



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

August 12, 2015

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File Nos. DI-15-1267 & DI-15-2012

Dear Ms. Lerner:

I am responding to your letter regarding allegations made by two whistleblowers at the Phoenix Department of Veterans Affairs (VA) Health Care System, (hereafter, the Medical Center) in Phoenix, Arizona. The whistleblowers alleged that mental health counselors were not adequately trained, that the Emergency Department (ED) did not properly monitor suicidal or impaired Veterans, and that the electronic health record (EHR) of one of the whistleblowers had been improperly accessed. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

The Secretary asked that the Interim Under Secretary for Health refer the whistleblower's allegations to the Office of the Medical Inspector that assembled and led a VA team on a site visit to the Medical Center on March 16-19, 2015. VA did not substantiate the first allegation but did substantiate improper monitoring in the past and the improper access to the EHR.

VA made nine recommendations to the Medical Center to re-evaluate the time spent on suicide prevention training, to assess clinicians' suicide evaluations, to revise policy, to monitor effectiveness of changes in the ED to prevent elopement, to consider an ED for mental health, to improve communications with a non-VA provider, to assess privacy training and compliance, to highlight the availability of the Employee Assistance Program, and to continue staffing the ED with social workers. Findings from the investigation are contained in the report, which I am submitting for your review.

Thank you for the opportunity to respond.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert Nabors II". The signature is stylized and includes a large, sweeping flourish at the end.

Robert L. Nabors II
Chief of Staff

Enclosure

**DEPARTMENT OF VETERANS AFFAIRS
Washington, DC**

**Report to the
Office of Special Counsel
OSC File Numbers DI-15-1267 and DI-15-2012**

**Department of Veterans Affairs
Phoenix Veterans Affairs Health Care System**

Phoenix, Arizona



Report Date: June 17, 2015

TRIM 2015-D-128

Executive Summary

The Interim Under Secretary for Health (I/USH) requested that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the Mental Health (MH) and Social Work (SW) Services of the Phoenix VA Health Care System, (hereafter, the Medical Center) located in Phoenix, Arizona. Whistleblower 1 (whistleblower 1), a rehabilitation counselor, and Whistleblower 2 (whistleblower 2), a substance abuse addiction counselor, both of whom consented to the release of their names, alleged that employees are engaging in conduct that may constitute violations of laws, rules or regulations, and gross mismanagement, which may lead to a substantial and specific danger to public health. The VA team conducted a site visit to the Medical Center on March 16–19, 2015.

Specific Allegations of the Whistleblowers

The whistleblowers disclosed the following allegations concerning the Medical Center.

1. Lack of adequate training for its MH counselors and SW to manage Veterans presenting with suicidal ideations;
2. Failure to monitor and provide suitable care and treatment for Veterans who present to the emergency room with suicidal ideations;
3. Failure to adequately monitor patients who present to the emergency room after 4 p.m. while under the influence of drugs or alcohol, particularly those with substance abuse problems; and
4. The improper accessing of Whistleblower 2 medical records in violation of privacy laws.

VA **substantiated allegations** when the facts and findings supported that the alleged events or actions took place and **did not substantiate allegations** when the facts and findings showed the allegations were unfounded. VA was **not able to substantiate allegations** when the available evidence was not sufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of findings, VA makes the following conclusions and recommendations.

Conclusions for Allegation 1

- VA **did not substantiate** a lack of training for its MH counselors and SWs to manage Veterans presenting with suicidal ideation.

- The mandated suicide training provided during new employee orientation, while meeting a requirement, is only allotted 15 minutes, and there is concern that due to the rapidity of the presentation the educational impact is limited.
- While one SW did not correctly complete a suicide risk level assessment for Veteran 1, he did arrange for hospital admission and inpatient treatment, which was the appropriate level of care for this patient. The SW was appropriately re-educated.

Recommendations to the Medical Center

1. Re-evaluate the time allotted for suicide prevention training during new employee orientation to ensure the desired impact is achieved.
2. Assess clinician's suicide risk assessments to ensure they have the knowledge and apply the skills to competently assess Veterans (e.g., chart reviews)

Conclusions for Allegation 2

VA substantiated that:

- In the past, the Medical Center was not in compliance with the provisions of Policy 11-98 or Directive 2010-008 regarding 1:1 observation of potentially-suicidal patients, they had assigned one staff member to observe more than one high-risk patient at a time. Prior to our site visit, the Medical Center had changed their practice and designated one trained observer per patient.
- In the past, the Medical Center did not adequately monitor Emergency Department (ED) patients with suicidal ideations, some of whom eloped. Before our site visit, the Medical Center leadership had recognized this issue and redesigned the physical space and practices to reduce the elopement of patients with suicidal ideation. No such patients have eloped from the ED since February 15, 2015.
- Veteran 3 was escorted to the ED for treatment of alcohol intoxication and suicidal ideation and did leave without receiving treatment. However, the Veteran stated he was not suicidal, was assessed by two ED staff members and determined not to be suicidal, and was therefore appropriately not placed on a medical hold and exercised his right to leave.

VA did not substantiate that:

- Housekeeping and clerical staff members were assigned as safety observers to provide 1:1 observation of ED patients with suicidal ideation.
- During the week of January 23, 2015, five patients with suicidal ideation eloped from the ED.

- An ED SW refused to speak with or treat Veteran 2.

Recommendations to the Medical Center

3. If not already completed, revise the local policy, Medical Center Policy Memorandum 11-98, *Suicidal/Homicidal Ideation and Other High-Risk Patient Management in the Emergency Department* to reflect current practices. Continue to provide training about the changes, monitor compliance, and take appropriate educational, administrative, or disciplinary actions to address any non-compliance.
4. Monitor effectiveness of changes made in the ED to address elopement of patients with suicidal ideation. Make changes as needed to improve effectiveness.
5. Consider exploring the feasibility and cost-effectiveness of opening a dedicated MH ED, to concentrate the skills to address the volume of patients who present for emergent MH services.

Conclusions for Allegation 3

- VA was not able to substantiate the allegation that the Medical Center failed to adequately monitor patients who present to the emergency room after 4 p.m. while under the influence of drugs or alcohol, particularly those with substance abuse problems.
- The lack of routine communication between the Medical Center and the community-based detoxification center results in a gap in continuity of Veteran care.

