the psychologist about noncompliance with medication. A few days later, the patient was admitted to the inpatient mental health unit. During the patient's inpatient mental health unit admission, psychiatry resident physician 4 noted that the patient "switched to seeing [psychiatrist 2] but only saw [psychiatrist 2] once" following the patient's late spring 2017 admission. In spite of the noted lack of the patient's engagement in outpatient care with psychiatrist 2, inpatient mental health unit staff included an appointment with psychiatrist 2 scheduled for eight days after discharge as the outpatient care plan. On the day of that appointment, psychiatrist 2 called the patient after the patient canceled the appointment and the patient reported being "no longer interested in medication management," and declined psychiatrist 2's offer for "infrequent check-ins."

The OIG found that in fall 2017, the inpatient mental health unit staff did not document collaboration with the patient or psychiatrist 2 in the development of the outpatient care plan, as encouraged by VHA.[56] Given the patient's refusal to take medications and staff's awareness of the patient's minimal contact and lack of a working relationship with psychiatrist 2, the OIG would have expected staff to make efforts to enhance the patient's engagement and identify the patient's concerns about medication and providers. The OIG concluded that inpatient mental health unit staff failed to maximize the likelihood of the patient's psychiatric care follow-up by not engaging in efforts to identify barriers to the patient's participation in medication management.

The discharge instructions listed the psychologist as the patient's MHTC. Ten days after the patient's discharge, social worker 1 called the patient after a missed appointment. The patient reported wanting to attend appointments with "only [the patient's] medication provider." Social worker 1 alerted psychiatrist 2 of the patient's request. Three days later, a staff member mailed the patient a letter identifying social worker 1 as the patient's MHTC and no further follow-up was documented in the patient's EHR.

The psychologist and social worker 1 told the OIG about being unaware that they had been assigned as the patient's MHTC. Social worker 1 speculated that the MHTC assignment was a result of case managers serving as MHTCs at that time. In an interview with the OIG, the Acting Chief, Mental Health, confirmed a lack of "official documentation" and clarity in the patient's EHR regarding an assigned MHTC at that time.

The OIG found that staff did not document information about MHTC assignment using the required EHR note title in spring or fall 2017, and that the failure to do so may have contributed to staff's lack of awareness of the assignment. Further, the patient's EHR documentation did not

[56] VHA Handbook 1160.06, September 16, 2013; VHA Directive 1160.06 September 27, 2023.

include the rationale for changes or confirmation that the patient was involved and informed about the MHTC assignments, as required by VHA.[57]

Later in the week that the letter identifying social worker 1 as the patient's MHTC was mailed, the patient tried to check in for an appointment at the clinic and did not have an appointment scheduled. The patient appeared frustrated and said, "I am done with the VA" and left the clinic. The following day, social worker 1 left the patient a voicemail message. The OIG did not find documentation that reflected additional outreach to the patient.

The OIG concluded that Ann Arbor VA staff's failure in fall 2017 to identify and address barriers to the patient's participation in medication management and to ensure that a staff member was functioning in the MHTC role to promote continuity of care and engagement in outpatient care may have contributed to the patient's abrupt cessation of care and staff's lack of follow-up with the patient.

3. Battle Creek VA Inadequate Transfer Coordination with Non-VA Programs in 2021

After the patient discontinued receiving VA care following the fall 2017 Ann Arbor VA inpatient mental health unit admission, the next documented contact occurred in 2021 when multiple non-VA agencies' staff members contacted the Battle Creek VA requesting information regarding transfer for the patient. In response to concerns about inadequate transfer coordination for the patient and the absence of a "standard process" for accepting transfers from non-VA agencies that was "creating frustration with our community partners . . . and ultimately leaving Veterans in inappropriate levels of care," Battle Creek VA leaders initiated a RPIW in January 2022.[58]

The OIG was unable to determine if, in late spring 2021, a Battle Creek VA staff member inaccurately informed a non-VA staff member that the patient was not registered for VA health care because of the absence of documentation.[59]

The OIG found that in early to mid-fall 2021, Battle Creek VA staff responded appropriately to non-VA staff's inpatient mental health unit inquiries regarding the patient. However, the patient

[57] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

[58] Battle Creek VA, *Lean Project Charter*, January 5, 2022.

[59] Battle Creek VA staff used the term "registered" when referring to enrollment procedures. VHA Directive 2010-038, *Enrolled Veterans Intake and Registration*, August 30, 2010. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1601A.01(2), *Registration and Enrollment*, July 7, 2020, amended June 6, 2023 and April 4, 2024, and VHA Directive 1601A.02(6), *Eligibility Determination*, July 6, 2020, amended March 6, 2024. Unless otherwise specified, the 2024 directives contain the same or similar language regarding placement of enrolled patients seeking care at any VA facility as the rescinded 2010 directive.

was not considered for transfer due to critical bed status rendering beds unavailable at the time of the transfer request.

The OIG also found that the Battle Creek VA August 2021 standard operating procedure prohibiting veteran self-referral to MH RRTP was inconsistent with the VHA requirement for veterans to be able to self-refer or be referred from non-VA agencies.[60]

Battle Creek VA RPIW

VHA requires medical center leaders to establish a program for the continuous "improvement of services through the evaluation, monitoring, and implementation of process changes."[61] In January 2022, the Battle Creek VA Director chartered a RPIW to review transfer coordination processes as "the current Transfer Coordination process is disjointed" and lacks a standard process for patient admissions and transfers from internal units and non-VA facilities.[62]

The Battle Creek VA Director reported to the OIG that non-VA providers had given feedback regarding navigating the transfer process and having to contact multiple staff members. The Battle Creek VA Director said that the patient's contacts provided "a sense of urgency to move forward" with the RPIW to evaluate transfer coordination at the Battle Creek VA and was unable to recall if decentralizing the transfer process was planned prior to the patient's contacts.

As a result of the RPIW, a workgroup was organized in January 2022 to establish a Transfer and Admission Coordination (TAC) Office with the goal of centralizing the management of the transfer and admission process.

In January 2024, the chief, quality resource service reported that most of the actions to establish the TAC Office had been implemented and remaining open items included the TAC Office centralized phone number, ongoing staff training regarding bed management, standard operating procedure implementation, and expanding TAC Office staffs' involvement in the MH RRTP screening and admission processes. The OIG concluded that Battle Creek VA leaders implemented recommendations from the RPIW to improve the transfer coordination processes.

Verification of Eligibility

The OIG was unable to determine if, in late spring 2021, a Battle Creek VA staff member spoke with the non-VA agency supervisor, who documented being informed that the patient was not registered, because of the absence of Battle Creek VA documentation and the absence of a name or phone number in the non-VA documentation.

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[60] Battle Creek VA Standard Operating Procedure 116B-5, "Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)," August 9, 2021; VHA Directive 1162.02.

[61] VHA Directive 1026.01.

[62] The RPIW convened for three days in January 2022.