Recommendation to the Medical Center

6. Continue efforts to establish consistent communication with non-VA detoxification center about Veterans under their care, consistent with and to the extent permitted by law and VA policy.

Conclusion for Allegation 4

- VA substantiated that **Employee 1** access into the whistleblower's electronic health record (EHR), although believed to be inadvertent, was impermissible. VA also determined that the prior designation as permissible was the result of a misunderstanding of the Network Security Operations Center (NSOC) determination. VA determined that Medical Center management re-educated the Privacy Office about the misunderstanding and took appropriate action upon learning of the impermissible access. As a result, no additional action is warranted.
- VA did not substantiate that **Employee 2** entered or deleted a note from the whistleblower's medical record.

- VA **substantiated** that 2 of 12 additional accesses were unauthorized. VA determined that Medical Center management took appropriate action upon learning of the impermissible accesses. As a result, no additional action is warranted.

Recommendation to the Medical Center

7. Continue to assess training and compliance with privacy laws and rules and provide appropriate educational, administrative, or disciplinary action to address non-compliance.

During the investigation, each of the whistleblowers submitted additional allegations.

Additional Allegation RE: Whistleblower 1

The Medical Center leadership engaged in gross mismanagement by failing to adequately staff ED SW positions.

Additional Conclusion RE: Whistleblower 1

- VA **did not substantiate** that Medical Center leadership engaged in gross mismanagement by failing to adequately staff ED SW positions. The Medical Center's prior method of providing coverage using on-call SWs is an acceptable way to ensure patient needs are met.

Additional Allegations RE: Whistleblower 2 allegations, April 17, 2015

Whistleblower 2 alleged that after the Medical Center discontinued his Motivation for Change program, it did not continue to provide the follow-up services participants required to meet the conditions of their legal arrangements.

Whistleblower 2 alleged that the Medical Center lacked support for staff to deal with a patient's suicide.

Additional Conclusions RE: Whistleblower 2 allegations, April 17, 2015

- VA **did not substantiate** that patients were abandoned after the Medical Center discontinued the Motivation for Change program.
- VA **did not substantiate** the Medical Center lacked support for staff dealing with patient loss by suicide.

Recommendation for the Medical Center

8. Continue to highlight the availability of the Employee Assistance Program (EAP) for MH staff whose patients have committed suicide.

Additional Allegations RE: Whistleblower 2, June 8, 2015

Whistleblower 2 raised concerns about scheduling overtime for ED SW coverage.

Whistleblower 2 made allegations related to a news report of a Veteran who committed suicide in a Veterans Benefits Administration parking lot, where he "wonders if the Veteran stopped by the ED in the weeks leading up to his suicide...and if they were unable to fill [his opioid prescriptions]?"

Additional Conclusions RE: Whistleblower 2 allegations, June 8, 2015

- With regard to the ED SW overtime scheduling, although it is not ideal scheduling a provider for multiple shifts in a short time period, there was no violation of policy, law, rule, or regulations in scheduling these shifts.
- VA did not substantiate that Veteran 4 had presented to the Medical Center's ED for care related either to suicide ideation or pain management.

Recommendation to the Medical Center

9. Ensure adequate staffing to cover SW shifts in the ED to limit the use of overtime.

Summary Statement

VA has developed this report in consultation with other Veterans Health Administration (VHA) and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, the Office of General Counsel (OGC) has provided a legal review, and the Office of Accountability Review (OAR) has examined the issues from a Human Resources (HR) perspective to establish accountability, when appropriate, for improper personnel practices. VA found no violation or apparent violation of any law, rule, or regulation. VA found evidence of violations of VA and VHA policy that were being addressed prior to this investigation. Therefore, as a result of this investigation, there are no changes in rules, regulations, or policy planned and no additional accountability actions warranted except as noted above.

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I. Introduction

The I/USH requested that OMI assemble and lead a VA team to investigate allegations lodged with OSC concerning the Medical Center's MH and SW Services. [REDACTED] and Whistleblower 2 alleged that employees are engaging in conduct that may constitute violations of laws, rules or regulations, and gross mismanagement, which may lead to a substantial and specific danger to public health. The VA team conducted a site visit to the Medical Center on March 16-19, 2015.

II. Facility Profile

The Medical Center, part of Veterans Integrated Service Network (VISN) 18, is a teaching hospital, providing a full range of patient care services, with state-of-the-art technology and research. Comprehensive health care is provided through primary care, long-term care, and tertiary care in the areas of medicine, surgery, MH, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics and extended care, and nutrition. The Medical Center serves over 80,000 Veterans in its primary service area with its main facility and six Community-Based Outpatient Clinics (CBOC). It has 464 affiliation agreements with more than 145 institutions and supports and funds over 80 resident positions annually, with fully-integrated training programs with Banner Good Samaritan (family medicine, general surgery, oral maxillofacial surgery, internal medicine, obstetrics and gynecology, orthopedics, psychiatry, cardiology, endocrinology, gastroenterology, geriatrics, and pulmonary/critical care medicine), Maricopa Integrated Health System (psychiatry and radiology), and the Mayo School of Graduate Medical Education (dermatology, otolaryngology, and gastroenterology). The Medical Center also has an active affiliation with the University of Arizona College of Medicine-Phoenix, A.T. Still University, and Midwestern College of Osteopathic Medicine. It has nursing affiliations with Arizona State University, University of Phoenix, Grand Canyon University, Chamberlain College, Northland Pioneer College, and the Maricopa Community Colleges.

III. Specific Allegations of the Whistleblowers

The whistleblowers disclosed the following allegations concerning the Medical Center.

1. Lack of adequate training for its MH counselors and SWs to manage Veterans presenting with suicidal ideations;
2. Failure to monitor and provide suitable care and treatment for Veterans who present to the emergency room with suicidal ideations;
3. Failure to adequately monitor patients who present to the emergency room after 4 p.m. while under the influence of drugs or alcohol, particularly those with substance abuse problems; and

4. The improper accessing of Whistleblower 2 medical records in violation of privacy laws.

IV. Conduct of Investigation

The VA team conducting the investigation consisted of [REDACTED] M.D., Deputy Medical Inspector, and [REDACTED], RN, Clinical Program Manager of OMI; [REDACTED], Suicide Prevention Specialist of the Puget Sound VA Medical Center; [REDACTED], OAR, VISN 11 HR Specialist; and [REDACTED] VHA Privacy Office Manager. VA reviewed relevant policies, procedures, professional standards, reports, memorandums, and other documents listed in Attachment A. We toured the Medical Center's ED, Substance Abuse Residential Rehabilitation Treatment Program (SARRTP) area and the outpatient MH clinic, and held entrance and exit briefings with Medical Center leadership.

Via teleconference, VA initially interviewed Whistleblower 1 on March 10, 2015, and Whistleblower 2 on March 11, 2015. We interviewed them again in person during the site visit and also interviewed the following Medical Center employees:

- [REDACTED] M.D., ED
- [REDACTED] M.D., ED
- [REDACTED], RN, ED Nurse Manager
- [REDACTED], ED
- [REDACTED], RN, ED
- [REDACTED], RN, ED
- [REDACTED], Nursing Assistant, ED
- [REDACTED], LPN, ED
- [REDACTED], SW, ED
- [REDACTED], SW, ED
- [REDACTED] M.D., Specialty Psychiatry Section Chief
- [REDACTED] SARRTP Manager/Substance Abuse Clinic Manager
- [REDACTED] Oberback, RN, Assistant Nurse Manger, SARRTP
- [REDACTED], RN, SARRTP
- [REDACTED], RN, SARRTP
- Employee 1, SW, Veterans Justice Outreach (VJO)
- [REDACTED], SW, Assistant Program Manager Substance Abuse Clinic
- [REDACTED], SW, Substance Abuse Clinic
- [REDACTED], SW, Substance Abuse Clinic
- [REDACTED], Vocational Rehabilitation Specialist
- [REDACTED], Peer Support Specialist (requested by whistleblowers)
- [REDACTED] D.O., Acting Chief of Psychiatry
- [REDACTED] M.D., staff psychiatrist
- [REDACTED], Staff Psychiatrist
- [REDACTED], Staff Psychiatrist
- [REDACTED], SW Chief, Social Work Service

- [REDACTED], SW, Acting Lead Suicide Prevention Coordinator
- [REDACTED], SW, Former Suicide Prevention Coordinator
- [REDACTED], SW
- [REDACTED], SW
- [REDACTED], VISN 18 Information Security Officer
- [REDACTED], Program Support Assistant in Home and Clinical Video Technology Telehealth (requested per whistleblowers)
- [REDACTED], Privacy Officer
- [REDACTED], Privacy and FOIA Officer

VA **substantiated allegations** when the facts and findings supported that the alleged events or actions took place and **did not substantiate allegations** when the facts and findings showed the allegations were unfounded. VA was **not able to substantiate allegations** when the available evidence was not sufficient to support conclusions about whether the alleged event or action took place with reasonable certainty.

V. Findings, Conclusions, and Recommendations

Allegation 1

Lack of adequate training for its mental health counselors and social workers to manage Veterans presenting with suicidal ideation[s].

Background

Suicide Prevention Training

Suicide is defined as “a death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior.”¹ Eight million of the approximately 21 million Veterans in the United States receive care within VHA, and between 2001 and 2003, the rate of suicide for these 8 million Veterans averaged 38.2 per 100,000 individuals.² To address this problem, VA developed the 2004 Mental Health Services Strategic Plan that outlines a systematic response to Veterans contemplating suicide; it improves Veteran access to, and support by, VA staff who receive mandatory training in dealing with persons at risk. The agency launched a 24/7 telephonic crisis line to provide support to Veterans in emotional distress and improved access to MH services by establishing 24/7 triage services and designated a Suicide Prevention Coordinator (SPC) at each medical center. The SPC promotes awareness about suicide, suicide prevention, and trains staff about suicide, as well as addressing within 24 hours any consults received from the crisis line to ensure that Veterans receive appropriate, timely care.

¹ Injury Prevention and Control: Division of Violence Prevention. Centers for Disease Control and Prevention (<http://www.cdc.gov/violenceprevention/suicide/definitions.html>)

² VA Mental Health Services, Suicide Prevention Program, Suicide Data Report, 2012.

As part of their professional education, MH Service's professional employees, including psychiatrists, psychologists, counselors, and SWs are trained in suicide assessment and prevention and should have these skills at the time they are hired. To ensure consistency in knowledge, VHA developed a web-based program, incorporating the best practices for suicide prevention. VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*, June 27, 2014, mandates that all VHA health care providers must complete the required suicide risk and intervention training module and pass the post-test within 90 days of entering their position. This program provides an overview of information regarding suicide and suicide prevention. Topical discussions include: 1) suicide as a social and medical issue; 2) suicide assessment and referral; 3) systemic and environmental issues; and 4) safety planning. The target audience for this course consists of full-time, part-time, and intermittent employees engaged in patient care such as physicians, psychologists, nurses, SWs, physician assistants, pharmacists, or dentists, as well as any employee serving in the capacity of Case Manager or Vet Center Team Leader and Counselor.

As suicide prevention is a high priority in VHA, suicide awareness training is part of all VA new employee orientation programs. The standardized presentation is usually allotted 30-60 minutes.

The SPC provides ongoing suicide prevention training through the Operation S.A.V.E. Program (Signs of suicide, Asking about suicide, Validating feelings, Encouraging help and Expediting treatment). This program includes training on:

1. Brief overview of suicide in the Veteran population.
2. Suicide myths and misinformation.
3. Risk factors for suicide.
4. Components of the S.A.V.E. model.

The Suicide Prevention Resource Center, a non-VA nationally-recognized educational data warehouse, acknowledges VA's Operation S.A.V.E. program on their "Best Practices Registry."