However, as discussed below, the OIG determined that in early fall 2021 the Battle Creek VA MH RRTP screening coordinator's (screening coordinator) failure to recognize the patient's eligibility for VA care may have contributed to barriers for non-VA staff to submit a referral for the patient resulting in a delay of consideration of the patient's suitability for MH RRTP care.

Veterans who served a minimum duration on active duty in the "active military, naval, or air service," are eligible for basic VA health care.[63] A veteran may apply to be enrolled in the VA healthcare system by completing an eligibility form.[64] Medical center enrollment and eligibility staff review submitted eligibility forms and place enrolled patients in a priority group.[65] Once enrolled, a patient "may seek care at any VA facility without being required or requested to reestablish eligibility."[66]

In fall of 2015, the patient completed the eligibility form and the next day was deemed eligible for VA healthcare benefits for 10 years based on VHA guidelines.[67] In late spring 2021, the patient was admitted involuntarily to a non-VA facility. On the same day during evening hours, a non-VA agency supervisor documented speaking with an unidentified Battle Creek VA staff member who reported "that they cannot assist" because the patient was "not registered." In an OIG interview, the non-VA agency supervisor reported calling the Battle Creek VA main number and not obtaining identifying information for the staff member who answered the call.

The patient's EHR did not include documentation of the non-VA agency supervisor's contact with Battle Creek staff. In an interview with the OIG, the administrative officer of the day (AOD), on duty at the time of the non-VA agency supervisor's contact, did not recall the phone call. The AOD explained that an AOD can register a patient after hours and telephone requests are documented in an AOD log, a daily written record of significant activities during an AOD's

[63] VHA Directive 2010-038; 38 C.F.R. § 17.31 (2017).

[64] VHA Directive 2004-041*, Implementation of the VA Form 10-10EZ, Revised Application for Health Benefits, and VA Form 10-10EZR, Health Benefits Renewal Form*, August 4, 2004.

[65] VHA Directive 2004-041; "Priority Groups are established by 38 U.S.C. § 1705 to determine which categories of Veterans are eligible to be enrolled," VHA Directive 2010-038; 38 C.F.R. § 17.36 (2015).

[66] VHA Directive 2010-038.

[67] The patient was considered to be in priority Group 6, which includes patients who were "toxic-exposed," "Vietnam-era herbicide-exposed" patients, "Radiation-exposed" patients, patients that served in "Southwest Asia during the Persian Gulf War," and "Combat Veterans who served in a theater of combat operations after the Persian Gulf War and those Veterans who served in combat against a hostile force during a period of hostilities after November 11, 1998," VHA Directive 2010-038; VHA Directive 1601A.01(2); VHA Directive 1601A.02(6). VHA Directive 1601A.01(2) provides information on priority group placement. In 2020, as noted in VHA Directive 1601A.02(6), VHA extended the eligibility period for Combat Veterans from 5 to 10 years after the date of active duty discharge; 38 C.F.R. § 17.36 (2015).

shift.[68] The AOD told the OIG that there would be an entry in the AOD log if the AOD had received the call.

The AOD log did not include documentation of contact regarding the patient. The AOD told the OIG that if a patient was eligible for VA healthcare services but not registered, the patient's information could be entered into the system to add the patient to the facility's EHR. The assistant chief, health administration services explained that AODs and select other administrative staff register veterans in VA healthcare services via the national electronic enrollment system.[69] The AOD confirmed using the national electronic enrollment system since 2016.

In an interview with the OIG, the chief of police reported that during non-administrative hours a phone call to the Battle Creek VA main phone number might be answered by dispatch staff and that the dispatch staff would transfer the call to the AOD if the call was about a patient's eligibility.

The OIG was unable to identify any Battle Creek VA staff member who spoke with the non-VA agency supervisor in late spring 2021 because of the absence of a name or phone number in the non-VA records and a lack of documentation in the patient's EHR and AOD log. Since the patient was deemed eligible for VA healthcare benefits in 2015, if an enrollment request was submitted to a Battle Creek VA staff member, the patient should have been registered.

The OIG found that Battle Creek VA leaders likely did not have knowledge of the non-VA agency supervisor's call because of the absence of Battle Creek VA documentation. However, as part of the RPIW, Battle Creek VA leaders initiated efforts to streamline the transfer and admission coordination process that included a standardized document checklist and a centralized phone and fax number. The November 2023 workgroup meeting minutes reflect completed review of the standardized checklist, that the centralized fax number was in effect as of December 2022, and efforts to establish the phone number were ongoing.

Inadequate Inpatient Mental Health Unit Bed Management

The OIG found that in early to mid-fall 2021, Battle Creek VA staff responded appropriately to non-VA staff's inpatient mental health unit inquiries regarding the patient. However, the patient

[68] The AOD's responsibilities include responding to administrative issues that occur during evening, night, and weekend hours such as patient registration; The AOD in late spring 2021 transitioned to a program analyst in late fall 2021. Battle Creek VA Standard Operating Procedure 136-10, "Administrative Officer of the Day (AOD)," April 30, 2021.

[69] The assistant chief, health administrative services reported serving as the acting chief, health administrative services from January 2023 through May 22, 2023. For purposes of this report, the OIG referred to the acting chief, health administrative services as the assistant chief, health administrative services.

was not considered for transfer due to critical bed status rendering beds unavailable at the time of the transfer request.

Prior to transferring a patient into a VA facility, VHA requires that

- patient transfers receive prior approval from an authorized VA provider or designee to accept the patient;
- staff document the transfer date and time, the patient's informed consent, "medical and/or behavioral stability," clinical need, and anticipated level of care; and
- obtain the patient's medical records and the active medication list.[70]

Battle Creek VA policy in effect in mid-fall 2021 assigned transfer coordinators the responsibility "for the facilitation of in-coming inter-facility transfers" and to "act as a liaison" between facilities to ensure coordinated and timely patient transfers.[71]

Bed Diversion and Critical Bed Status

Battle Creek VA policy defines bed diversion as "the rerouting of patients" to other facilities "for unplanned reasons" including lack of bed availability and staffing shortages. During bed diversion status, staff are required to "direct patients or those seeking admission for patients to an alternative site of treatment until the limiting condition has been resolved."[72]

Battle Creek VA leaders told the OIG that in October and November 2021 the use of critical bed status was operational. The Battle Creek VA chief, quality resource service reported that critical bed status was initiated to reserve three inpatient mental health unit beds for patients referred from urgent care or community-based outpatient clinics. In January 2022, the RPIW advised leaders to "either eliminate [critical bed status] or reduce to 'one' bed hold."

On February 15, 2022, the Chief of Staff notified Battle Creek VA leaders and staff involved in patient admissions and transfers that critical bed status would be initiated when there was one

[70] VHA Directive 1094, *Inter-Facility Transfer*, January 11, 2017. This directive was in place during the time of the events discussed in this report. It was updated and replaced with VHA Directive 1094, *Interfacility Transfer,* January 20, 2022. The January 2022 directive was removed on February 24, 2022, and replaced with the 2017 directive. Unless otherwise specified, the 2022 directive contains the same or similar language regarding interfacility transfers as the 2017 directive. The 2022 directive required documentation of "medical and behavioral stability."