Suicide Risk Assessment

A Suicide Risk Assessment is a clinical evaluation to determine the nature and degree of suicide risk/probability. According to the Medical Center Policy Memorandum No. 122-19, *Suicide and Suicide-Related Behavior*, November 13, 2014, a suicide risk assessment may be completed by psychiatrists, psychologists, MH Register Nurses (RN), SWs, physician assistants, or nurse practitioners. It includes the documentation of factors associated with increased risk, such as suicidal intent, a plan, evidence of self-harm, previous attempts, and availability of lethal means (weapons, drugs, etc.), as well as family history, psychiatric conditions, and demographic factors. The suicide risk assessment also identifies the presence of any protective factors such as positive social support, sense of responsibility to family, strong religious affiliation, life satisfaction, and the presence of children. A patient's risk of attempting suicide is stratified using a scale

of 0-4, with a score of 0 signifying no evidence that the patient is thinking about suicide and a score of 4 indicating that the patient has multiple risk factors present, few protective factors, clear intent, and a specific suicide plan. Risk stratification is used to guide clinical treatment including required level of observation, treatment approach, and need for inpatient admission.

Findings

The Medical Center's MH Service's professional employees, including psychiatrists, psychologists, counselors, and SWs, received specialized training that included suicide assessment and prevention as part of their professional education. All SWs and ED clinicians had completed VA's web-based course entitled "Suicide Risk Management Training for Clinicians."

According to the former SPC and other interviewed employees, the Medical Center provides the mandated suicide training at new employee orientation every 2 weeks. The program is allotted 15 minutes on the orientation schedule. Most employees that we interviewed remembered receiving the training, but noted the training was brief. They were; however, able to articulate the appropriate suicide prevention measures and documentation expectations.

The SPC conducted 43 Operation S.A.V.E. training episodes in the last 12 months at the Medical Center and its CBOCs. VA reviewed the education schedule and the services' training records, which included MH counselors and SWs.

On February 20, 2015, the ED Nurse Manager notified nursing staff in that department that additional training will be provided on the management of patients with suicidal ideation. The additional training will be mandatory and include suicide risk prevention and evaluation.

To highlight his concerns about the appropriateness of risk assessment stratification training, **Whistleblower 2** described a specific risk assessment evaluation that occurred on December 23, 2014. He reported that a patient (Veteran 1) was brought into the ED after expressing suicidal ideation. He alleges that the ED SW assessed the patient to be at low risk for suicide and inappropriately treated him.

We reviewed Veteran 1's EHR: he is a 32-year-old male with a history of depression, alcohol dependence, and previous hospitalization for treatment of suicidal ideation. According to the whistleblower, the patient called him and stated that he had been robbed and was under the influence of alcohol and morphine. The patient said he intended to start shooting his neighbors and then planned to kill himself. The whistleblower alerted police and the patient was brought into the ED. In the EHR of Veteran 1, the ED SW who completed the suicide risk assessment rated the patient as low risk. Although a Veteran stratified as low risk would not usually be admitted to the hospital, the SW recommended an inpatient admission to the MH unit for observation because the patient was still under the influence of alcohol and drugs. Later that same

day, the patient was admitted for inpatient treatment. The following day, the Veteran requested to leave the hospital; as he did not meet the requirements for involuntary commitment, he was discharged against medical advice. On January 9, 2015, in the Veteran's EHR it is reported "I am willing to do what it takes at Terros.³ I am not willing to continue with Motivation for Change (M4C) at this time or enter an inpatient substance-abuse program.⁴ In the event I relapse I will consider inpatient treatment at that time." This Veteran is still being followed at the Medical Center and was last seen by a SW on April 29, 2015.

Whistleblower 2 reported that when he confronted the ED SW about his low suicide risk assessment, the ED SW responded that he had been instructed not to rate anyone under the influence of drugs or alcohol as medium or high, since the patient might not be coherent enough to understand and answer questions. During his VA interview, the ED SW confirmed that a previous supervisor had instructed him to rate intoxicated patients as low risk for suicide until they were sober and could be re-assessed. The ED SW also stated that after this incident occurred, his current supervisor re-educated him about suicide risk assessment of intoxicated patients, emphasizing that intoxication did not mandate a low-risk score. No other SWs or MH counselors stated that they used this approach when assessing the risk of suicide in intoxicated patients. No other clinicians raised concerns about risk assessments done in the ED.

Conclusions for Allegation 1

- VA did not substantiate a lack of training for its MH counselors and SWs to manage Veterans presenting with suicidal ideation.
- The mandated suicide training provided during new employee orientation, while meeting a requirement, is only allotted 15 minutes, and there is concern that due to the rapidity of the presentation the educational impact is limited.
- While one SW did not correctly complete a suicide risk level assessment for Veteran 1, he did arrange for the appropriate level of care for this patient, hospital admission, and inpatient treatment. The social worker was appropriately re-educated.

Recommendations to the Medical Center

1. Re-evaluate the time allotted for suicide prevention training during new employee orientation to ensure the desired impact is achieved.
2. Assess clinician's suicide risk assessments to ensure they have the knowledge and apply the skills to competently assess Veterans (e.g., chart reviews).

Allegation 2

³ Terros: A non-VA health care organization providing primary care, substance use, and MH disorder treatment, recovery, crisis, and prevention services.

⁴ Motivation for Change is a program set up by **Whistleblower 2** as an extension of existing Veteran Justice Outreach programs to provide extended assistance to Veterans involved in the Criminal Justice System.

Failure to monitor and provide suitable care and treatment for Veterans who present to the emergency room with suicidal ideations.

Background

VA's Serious Mental Illness Treatment Research and Evaluation Center (SMITREC) conducts ongoing monitoring of suicide mortality among patients receiving care in VHA, and this includes assessment of suicide rates by administrative parent station. Observed differences in suicide rates may reflect differences in risk factors. As part of ongoing suicide risk assessment, SMITREC has developed an approach to quantifying suicide risk among VHA patients. Based on over 300 individual predictors, including patient clinical, contextual, demographic, prior suicide attempt, and VHA utilization measures, SMITREC has estimated predicted suicide rates for VA facilities and compared these to observed suicide mortality in fiscal year (FY) 2011, the most recent year for which National Death Index data are currently available for VHA analysis. Three approaches are used to assess predicted suicide rates.