[71] The AOD is responsible for inter-facility transfer facilitation during evening, night, and weekend hours. Battle Creek VA Policy 11-1027, *Inter-facility Transfers*, October 2019. This facility policy was in place during the time of the events discussed in this report. The Battle Creek VA chief, quality resource service reported that the policy was rescinded February 14, 2022, and was not replaced because VHA Directive 1094, January 11, 2017, states that a local policy was not required.

[72] Battle Creek Standard Operating Procedure, SOP 11-03, "Medical Center Diversion," May 11, 2020. This Battle Creek VA standard operating procedure was in place during the time of the events discussed in this report. It was updated and replaced with Battle Creek VA standard operating procedure, SOP 11-03, "Medical Center Diversion," April 12, 2023. The 2023 Battle Creek VA standard operating procedure removed the diversion status occurring for medical and inpatient mental health unit beds and only applies to inpatient mental health unit beds.

inpatient mental health bed available. In April 2023, the Battle Creek VA Associate Director Patient Care Services alerted Battle Creek VA leaders that the use of critical bed status was discontinued. In meeting minutes, the TAC Office workgroup reported "If we have beds, we will admit regardless of where the Veteran is coming from."

Transfer Communication and Bed Availability at the Time of the Patient's Care

Battle Creek VA policy specifies that the transfer coordinator arranges consultation between the referring provider and appropriate Battle Creek VA providers and an appropriate Battle Creek VA provider must approve the transfer.[73]

In early fall 2021 (day 1), in response to a non-VA transfer request the transfer coordinator contacted a health administration services staff member who confirmed the patient's eligibility and added the patient's information into the Battle Creek VA EHR. Non-VA social worker 2 told the transfer coordinator that the patient was not on one-to-one observation and the transfer coordinator faxed a transfer packet to non-VA social worker 2.

On day 4, the Chief of Staff's executive secretary sent an email to the Battle Creek bed diversion email group that stated "as of [9:37 a.m.], we are on 1:1 Psychiatric Diversion. There are four single occupancy beds available." At approximately 11:30 a.m., non-VA staff faxed the patient's transfer packet to the transfer coordinator. That day, non-VA social worker 2 documented that the transfer coordinator reported no bed availability.[74] In the late afternoon on day 4, the transfer coordinator sent an email to relevant Battle Creek VA leaders and staff requesting a review of four transfer packets, including the patient's, for consideration of inpatient mental health unit admission "if taken off critical bed status."[75]

The chief, quality resource service informed the OIG that a Battle Creek VA leader initiated critical bed status during day 4 and could not identify the time this occurred because "times critical bed status was initiated" were not documented. The chief, quality resource service told the OIG that critical bed status was in effect on days 5 through 7.

On day 5, the transfer coordinator emailed relevant Battle Creek VA leaders a transfer request list including the patient's information for follow-up "if taken off critical bed status." On day 8, the case manager told the transfer coordinator that the patient was transferred to the non-VA residential crisis unit and "not currently in need of acute LOC [level of care]." The case manager "reported interest in" MH RRTP for the patient, and the transfer coordinator provided MH RRTP

[73] Battle Creek VA Policy 11-1027, *Inter-facility Transfers,* October 2019.

[74] The OIG was unable to determine time of contact between non-VA social worker 2 and the transfer coordinator because of a lack of documentation.

[75] On day 4, the transfer coordinator documented contact with non-VA staff regarding the patient and three other patients. None of the four patients were admitted to the Battle Creek VA inpatient mental health unit.

staff contact information. The patient's EHR did not include documentation of further contact with non-VA staff until day 41 as discussed below.

One month later, on day 39, the patient was admitted to the adult foster care home. On day 41, the veteran liaison and veteran navigator both contacted the transfer coordinator to request inpatient mental health unit transfer for the patient.[76] The transfer coordinator emailed the veteran liaison a transfer packet. The transfer coordinator also emailed facility leaders and staff that the patient's referral source was notified of the facility's critical bed status and the recommendation for the patient to be evaluated at an urgent care site or the nearest emergency department if an inpatient mental health unit transfer was needed.

Nine days later on day 50, the transfer coordinator unsuccessfully attempted to contact the veteran navigator regarding the status of the transfer request. The transfer coordinator notified the non-VA agency supervisor that the patient "would need to be assessed either at a VA, or at another hospital to determine medical necessity" and medical stability for inpatient mental health admission or "lower level of care." The non-VA agency supervisor agreed to "check on status of veteran" and notify the transfer coordinator. The transfer coordinator also reached out to the veteran liaison who planned to check on the patient's status and notify the transfer coordinator. In an interview with the OIG, the transfer coordinator reported the outreach to non-VA staff on day 50 was prompted by a request from mental health leaders.

The OIG found that Battle Creek VA staff were responsive to non-VA staff inquiries about transferring the patient to the inpatient mental health unit. However, the patient was not considered for transfer due to critical bed status rendering beds unavailable at the time of the transfer request.

The OIG determined that Battle Creek VA leaders' use of critical bed status prevented the consideration of the patient's transfer to the inpatient mental health unit and, consequently, denied the patient treatment at that time. As a result of Battle Creek VA leaders internal review, the use of critical bed status was discontinued in April 2023.

Battle Creek VA Leaders' Failure to Establish Written Transfer Procedures

The OIG found that from February 2022 until January 2024 Battle Creek VA leaders did not establish written guidance as was required by VHA during that time.[77] In 2017, VHA leaders required medical centers to have a written interfacility transfer policy. In January 2022, VHA

[76] The Michigan Department of Health and Human Services veteran navigators assist veterans and their families in connecting to resources to address needs including mental health, substance abuse, and housing. "Veteran Navigators" (web page), Michigan Department of Health and Human Services, accessed October 26, 2023, https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/veteran-navigators.