According to VHA Directive 2010-008, *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities*, February 22, 2010, and Medical Center Policy Memorandum No. 11-98, *Suicidal/Homicidal Ideation and Other High-Risk Patient Management in the Emergency Department*, "Suicidality must be treated as a life-threatening condition and needs to take priority as in any other life-threatening condition. Patients presenting with suicidal ideation are to be placed on one-to-one (1:1) observation by clinical staff and evaluated immediately. The 1:1 observation needs to remain active up until the time the patient is no longer deemed a risk by the ED physician or psychiatric consultant or until the patient is transferred to another appropriate setting."

VHA Directive 2010-008 defines 1:1 observation in relevant part as: "the constant observation of the patient by a staff member." Furthermore, it provides that "while under 1:1 observation, the patient is not allowed to leave the room for smoking or snacks; and any restroom visits require an escort who can visually monitor the patient for suicidal behavior." While the employees who provide the 1:1 observation were formerly referred to as "sitters," the Medical Center now refers to these trained individuals as "safety observers," who may be either licensed or unlicensed health care workers and who have completed the required training in basic suicide precautions, environmental safety, and a competency evaluation. VA reviewed training records of all ED safety observers and verified that they had met this requirement.

A patient presenting to the ED with suicidal ideation is encouraged to accept treatment and evaluation voluntarily. If he or she refuses voluntary treatment but the clinician assesses them to be at high risk for suicide, the clinician may order a "medical hold," a 24-hour period of involuntary inpatient admission (excluding weekends and holidays) for clinical observation of a patient determined to be a danger to self or others. In the State of Arizona, an emergency admission for evaluation may be filed when there is an immediate concern for the safety of the person or others, this allows the person to be

admitted and detained involuntarily in a hospital for 24 hours without a court order. According to the Medical Center's Memorandum, during a medical hold, the patient is not free to leave and remains under 1:1 observation either until the patient is discharged by a physician or the medical hold is cancelled. If the patient demands to be discharged or attempts to leave, the VA Police Service must be notified for assistance. VHA Directive 2010-008 states in relevant part: "Patients who have been determined by clinical staff to be a threat (or danger) to themselves or others are not allowed to voluntarily leave the ED or Urgent Care Clinic until a discharge plan is in place. In these situations, facility police must prevent their departure consistent with applicable statutes, regulations, or departmental policies. Whenever this occurs, the facility police are to use the minimum amount of force determined necessary to control the situation." It is important for the facility police to abide by law and policy when preventing departures and not violate patient rights. If the patient leaves the ED while still on a medical hold, the facility police must be notified and efforts initiated immediately to locate the patient. If the patient is not found on VA premises, the facility police notify the local police for assistance.

Findings

The SMITREC provided FY 2011 suicide data to the VA team. The cohort of VHA users at the Medical Center reported 36 suicide deaths, observed in a patient population with 67,468 combined person-years of risk time. SMITREC noted that, in the entire adult population of the State of Arizona, the suicide rate in 2011 exceeded the National rate (23.1 vs. 16.2), and rates in the entire Western region were higher than the National average. Utilizing the three different analysis approaches of observed rate to predicted rate, patients at the Medical Center were close to 1. (Method 1: Observed rate / predicted rate = 1.01; Method 2: 0.99; and Method 3: 0.97.) That is, for all three approaches, the Medical Center was not highlighted as having either a substantially elevated or a substantially decreased suicide rate relative to the predicted rate. These analyses suggest that the Phoenix VAMC serves a population with elevated suicide rates compared to VA nationally; however, when adjusting for suicide risk factors, the observed rates did not substantially differ from predicted suicide rates.

Currently the Medical Center cares for MH patients in the general ED. It does not have a specialized MH ED. From March 9, 2014, through March 9, 2015, the Medical Center had 782 encounters with patients presenting for mental health issues, and of these encounters, 710 were for patients presenting with suicidal ideation.

Both whistleblowers stated that they had been informed by another staff member that untrained housekeeping and clerical employees had sometimes been assigned as "sitters," alleging that because such staff lacked the training to perform 1:1 observation, they could not provide the appropriate care needed for these patients. The whistleblowers were not able to provide the dates of specific occurrences or names of patients whose 1:1 observation had been performed by such employees. Instead, they provided the name of an employee whom they believed had specific patient information pertaining to this allegation. However, this employee stated that she had not seen any

housekeeping or clerical employees providing 1:1 observation for ED patients. No other interviewed employees recalled any instances of such employees being assigned to perform 1:1 observation of potentially-suicidal patients in the ED.

We reviewed ED staffing records and found no instances where non-clinical staff members were given patient assignments, including 1:1 observation.

VA Police Elopement Reports document 10 patients deemed at high risk for suicide eloping from the ED between October 2014, and February 15, 2015.⁵ Seven of these patients were on medical hold; five of them were apprehended and returned to the ED.

Whistleblower 2 alleged that during the week of January 23, 2015, five patients who had been brought to the ED for evaluation of suicidal ideation eloped. According to the ED's workload report for that week, four such patients had been seen that week, but none eloped. Neither the whistleblower nor any other MH or ED staff member was able to provide the names of any patients eloping that week. VA reviewed the Police Elopement Report and found no instances of elopement of potentially-suicidal patients from the ED during that week.

Prior to February 2015, the Medical Center placed ED patients who had been assessed to be at high risk for suicide in a 4-bed area close to the nurse's station. This area does not have any separating walls, allowing the safety observer to maintain visibility on all patients. **Whistleblower 1** stated that while he was a patient in the ED (for a non-suicide issue), he was placed in this 4-bed area next to patients he believed were suicidal, and that during this time only one person had been assigned to watch the patients adjacent to him. While the whistleblower was not able to provide the date of this encounter with VA, the Medical Center confirmed that, in the past, one safety observer would be assigned to observe multiple patients in this area, since all four beds were visible at once and the area was close to the nurses' station. This practice was not compliant with Policy 11-98, or Directive 2010-008. These beds were also in close proximity to an exit door that in the past lacked a delayed lock-release mechanism.

The ED has since designated four private rooms farther from the exit for patients with suicidal ideation and equipped the exit door with a time-delayed opening mechanism. A safety observer is assigned to each patient and must stay in the room with the patient at all times until the patient is either transferred, or the 1:1 observation is deemed no longer necessary. To discourage elopement, the patient's clothes are removed, the patient is placed in hospital gowns or pajamas, and his/her personal belongings (including clothing) are secured in a different location. Since mid-February, no patients with suicidal ideation have eloped from the ED.