[77] VHA Directive 1094, January 11, 2017. This directive was in place during the time of the events discussed in this report. It was updated and replaced with VHA Directive 1094, January 20, 2022. The January 2022 directive was removed on February 24, 2022, and replaced with the 2017 directive.

leaders discontinued this requirement and mandated medical center directors to make certain "that written standard operating procedures ensure the safe, appropriate and orderly transfer of patients on a clinically appropriate timeline."[78] The chief, quality resource service told the OIG that Battle Creek VA leaders rescinded the applicable Battle Creek VA policy in February 2022, and that staff then referred to the VHA directive for guidance. The VA Office of General Counsel informed the OIG that the January 2022 directive was "taken down" in February 2022 and the 2017 directive was considered in effect. On June 24, 2024, VHA no longer required medical centers to "create or maintain" an interfacility transfer policy.[79]

Inaccurate and Inadequate MH RRTP Referral Procedures

The OIG found that the Battle Creek VA August 2021 standard operating procedure prohibiting veteran self-referral to an MH RRTP was inconsistent with the VHA requirement for veterans to be able to self-refer or be referred from non-VA agencies.[80] Additionally, at the time of the patient's potential referral to the MH RRTP, the screening coordinator was not aware of the requirement to consider non-VA agency referrals, although reported an accurate understanding in a 2023 OIG interview.[81]

For MH RRTP admission, VHA requires the veteran to

- not meet criteria for an inpatient mental health or medical unit admission;
- require a level of care higher than outpatient care;
- require the services, structure, and support of a mental health residential environment for treatment;
- not be at imminent risk of harm to self or others; and
- be capable of self-preservation and activities of daily living without assistance, such as bathing, dressing, and taking medications.[82]

VHA advises that veterans may apply directly for MH RRTP "services or be referred from other programs, both within and outside" VHA and that "MH RRTPs must take steps to reduce barriers to treatment."[83] VHA suggests that MH RRTPs "may use a short paper application for

[78] VHA Directive 1094, January 11, 2017; VHA Directive 1094, January 20, 2022.

[79] VHA Notice 2024-08, "Suspension of Implementation of Local Policy Mandates in Overdue VHA National Polices," June 24, 2024.

[80] Battle Creek VA Standard Operating Procedure 116B-5, "Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)"; VHA Directive 1162.02.

[81] The current Battle Creek VA chief, Psychology Services told the OIG about serving as the MH RRTP manager at the time of the events relevant to the patient's potential referral to the MH RRTP.

[82] VHA Directive 1162.02.

[83] VHA Directive 1162.02.

Veterans being referred from an outside agency that does not have access to the VHA electronic consult."[84] Further, "the screening process must consider the circumstances of each Veteran and determine how the program can meet the individual Veteran's needs."[85]

A Battle Creek VA MH RRTP standard operating procedure stated that "Veterans may not self-refer to the MH RRTPs, but rather must be referred by a provider currently involved in their care. The referring clinician must complete the electronic consult entitled, 'Residential Screening Consult.'"[86] In an interview with the OIG, the Battle Creek VA chief, Psychology Service reported that the MH RRTP did not utilize a short paper application for veterans referred from outside agencies, but a consult could be entered on behalf of the veteran.

Upon the OIG's inquiry about the discrepancy, the Battle Creek VA chief, Psychology Service acknowledged becoming aware of the inconsistency between the VHA directive and the standard operating procedure. That same day, the Battle Creek VA chief, Psychology Service updated the standard operating procedure to be consistent with the VHA directive and provided MH RRTP staff with the updated standard operating procedure and guidance on how to manage a veteran's self-referral.

Delays in Consideration of the Patient's MH RRTP Suitability

The patient was discharged from a non-VA inpatient mental health unit to the non-VA residential crisis unit on day 5. On day 8, the transfer coordinator contacted the case manager who "reported interest" in the MH RRTP and noted that the patient did not require inpatient mental health care. The transfer coordinator alerted the Battle Creek VA MH RRTP screening coordinator and the screening coordinator then informed the Battle Creek VA patient advocate (patient advocate) that the case manager inquired about referring the patient to MH RRTP and asked the patient advocate to contact the case manager.

The screening coordinator messaged the patient advocate and noted awareness of the transfer coordinator's note in the patient's EHR that the patient "can't start by coming to RRTP," and that, "we can't help in RRTP if [the patient] doesn't have a provider." Later that day, the patient advocate messaged the screening coordinator about being "not sure what else to do," and that once the transfer packet was returned "eligibility should assign [patient] to a [patient aligned care team]." The screening coordinator responded, "I was no help as all I know is how to get them from within the VA to RRTP – not how to get them in the VA from scratch."

In an interview with the OIG, the screening coordinator was unsure why the patient's VA enrollment was not clearly understood given awareness of the patient's EHR existence. In 2021,

[84] VHA Directive 1162.02.

[85] VHA Directive 1162.02.

[86] Battle Creek VA Standard Operating Procedure 116B-5, "Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)."

the screening coordinator inaccurately communicated that the patient was not able to be referred from a non-VA agency; however, in a 2023 interview with the OIG, the screening coordinator was knowledgeable about the VHA self-referral requirement.

Between days 13 and 19, Saginaw VA staff provided the case manager with requested MH RRTP referral information and contacted the screening coordinator about the patient's "possible placement." On day 33, the Saginaw VA VJO social worker documented a plan to submit a Battle Creek VA MH RRTP consult for the patient after the patient was "settled."

On day 41, the transfer coordinator provided MH RRTP contact information to the veteran liaison. Two days later, the veteran navigator requested a PTSD RRTP bed for the patient and the MH RRTP social worker contacted the veteran navigator and "reviewed the process for referrals to the program" and provided contact information for additional questions.[87]

The same day, the Saginaw VA VJO social worker contacted the Battle Creek VA VJO social worker to review the patient's case and potential referral. The Battle Creek VA VJO social worker documented being unable to place the PTSD RRTP consult since the patient did not meet VJO criteria and was not established with VA care and "reached out to residential care screening team to inquire further as it appears there was already contact made regarding this Veteran and residential care."

A week later, on day 50, the transfer coordinator contacted the veteran liaison regarding the patient's status and asked if an MH RRTP admission was needed. The veteran liaison noted that the "[community agency] held administrative responsibility" and a plan to check on the patient's status and notify the transfer coordinator. That day, the associate chief of staff contacted the patient's emergency contact, family member 3, to determine if the patient "had any current needs or if transfer to the VA was needed at this time." Family member 3 reported the patient died that morning.

The OIG determined that Battle Creek VA MH RRTP staff's lack of awareness of both the patient's enrollment status and the VHA requirement to consider non-VA agency referrals likely created barriers for non-VA staff to submit a referral for the patient resulting in a delay of consideration of the patient's suitability for MH RRTP care.[88]

[87] The MH RRTP social worker did not document additional information about the contact with the veteran navigator. The Battle Creek VA chief, quality resource service told the OIG that the MH RRTP social worker left VHA in late summer 2022.

[88] VHA Directive 1162.02.

4. VHA Leaders' Actions Related to Transfer Coordination Efforts for the Patient

The OIG found that VHA leaders responded within 24 hours upon notification of the patient's situation in mid-fall 2021. As discussed above, over a month later in January 2022, Battle Creek VA leaders initiated an RPIW to improve transfer coordination. Additionally, the OIG found that VISN 10 leaders established the IRC to streamline communication between Michigan VA facilities and other VA and non-VA agencies.

VHA Leaders' Actions in Mid-Fall 2021

In mid-fall 2021, on day 49, the Director received an email from a professional acquaintance who reported that the patient was "in need of urgent medical care," and requested assistance in accessing VA care for the patient. The Director agreed to "sort through some options" for VA care for the patient. The Director also notified the VISN 10 CMHO, and the then-Executive Director and Chief of Staff, Office of Mental Health and Suicide Prevention, about the request.[89] The VISN 10 CMHO was unable to reach the ACOS later that afternoon.