Case examples provided by the whistleblowers

⁵ Elope: to slip away or escape.

The whistleblowers provided the names of two Veterans as examples of the Medical Center's failure to provide suitable care and treatment for Veterans with suicidal ideation:

Veteran 2

Whistleblower 1 stated he overheard a vocational rehabilitation specialist speaking about a SW who refused to speak with or treat a patient in the ED. The whistleblower did not know the SW's name but stated this SW is no longer employed at the Medical Center. We interviewed this vocational rehabilitation specialist, who said he had been contacted by the Veteran's mother on July 17, 2014, for help for her daughter who was abusing drugs and alcohol. He instructed the mother to bring the Veteran to the ED that day, where a SW would screen her and refer her for treatment. He further reported that the Veteran did not report to the ED until the next day, July 18, 2014, at which time he says she arrived intoxicated but not exhibiting suicidal or homicidal ideation. He explained that because the Veteran did not meet the criteria for inpatient mental health admission, the SW referred her to a non-VA community facility for detoxification. This vocational rehabilitation specialist was not aware of the Veteran's outcome.

The following is the sequence of care reported in the patient's EHR. The Veteran is a 27-year-old female with a history of marijuana, methamphetamine, and cocaine abuse. On June 27, 2014, she contacted the Medical Center requesting halfway house placement for sober housing and drug abuse treatment. That same day, a readjustment counselor authorized placement at a community detoxification facility for up to 60 days. Five days later on July 2, she came to the Medical Center as a walk-in, stating she had left the halfway house and started using drugs again. She requested treatment for her substance use disorder. An ED SW completed her suicide risk assessment, rated her low risk, and referred her back to the halfway house to obtain sobriety and outpatient substance abuse treatment. The Veteran relapsed again, and on July 8 returned to the Medical Center and was escorted to the ED for evaluation for possible MH admission.⁶ A different ED SW evaluated her, determined that she was not exhibiting suicidal ideation and recommended VA's SARRTP, a supportive residential program designed to provide a stable drug- and alcohol-free, supervised environment for treatment and rehabilitation of those Veterans with substance use disorders who need a residential treatment setting for addiction-focused pharmacotherapy and psychosocial interventions.⁷ Because the SARRTP did not have any beds available that day, they gave her an appointment for an intake assessment and admission on the following day, July 9, 2014, at which time she was admitted. While on the SARRTP unit on the day of the alleged intervention on behalf of her mother, July 18, the Veteran injured her right foot. She was escorted to the ED, where her injury was treated. During this ED visit, she did not voice any psychosocial needs that would require SW or additional MH

⁶ Any patient being considered for psychiatric inpatient admission undergoes a medical clearance evaluation in the ED prior to be accepted for admission.

⁷ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*. December 22, 2010. (http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2354)

intervention. Following treatment, she was sent back to the SARRTP unit. No other ED encounters are noted in the EHR nor is there any indication that she was refused treatment by any ED SW.

Veteran 3

Whistleblower 2 described escorting an intoxicated patient who had twice expressed suicidal ideation to the ED and leaving after handing the patient off to a nurse. The next day, the whistleblower discovered that the Veteran had left before receiving treatment, according to his EHR, and assumed that the patient had been sent back out to the ED's general waiting area. The whistleblower alleged that the patient's blood alcohol level had been 0.3.⁸

According to the EHR, the whistleblower had spoken with the Veteran earlier in the day and the Veteran admitted to drinking alcohol and making statements that were concerning for suicidal ideation. The whistleblower contacted the local police for a welfare check. No follow up of this check is noted in the EHR. Later that day, the Veteran drove himself to the Medical Center and met with the whistleblower, who was concerned about the Veteran's alcohol consumption, in violation of conditions of his parole and the possible suicidal statements the Veteran had made earlier in the day. He recommended an assessment in the ED to the Veteran, who initially refused, but then agreed. The whistleblower escorted the patient to the ED at approximately 5:02 p.m. on April 14, 2014, for treatment of alcohol intoxication and suicidal ideation, reporting that as they walked to the ED, the Veteran stated twice "I don't want to live." A note in the EHR states, "During the triage process, the Veteran interrupted his counselor's report to make sure that we understood that 'he was not suicidal' at that time." One of the ED technicians present during the triage interview confirmed the patient stated that he was not suicidal. The triage nurse conducted a Safety Assessment as part of the Veteran's triage evaluation and noted the patient was living in a safe environment, was not carrying weapons or contraband, did not have suicidal or homicidal ideation, and did not have a psychiatric complaint or obvious psychiatric problem. In addition, in the section "notes/details about safety survey," it is reported that the patient continued to deny suicidal or homicidal ideation and states he "just wants a place to rest."

After the assessment, the triage nurse left the patient in the triage area — not unattended in the general waiting area — while preparing a space for him and giving a report to the nurse assigned to care for him. When the triage nurse returned to the triage area to bring the patient back, the Veteran was missing, and another ED staff member stated that he had gone to use the bathroom. According to the EHR, ED nurses and volunteers conducted an extensive search of the inside and outside of the ED, and the Veteran was not found. It was also recorded, "As the patient was not

⁸ Blood alcohol level: The amount of alcohol in a person's body is measured by the weight of the alcohol in a certain volume of blood. This is called the blood alcohol concentration (level), or "BAC." A blood alcohol test is often used to find out whether an individual is legally drunk or intoxicated (<http://www.nhtsa.gov/links/sid/ABCsBACWeb/page2.htm>).

suicidal or under medical, psychiatric, or legal hold at that time, the VA police were not contacted." The case was reviewed with the ED physician. VHA Handbook 1101.05, *Emergency Medicine Handbook*, May 12, 2010, paragraph 15.d (*Treatment of Intoxicated Patients*), states if a patient "...is unwilling to remain for extended observation, the patient may not be held against his or her will by clinical staff." No laboratory results, including blood alcohol levels, are listed in the EHR for this visit. Whistleblower 2 attempted to contact the patient the next day but was unable to reach him. The patient was later located at his daughter's house. Other than the whistleblowers, none of the other interviewed employees reported observing inadequate care of ED patients with suicidal ideation.

Conclusions for Allegation 2

VA substantiated that:

- In the past, the Medical Center was not in compliance with the provisions of Policy 11-98 or Directive 2010-008 regarding 1:1 observation of potentially suicidal patients. They had assigned one staff member to observe more than one high-risk patient at a time. Prior to our site visit, the Medical Center had changed its practice and designated one trained observer per patient.
- In the past, the Medical Center did not adequately monitor ED patients with suicidal ideations, some of whom eloped. Before our site visit, the Medical Center leadership had recognized this issue and redesigned the physical space and practices to reduce the elopement of patients with suicidal ideation. No such patients have eloped from the ED since February 15, 2015.
- Veteran 3 was escorted to the ED for treatment of alcohol intoxication and suicidal ideations and did leave without receiving treatment. However, the Veteran stated he was not suicidal, was assessed by two ED staff members and determined not to be suicidal, and was therefore appropriately not placed on a medical hold and exercised his right to reject treatment and leave.

VA did not substantiate that:

- Housekeeping and clerical staff members were assigned as safety observers to provide 1:1 observation of ED patients with suicidal ideation.
- During the week of January 23, 2015, five ED patients with suicidal ideation eloped from the ED.
- An ED SW refused to speak with or treat Veteran 2.

Recommendations to the Medical Center

3. If not already completed, revise the local policy, Medical Center Policy Memorandum 11-98, *Suicidal/Homicidal Ideation and Other High-Risk Patient Management in the Emergency Department* to reflect current practices. Continue to provide training about the changes, monitor compliance, and take appropriate educational, administrative, or disciplinary actions to address any noncompliance.
4. Monitor the effectiveness of the changes made in the ED to address elopement of patient with suicidal ideation. Make changes as needed to improve effectiveness.
5. Consider exploring the feasibility and cost-effectiveness of opening a dedicated MH ED, to concentrate the skills needed to address the volume of patients presenting for emergent MH services.

Allegation 3

Failure to adequately monitor patients who present to the emergency room after 4 PM while under the influence of drugs or alcohol, particularly those with substance abuse problems.

During normal business hours, intoxicated patients without delirium tremens who presented to the substance abuse clinic were referred to one of the MH Clinics for evaluation and possible transfer to a detoxification center in the local community.⁹ After normal business hours, these patients are offered the opportunity to voluntarily go to a non-VA facility if detoxification is desired. These patients do not report to the ED unless they express suicidal or homicidal ideation, or are experiencing acute medical symptoms that warrant immediate attention. Patients not deemed suicidal or homicidal are not placed on medical hold; they may refuse treatment and leave the ED at any time.

The Medical Center provides 24/7 MH services for patients under the influence of drugs or alcohol, but as it lacks a detoxification unit, it refers patients in need of detoxification to community-run, non-VA facilities. These facilities do not routinely inform the Medical Center about treatment they provide to Veterans, and some employees specifically expressed concern that they were not notified when their patients were discharged. The SW Service has designated a staff member to act as the MH community liaison to work with the facilities. The liaison would assist in obtaining treatment information about Veterans (who have consented in writing to the release of their patient information) for the purpose of including such information in their EHR.

██████████ identified two of the three Veterans already discussed above as examples of patients he believed were not adequately monitored in the ED while under the influence of alcohol. Veteran 1 had been brought to the ED by local police for evaluation and treatment of suicidal ideation and intoxication. He was monitored and

⁹ Delirium tremens is a severe form of alcohol withdrawal that involves sudden and severe mental or nervous system changes.

admitted for inpatient MH treatment and discharged the following day. Veteran 3 was escorted to the ED after expressing suicidal ideation. Upon arrival at the ED, he denied any suicidal ideation, and there was no indication that he was in fact suicidal. He was not placed on 1:1 observation or subject to a medical hold, and he left before receiving treatment. The Medical Center could not detain him against his will and the patient had the right to refuse VA treatment. No interviewed employees other than the whistleblowers reported that they had directly observed or otherwise knew of the Medical Center failing to adequately monitor patients presenting to the emergency room after 4 p.m. under the influence of drugs or alcohol, particularly those with a substance abuse diagnosis. VA found no evidence the facility failed to monitor the patients named by the whistleblower,

Conclusions for Allegation 3

- VA was not able to substantiate the allegation that the Medical Center failed to adequately monitor patients who present to the emergency room after 4 p.m. while under the influence of drugs or alcohol, particularly those with substance abuse problems.
- The lack of routine communication between the Medical Center and the community-based detoxification centers results in a gap in continuity of Veteran care.

Recommendation to the Medical Center

6. Continue efforts to establish consistent communication with the non-VA detoxification center about Veterans under their care, consistent with and to the extent permitted by law and VA policy.

Allegation 4

The improper accessing of Whistleblower 2 medical records in violation of privacy laws.

Whistleblower 2 alleged that a co-worker, Employee 1, improperly accessed his EHR on June 25, 2014, and possibly entered a note into the record, which was subsequently removed. He stated that Employee 1 did not notify him that she had mistakenly accessed his record until early October 2014. He was concerned that Employee 1 may have read other entries in his health record and entered a note.

Employee 1 is an SW in the Medical Center's VJO Program. The purpose of this program is to avoid the unnecessary criminalization of mental illness and extended incarceration of enrolled Veterans by ensuring that those involved in the criminal justice system have timely access to VHA services as clinically indicated. VJO specialists are responsible for outreach, assessment, and case management of such Veterans in local courts and jails, and for liaison with local justice system partners.¹⁰ Whistleblower 2 oversaw an

¹⁰ <http://www.va.gov/HOMELESS/VJO.asp>

initiative called "Motivation for Change" that complemented the VJO Program by assisting Veterans with legal problems and attempting to get legal charges reduced.

Employee 1 responsibilities include conducting case reviews with parole officers. She reported that during a case review on June 25, 2014, **Whistleblower 2** name and program were mentioned as part of a discussion of cases with the parole officer. She stated at that time she mistakenly entered his name and accessed his EHR. She states that once she realized her error, she did not read any information, immediately closed the medical record, and did not enter a note. She stated that she informed the whistleblower that same day, but did not notify her supervisor about the inadvertent record access.