The next morning, the ACOS provided the VISN 10 CMHO with information about the outreach for the patient's transfer and the transfer coordinator's plan to reach out to the non-VA mental health agency. In an interview with the OIG, the ACOS reported having attempted to contact the adult foster care home unsuccessfully. The Director told the OIG about alerting the VISN 10 CMHO of the patient's death on the same day. The ACOS, at the request of the VISN 10 CMHO, contacted family member 3 who confirmed the patient died earlier that day. In an interview with the OIG, the ACOS reported notification of the patient's death to the VISN 10 CMHO and Battle Creek VA chief, psychiatry.

The OIG concluded that upon notification of the patient's situation, the Director, VISN 10 CMHO, and the ACOS took actions within 24 hours to identify the patient's treatment needs and options; the patient died within that time frame before treatment arrangements could be made.

Interagency Reconciliation Council

In spring 2022, Senator Gary Peters sent a letter to the VA Secretary asking if the VA was conducting an investigation related to the patient's death and what actions the VA was taking "to ensure that servicemembers struggling with a mental health crisis" are able to obtain VA services. In mid-summer 2022, the VISN 10 Director responded that the "circumstances leading up to" the patient's death were reviewed and reported a plan to create the IRC. VISN 10 leaders and the Michigan Veterans Affairs Agency implemented the IRC, a pilot program to improve

[89] The Executive Director, Office of Mental Health and Suicide Prevention, who was in the position at the time of the outreach regarding the patient's transfer to VA care, was in the position from January 2015 until April 2022.

communication regarding needs and resources, including care transitions, for reservists, national guard members, transitioning service members, and their families in Michigan.[90]

The IRC covered the Michigan VA medical centers, VISN 10, and Iron Mountain VA. Participants included the VISN 10 CMHO and suicide prevention program manager; the chief of mental health and suicide prevention coordinator from each medical center; Veterans Benefits Administration staff; Regional Manager of Vet Centers; and representatives from the Michigan Veteran Affairs Agency and the Michigan Department of Health and Human Services. At the first meeting in July 2022, IRC participants established a plan to meet monthly and then quarterly.

In a review of meeting minutes from August 2022 through October 2023, the OIG found that IRC members shared information about programs and legislation and discussed the structure and processes of the IRC.

In a June 2023 interview with the OIG, the VISN 10 suicide prevention program manager reported serving as the IRC chair and described a plan to assess goals and monitor progress using a strengths, weaknesses, opportunities, and threats analysis (analysis) at the end of fiscal year 2023.[91] The progress report was intended to "steer each year to continue momentum and conversation" and noted that "at this time, there is no formal tracking mechanism specific to the IRC." The VISN 10 suicide prevention manager provided the OIG with the October 2023 analysis that included an opportunity to define IRC's goal and the lack of goals as a threat.

The OIG found that since IRC's initiation in July 2022, the IRC has not identified or taken steps beyond information sharing to improve communication regarding needs and resources for reservists, national guard members, transitioning service members, and their families in Michigan. The OIG concluded that the IRC's lack of clearly defined objectives and processes to monitor progress and address identified barriers may hinder the IRC's success in meeting the intended outcomes.

[90] The Michigan Veterans Affairs Agency began in 2013 and serves as the coordinating agency for supporting and providing advocacy to veterans and their families in Michigan. "Michigan Veterans Affairs Agency" (web page), State of Michigan, accessed October 18, 2023, https://www.michigan.gov/mvaa/about-us/panel-content.

[91] A fiscal year is a 12-month cycle that spans October 1 through September 30. Fiscal year 2023 began on October 1, 2022, and ended on September 30, 2023. VA/VHA Employee Health Promotion Disease Prevention Guidebook, *VA Finance Terms and Definitions,* July 2011, accessed November 16, 2023.

Conclusion

The OIG determined that Ann Arbor VA staff considered a PTSD diagnosis and assessment throughout the patient's care and based on reasonable medical decision-making, planned to assess PTSD symptoms upon stabilization of the patient's psychotic symptoms. However, the patient discontinued treatment in fall 2017 and a PTSD evaluation was not completed. The OIG determined that given the patient's psychotic symptoms and impaired functioning, Ann Arbor VA providers appropriately focused on stabilization and management prior to completing further PTSD assessment.

Ann Arbor VA staff screened the patient for toxic exposure and provided the patient with relevant information to proceed with toxic exposure evaluation, encouraged the patient to report concerns, and provided contact information, as required by VHA.[92]

The OIG concluded that Ann Arbor VA providers screened the patient for TBI as required by VHA and adequately considered the patient's history of head trauma in the formulation of the patient's diagnoses and treatment plans.[93]

Prior to the patient's discharge from the inpatient mental health unit in fall 2017, Ann Arbor VA inpatient mental health unit providers failed to sufficiently assess the severity of the patient's mental health condition and treatment needs prior to discharge. The OIG concluded that inpatient psychiatrist 2's failure to consider the patient's initial unmedicated presentation that reflected mental health deterioration, probable therapeutic responses to administered medication, and the inpatient mental health unit structured environment, likely contributed to an underestimation of the severity of the patient's mental health condition and ultimately a failure to treat the patient effectively.

Additionally, the OIG found that Ann Arbor VA providers failed to sufficiently consider the ongoing therapeutic effect of medication administered in the Emergency Department and inpatient structured environment on the patient's clinical presentation. The OIG determined that the patient was likely benefiting from an antipsychotic medication at the time of inpatient psychiatrist 2's evaluation; therefore, inpatient psychiatrist 2 could not sufficiently evaluate the patient's underlying mental health condition. Given the patient's refusal to take medications, the OIG would have expected a longer monitoring interval to assess the patient's condition when truly free of antipsychotic effects. The OIG determined that at the time of discharge, the patient could have been retained legally on the voluntary admission for an additional 50 hours, and therefore, the inpatient mental health unit providers did not have an immediate need for consideration of involuntary admission.

[92] VHA Handbook 1303.02; VHA Directive 1308.

[93] VHA Directive 2010-012; VHA Directive 1184 (2017).

Ann Arbor VA inpatient mental health unit providers did not address the potential causes of the patient's laboratory result abnormalities and did not include monitoring of the patient's potassium level, other indicators of metabolic disturbance, and white blood cell count in the discharge plan. Based on the patient's mental health condition and the possibility of the patient's diminished ability to effectively perform activities of daily living, such as nutritional intake, the OIG would have expected Ann Arbor VA providers to have addressed these concerns by (1) discussing activities of daily living needs with the patient; (2) considering retaining the patient in inpatient mental health treatment to adequately address these problems; or at a minimum, (3) alerting outpatient providers of the need for follow-up in these areas.

The OIG found that, although included as the patient's MHTCs in discharge instructions, psychiatrist 2 and social worker 1 did not assume the responsibilities of the MHTC and failed to foster the patient's continuity of care. Given the patient's refusal to take medications and staff's awareness of the patient's minimal contact and lack of a working relationship with psychiatrist 2, the OIG would have expected staff to make efforts to enhance the patient's engagement and identify the patient's concerns about medication and providers. The OIG concluded that inpatient mental health unit staff failed to maximize the likelihood of the patient's psychiatric care follow-up by not engaging in efforts to identify barriers to the patient's participation in medication management.

Ann Arbor VA staff did not document information about MHTC assignment using the required EHR note title in spring or fall 2017 and the failure to do so may have contributed to staff's lack of awareness of the assignment.[94] The OIG concluded that Ann Arbor VA staff's failure in fall 2017 to identify and address barriers to the patient's participation in medication management and to ensure that a staff member was functioning in the MHTC role to promote continuity of care and engagement in outpatient care may have contributed to the patient's abrupt cessation of care and staff's lack of follow-up with the patient.

The OIG was unable to determine if, in late spring 2021, a Battle Creek VA staff member inaccurately informed a non-VA staff member that the patient was not registered for VA health care because of the absence of documentation. Battle Creek VA leaders likely did not have knowledge of the non-VA agency supervisor's call because of the absence of Battle Creek VA documentation. However, as part of the RPIW, Battle Creek VA leaders initiated in January 2022, efforts to streamline the transfer and admission coordination process included a standardized document checklist and a centralized phone number and fax.

In early to mid-fall 2021, although Battle Creek VA staff responded appropriately to non-VA staff's inpatient mental health unit inquiries regarding the patient, the patient was not considered for transfer due to critical bed status rendering beds unavailable at the time of the transfer

[94] Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator,* memorandum.

request. Battle Creek leaders' use of critical bed status prevented the consideration of the patient's transfer to the inpatient mental health unit and, consequently, denied the patient treatment at that time. As a result of Battle Creek VA leaders internal review, the use of critical bed status was discontinued in April 2023. The OIG found that from February 2022 until January 2024, Battle Creek VA leaders did not establish written guidance as was required by VHA during that time.[95]

Battle Creek VA August 2021 standard operating procedure prohibiting veteran self-referral to an MH RRTP was inconsistent with the VHA requirement for veterans to be able to self-refer or be referred from non-VA agencies. Upon the OIG's inquiry about the discrepancy, the Battle Creek VA chief, Psychology Service updated the standard operating procedure to be consistent with the VHA directive and provided MH RRTP staff with the updated standard operating procedure and guidance on how to manage a veteran's self-referral.

Battle Creek VA MH RRTP staff's lack of awareness of both the patient's enrollment status and the VHA requirement to consider non-VA agency referrals likely created barriers for non-VA staff to submit a referral for the patient resulting in a delay of the consideration of the patient's suitability for MH RRTP care.

VHA leaders responded within 24 hours upon notification of the patient's situation in mid-fall 2021. Upon notification of the patient's situation, the Director, VISN 10 CMHO, and the ACOS took actions within 24 hours to identify the patient's treatment needs and options; the patient died within that time frame before treatment arrangements could be made.

VISN 10 leaders and the Michigan Veterans Affairs Agency established the IRC to streamline communication between Michigan VA facilities and other VA and non-VA agencies. In a review of meeting minutes from August 2022 through October 2023, the OIG found that IRC members shared information about programs and legislation and discussed the structure and processes of the IRC. However, since IRC's initiation in July 2022, the IRC has not identified or taken steps beyond information sharing to improve communication regarding needs and resources for reservists, national guard members, transitioning service members, and their families in Michigan. The OIG concluded that the IRC's lack of clearly defined objectives and processes to monitor progress and address identified barriers may hinder the IRC's success in meeting the intended outcomes.

Recommendations 1–6

1. The Ann Arbor VA Medical Center Director conducts a full review of the patient's spring to fall 2017 mental health care to identify quality of care improvement opportunities related to

[95] VHA Directive 1094, January 11, 2017; VHA Directive 1094, January 20, 2022. The January 20, 2022, directive was removed February 24, 2022, and replaced with the 2017 directive.

inpatient psychiatrist 2's medical decision-making, staff's pre-discharge outpatient care planning, and outpatient staff's collaboration in providing treatment and engagement efforts including the mental health treatment coordinator assignment and role, and takes actions as warranted.

2. The Battle Creek VA Medical Center Director ensures staff awareness and access to eligibility verification procedures.

3. The Battle Creek VA Medical Center Director expedites the full implementation of the Transfer and Admission Coordination Office including a centralized phone number and monitors compliance with the standardized checklist.

4. The Battle Creek VA Medical Center Director expedites the completion and implementation of the interfacility transfers standard operating procedure and monitors compliance.

5. The Battle Creek VA Medical Center Director ensures the mental health residential rehabilitation treatment program standard operating procedure is aligned with Veterans Health Administration requirements regarding referral and monitors compliance.

6. The Veterans Integrated Service Network Director evaluates the efficacy of the Interagency Resolution Council and identification of clearly defined objectives and processes to monitor progress and address identified barriers.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 14, 2024

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

Subj: Healthcare Inspection—Insufficient Mental Health Treatment and Access to Care for a Patient and Review of Administrative Actions in Veterans Integrated Service Network 10

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

1. Thank you for the opportunity to review and comment on OIG's draft report for the Healthcare Inspection—Insufficient Mental Health Treatment and Access to Care for a Patient and Review of Administrative Actions in Veterans Integrated Service Network 10.

2. I have reviewed and concur with the comments and action plans detailed in the response, which have been developed by leaders and subject matter experts from VISN 10, Battle Creek VA Medical Center and VA Ann Arbor Healthcare System.

3. The loss of this Veteran is distressing. We are committed to continuous improvement of our processes to ensure we are delivering the highest quality care to our Veterans. If you have additional questions or need further information, please contact the VISN Quality Management Officer.

(*Original signed by:*)

Laura E. Ruzick, FACHE
Network Director

[**OIG comment**: The OIG received the above memorandum from VHA on June 14, 2024.]

VISN Director Response

Recommendation 6

The Veterans Integrated Service Network Director evaluates the efficacy of the Interagency Resolution Council and identification of clearly defined objectives and processes to monitor progress and address identified barriers.

_X _Concur

____Nonconcur

Target date for completion: September 30, 2024

Director Comments

VISN 10 subject matter experts, and IRC members routinely evaluated the efficiency of the IRC through meeting polls and debriefs. It was determined that the resources being directed toward IRC would better serve the needs of Veterans if transitioned to an enhanced model that expands the council to all VISN 10 facilities. Thus, IRC meetings paused after the January 2024 meeting to plan and build coalitions that would be necessary for future IRC success. A Community Engagement and Partnership Coordinator (CEPC) will begin a special assignment to VISN 10 in June 2024 to further support implementation of the redesigned IRC. The CEPC will partner with the VISN 10 CMHO and Suicide Prevention Program Manager (SPPM) to refine the goals and objectives for the redesigned IRC. Progress will be reported to and monitored by the VISN 10 Mental Health Integrated Clinical Community, which reports to the VISN Healthcare Delivery Committee that is chaired by the VISN 10 Chief Medical Officer.

Appendix B: VA Ann Arbor Healthcare System Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 14, 2024

From: Medical Center Director, VA Ann Arbor Healthcare System in Michigan (506/00)

Subj: Healthcare Inspection—Insufficient Mental Health Treatment and Access to Care for a Patient and Review of Administrative Actions in Veterans Integrated Service Network 10

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

1. VA Ann Arbor Healthcare System is dedicated to the health and wellbeing of Veterans and ensuring adherence to Veterans Health Administration national policies.

2. The healthcare system proactively conducts retrospective reviews to identify health care policy adherence deficiencies and quality of care opportunities in the inpatient medical decision-making, staff's pre-discharge outpatient care planning, and outpatient staff's collaboration to improve the Veteran treatment and engagement efforts.

3. The tragic loss of this Veteran's life, as outlined in this report, will be used to create additional safeguards and compliance standards around these findings. Efforts have already been initiated due to the urgency of these issues and processes will continue to evolve as necessary to improve Veteran quality of care and ensure continued adherence to Veterans Health Administration national policies. Locally, improved emphasis on assessment of needs and discharge planning have been developed and a post-discharge team was formed in 2020 to better assist Veterans and increase provider coordination following discharge.

(*Original signed by:*)

Ginny L. Creasman, Pharm.D., FACHE
Medical Center Director

[**OIG comment**: The OIG received the above memorandum from VHA on June 14, 2024.]

VA Ann Arbor Healthcare System Director Response

Recommendation 1

The Ann Arbor VA Medical Center Director conducts a full review of the patient's spring to fall 2017 mental health care to identify quality of care improvement opportunities related to inpatient psychiatrist 2's medical decision-making, staff's pre-discharge outpatient care planning, and outpatient staff's collaboration in providing treatment and engagement efforts including the mental health treatment coordinator assignment and role, and takes actions as warranted.

_X _Concur

____Nonconcur

Target date for completion: January 2025

Director Comments

As recommended, the VA Ann Arbor Healthcare System will conduct a full review of the patient's spring to fall 2017 mental health care to identify quality of care improvement opportunities related to inpatient psychiatrist 2's medical decision-making, staff's pre-discharge outpatient care planning, and outpatient staff's collaboration in providing treatment and engagement efforts. The healthcare system will use the information collected to develop and implement necessary corrective action by June 30, 2024, which may include the assignment of a mental health treatment coordinator role, and other action, as warranted.

Appendix C: Battle Creek VA Medical Center Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 14, 2024

From: Executive Director, Battle Creek VA Medical Center

Subj: Healthcare Inspection—Insufficient Mental Health Treatment and Access to Care for a Patient and Review of Administrative Actions in Veterans Integrated Service Network 10

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

1. Thank you for the opportunity to review and comment on OIG's draft report for the Healthcare Inspection—Insufficient Mental Health Treatment and Access to Care for a Patient and Review of Administrative Actions in Veterans Integrated Service Network 10.

2. The loss of this Veteran is distressing. Battle Creek VA Medical Center is committed to continuous improvement and implemented corrective actions from this review with the utmost urgency. We continue to review and improve processes to ensure delivery of safe, high-quality care to Veterans.

3. If you have additional questions or need further information, please contact the Battle Creek Chief, Quality Resource Service.

(*Original signed by*:)

Michelle Martin
Executive Medical Center Director

[**OIG comment**: The OIG received the above memorandum from VHA on June 14, 2024.]

Battle Creek VA Medical Center Director Response

Recommendation 2

The Battle Creek VA Medical Center Director ensures staff awareness and access to eligibility verification procedures.

_X _Concur

____Nonconcur

Target date for completion: July 30, 2024

Director Comments

Instructions for eligibility verification are included in Standard Operating Procedure (SOP) 00Q-6, "Transfer and Admission Processes and Procedures," which is published in the electronic directory for the Medical Center and is accessible to all employees. There is also an email group that is utilized to initiate contact with eligibility staff. Additional plans to increase staff awareness and access to eligibility verification procedures will be presented in multiple venues, including the Director's Staff meeting, Employee Townhall, and in the Get in the Know newsletter.

Recommendation 3

The Battle Creek VA Medical Center Director expedites the full implementation of the Transfer and Admission Coordination Office including a centralized phone number and monitors compliance with the standardized checklist.

_X _Concur

____Nonconcur

Target date for completion: July 30, 2024

Director Comments

Full implementation of the Transfer and Admission Coordination Office, including a centralized phone, number was completed on February 6, 2024. Compliance with SOP 00Q-6, "Transfer and Admission Processes and Procedures," is being monitored with results shared monthly in "Data Day," which is a forum that includes the entire Executive Leadership Team. Quarterly data presentations will be included in the Soonest and Best Care Committee, to include compliance rates with the standardized checklist. The facility will implement the necessary corrective action(s) as warranted.

Recommendation 4

The Battle Creek VA Medical Center Director expedites the completion and implementation of the interfacility transfers standard operating procedure and monitors compliance.

_X _Concur

____Nonconcur

Target date for completion: July 30, 2024

Director Comments

The Standardized Operating Procedure 00Q-6, "Transfer and Admission Processes and Procedures," was implemented January 31, 2024. Compliance with SOP 00Q-6 "Transfer and Admission Processes and Procedures" is being monitored with results shared monthly in "Data Day," which is a forum that includes the entire Executive Leadership Team. Quarterly data presentations will be included in the Soonest and Best Care Committee, to include rates of compliance with the SOP. The facility will implement the necessary corrective action(s) as warranted.

OIG Comments

In January 2022, VHA required medical centers to have an interfacility transfer policy standard operating procedure rather than a policy as mandated in 2017. From February 2022 until January 2024 Battle Creek VA leaders did not establish any written interfacility transfer guidance and referred to the 2022 directive for instruction. However, the VA Office of General Counsel informed the OIG that the January 2022 directive was "taken down" in February 2022 and the 2017 directive was considered in effect.

On June 24, 2024, VHA no longer required medical centers to "create or maintain" an interfacility transfers policy. Therefore, the OIG considers this recommendation closed.

Recommendation 5

The Battle Creek VA Medical Center Director ensures the mental health residential rehabilitation treatment program standard operating procedure is aligned with Veterans Health Administration requirements regarding referral and monitors compliance.

_X _Concur

____Nonconcur

Target date for completion: July 30, 2024

Director Comments

The SOP 116B-5 "Residential Rehabilitation Treatment Program" was corrected on November 30, 2023, to ensure compliance with Veterans Health Administration requirements related to referrals. Compliance with SOP 116B-5 is being monitored with results shared monthly in "Data Day," which is a forum that includes the entire Executive Leadership Team. Quarterly data presentations will be included in the Soonest and Best Care Committee, to include rates of compliance with the referral process, including self-referrals, to ensure alignment with SOP 116B-5. The facility will implement the necessary corrective action(s) as warranted.

Glossary

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

activities of daily living. Fundamental skills required to independently care for oneself, such as eating, personal hygiene, food preparation, and managing medications.[1]

adjustment disorder. A disorder occurring within three months of a stressor with symptoms of "marked distress that is out of proportion to the severity or intensity of the stressor" and impairment in functioning.[2]

bilirubin. A "yellowish pigment that is made during the breakdown of red blood cells" with elevated levels possibly indicating liver or bile duct problems, an "increased rate of destruction of red blood cells," or decreased amount of the enzyme that breaks down bilirubin.[3]

blood urea nitrogen. A chemical compound measured through a laboratory test and used to evaluate kidney functioning.[4]

creatinine. A chemical compound that is filtered out of the blood by the kidneys and can be measured to "determine how well kidneys are working."[5]

delusional disorder. A disorder characterized by the presence of fixed false beliefs that is unrelated to another mental health or medical condition.[6]

handoff. A transfer and acceptance of patient information and responsibility from one provider or team to another with the purpose of continuity of care.[7]

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[1] VA, "Understanding the [Traumatic Injury Protection Under Servicemembers' Group Life Insurance] Loss of Activities of Daily Living Standards," accessed on March 25, 2024, google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiUmtKgkpCFAxWvjIkEHYMVAYc4HhAWegQIBRAB&url=https%3A%2F%2Fwww.benefits.va.gov%2FINSURANCE%2Fdocs%2FTSGLI_ADL_Training_Slides_revised_with_PM_input.pdf&usg=AOvVaw37KzvygVCaiuQijnkOIFKT&opi=89978449.

[2] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth edition (DSM-5 TR)*, "Adjustment Disorders," accessed December 15, 2023, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x07_Trauma_and_Stressor_Related_Disorders.

[3] Mayo Clinic, "Bilirubin test," accessed January 8, 2024, https://www.mayoclinic.org/tests-procedures/bilirubin/about/pac-20393041.

[4] Mayo Clinic, "blood urea nitrogen," accessed March 25, 2024, https://www.mayoclinic.org/tests-procedures/blood-urea-nitrogen/about/pac-20384821.

[5] Mayo Clinic, "Creatinine test," accessed January 3, 2024, https://www.mayoclinic.org/tests-procedures/creatinine-test/about/pac-20384646#Overview.

[6] Science Direct, "Delusional Disorder," accessed December 15, 2023,,https://www.sciencedirect.com/topics/neuroscience/delusional-disorder.

[7] The Joint Commission, "handoff," accessed November 8, 2023, https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_58_hand_off_comms_9_6_17_final_(1).pdf.

ketones. Acids found in an individual's urine when the body breaks down fats for energy that may occur due to fasting or starvation.[8]

major depressive episode. An episode characterized by depressed mood or loss of interest in activities; changes in sleeping patterns, appetite, and energy levels; feelings of worthlessness or guilt, and thoughts of death.[9]

manic episode. A period of at least one week in which an individual experiences "abnormally, and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy."[10]

posttraumatic stress disorder. A mental health condition triggered by experiencing or witnessing a terrifying event and characterized by symptoms such as flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event.[11]

psychotic disorders. Conditions characterized by symptoms that occur when an individual experiences "trouble telling the difference between what's real and what's not" and may include hallucinations and delusions.[12]

psychotic episode. A period of time during which an individual experiences disruption of thoughts and perceptions, may have "difficulty recognizing what is real," and engage in unpredictable behavior.[13]

sudden cardiac death in schizophrenia. The sudden and unexpected deaths of individuals diagnosed with schizophrenia that are most commonly due to cardiovascular causes with no clear explanation on postmortem examination and likely due to fatal irregular heartbeat.[14]

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[8] Mount Sinai, "Ketones urine test," accessed January 25, 2024, https://www.mountsinai.org/health-library/tests/ketones-urine-test.

[9] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders - Fifth edition – Text Revision (DSM-5 TR)*, "Major Depressive Disorder," accessed December 15, 2023, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x04_Depressive_Disorders#BCFJBII%20A.

[10] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders - Fifth edition – Text Revision (DSM-5 TR)*, "Bipolar and Related Disorders," accessed November 8, 2023, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x03_Bipolar_and_Related_Disorders.

[11] Mayo Clinic, "Post-traumatic stress disorder," accessed December 15, 2023, https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967.

[12] Cleveland Clinic, "Psychosis," accessed January 4, 2024, https://my.clevelandclinic.org/health/symptoms/23012-psychosis.

[13] National Institute of Mental Health, "Understanding Psychosis," accessed November 30, 2023, https://www.nimh.nih.gov/health/publications/understanding-psychosis.

[14] Jitendra Vohra, "Sudden cardiac death in Schizophrenia: A Review," Heart, Lung and Circulation, vol 29 (2020): 1427-1432. https://www.clinicalkey.com/#!/content/playContent/1-s2.0-S1443950620303838?returnurl=https:%2F%2Flinkinghub.elsevier.com%2Fretrieve%2Fpii%2FS1443950620303838%3Fshowall%3Dtrue&referrer=https:%2F%2Fpubmed.ncbi.nlm.nih.gov%2F.

toxic exposure. Exposure to a range of environmental and chemical hazards during military service that has "the potential to produce adverse health effects, either alone or in combination."[15]

tranquilizer. "A drug used to reduce mental disturbance (such as anxiety and tension)."[16]

traumatic brain injury. A condition that "usually results from a violent blow or jolt to the head or body," and can have a wide range of physical and psychological effects.[17]

unspecified depressive disorder. A disorder that occurs when an individual does not meet the full criteria of a depressive disorder but exhibits symptoms characteristic of a "depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning."[18]

unspecified schizophrenia spectrum and other psychotic disorder. A diagnosis for when an individual exhibits symptoms characteristic of a schizophrenia spectrum or other psychotic disorder and does not meet the full criteria for a specific diagnosis.[19]

[15] VHA Handbook 1303.02; VHA Directive 1325; VHA Directive 1308. VHA uses the term "military exposure" and notes that "Military exposure is sometimes called toxic exposure."

[16] *Merrian-Webster.com Dictionary*, "tranquilizer," accessed November 13, 2023, https://www.merriam-webster.com/dictionary/tranquillizer.

[17] Mayo Clinic, "traumatic brain injury," accessed November 2, 2023, https://www.mayoclinic.org/diseases-conditions/traumatic-brain-injury/symptoms-causes/syc-20378557.

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

[19] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders - Fifth edition – Text Revision (DSM-5 TR)*, "Schizophrenia Spectrum and Other Psychotic Disorders," accessed November 8, 2023, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x02_Schizophrenia_Spectrum.

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