According to the Medical Center's privacy office, on October 29, 2014, the whistleblower notified the privacy office that **Employee 1** had accessed his medical record, and requested a Sensitive Patient Access Report (SPAR) that identifies any individuals who have accessed a medical record. After receiving the SPAR confirming **Employee 1** access, he requested an investigation. The Medical Center's Privacy Office investigated the incident and determined that **Employee 1** had accessed the EHR but had not entered a note. They referred the case to VA's NSOC responsible for assigning risk severity ratings to each such incident. Since the NSOC had assigned this incident a low risk severity rating, the Medical Center's Privacy Office mistakenly took this to mean that the whistleblower's medical record had not been impermissibly accessed. The whistleblower was not satisfied with this result and left a message for the VISN 18 Information Security Officer requesting assistance. He never received a reply, and he provided no evidence to support this attempted contact. The VISN 18 Information Security Officer did not recall receiving a message from the whistleblower; at our request he reviewed his email, voice mail, and phone records and found no evidence of any call or email from the whistleblower.

In addition to reporting this incident to OSC, **Whistleblower 2** also requested a review of this matter by the VHA Central Office (VHACO) Privacy Office, that confirmed that they had received the whistleblower's request and completed their investigation in conjunction with our review, in addition to providing a subject matter expert (SME) to participate with the site visit team. The results of that review are contained in a letter to the whistleblower (Attachment B).

On April 16, 2015, the whistleblower submitted additional concerns to the VHACO Privacy Office about unauthorized accesses to his medical record. The office conducted an additional investigation into these concerns at our request, and found:

- Twelve individuals were identified as having accessed the whistleblower's EHR.
- In 10 of these 12 cases, the individuals were conducting official duties related to treatment, payment, or health care operations. These activities are appropriate exemptions under the Health Insurance Portability and Accountability Act.

- In the two remaining cases, the involved individuals - a Program Analyst in Mental Health and a Licensed Practical Nurse – reported that they had mistakenly entered the whistleblower's EHR while attempting to make entries in that of a different individual whose name is very similar to the whistleblower's. The VHACO Privacy Office treated both incidents as unauthorized accesses and took appropriate administrative action.

The Privacy Office verified that all involved parties had completed their mandatory annual privacy training.

Conclusion for Allegation 4

- VA **substantiated** that **Employee 1** access into the whistleblower's EHR, although believed to be inadvertent, was impermissible. VA also determined that the prior designation as permissible was the result of a misunderstanding of the NSOC determination. VA determined that Medical Center management re-educated the Privacy Office about the misunderstanding and took appropriate action upon learning of the impermissible access. As a result, no additional action is warranted.
- VA **did not substantiate** that **Employee 1** entered or deleted a note from the whistleblower's medical record.
- VA **substantiated** that 2 of 12 additional accesses were unauthorized. VA determined that Medical Center management took appropriate action upon learning of the impermissible accesses. As a result, no additional action is warranted.

Recommendation to the Medical Center

7. Continue to assess training and compliance with privacy laws and rules and provide appropriate educational, administrative, or disciplinary action to address non-compliance.

Additional allegations raised by **Whistleblower 1**

The Medical Center leadership engaged in gross mismanagement by failing to adequately staff ED SW positions.

He alleges that in the past, there was no dedicated SW in the ED, and off-tour coverage was provided by on-call SWs, as needed. He further alleged that increased SW coverage was provided only after he raised allegations of inadequate staffing. He did not provide a timeframe during which he made his concerns known to leadership.

According to the Chief, SW Service, and the ED Nurse Manager, prior to October 2013, a SW covered the ED during the day, an MH RN covered the ED during the evening shift, and no SW was assigned during the night shift. In October 2013, the MH RN was reassigned to a different department, and the ED was covered by on-call SWs during

the evening shift. According to Medical Center Policy Memorandum No. 122-04, *Social Work Emergency Department (ED) On Call Policy*, on-call SWs were required to respond to calls from the Medical Center within 20 minutes and report to the Medical Center, if needed, within 1 hour of the call during their on-call duty time. In January 2014, the Chief, SW Service, requested six additional SW positions to ensure 24/7 coverage of the ED. The request was approved August 6, 2014, by the Medical Center's Position Management Committee, and to date, five of the six positions have been filled.

Additional Conclusion RE: Whistleblower 1

- VA did not substantiate that Medical Center leadership engaged in gross mismanagement by failing to adequately staff ED SW positions. The Medical Center's prior method of providing coverage using on-call SWs is an acceptable way to ensure patient needs are met.

Additional allegations raised by Whistleblower 2, April 17, 2015

Whistleblower 2 alleged that after the Medical Center discontinued his Motivation for Change program, it did not continue to provide the follow-up services participants required to meet the conditions of their legal arrangements.

Whistleblower 2 alleged that the Medical Center lacked support for staff to deal with a patient's suicide.

From October 2012 through January 2015, Whistleblower 2 conducted a program called "Motivation for Change." The whistleblower alleged that after the program was discontinued, the Medical Center did not continue to provide the follow-up services participants required to meet the conditions of their legal arrangements.

Findings

VHA Handbook 1162.06, *Health Care for Re-entry Veterans (HCRV)*, April 9, 2010, is part of a continuum of services designed to serve justice-involved Veterans. HCRV provides outreach, assessment, referral, and linkage to services for Veterans within 6 months of release from state and Federal prisons, and sets forth the national authority for the administration, monitoring, and oversight of HCRV services. A related program, VJO, serves Veterans in contact with community law enforcement, Veterans incarcerated in local jails and Veterans involved with treatment courts. Whistleblower 2 implemented Motivation for Change as an extension of existing VJO programs to provide extended assistance to Veterans in the criminal justice system, and in some cases, to facilitate having their criminal charges or penalties reduced. To avoid imprisonment, participating Veterans were required to complete the 52-week Motivation for Change program activities and counseling. There is no formal Medical Center or VHA policy describing the program, its criteria for admission, or its procedures. The Medical Center discontinued the specific Motivation for Change program in January

2015. In order to ensure the participants were able to meet all VJO conditions, the Medical Center reassessed and contacted all Veterans in the program, reassigned some to other VJO programs, and referred others to other MH programs and clinics.

- **Whistleblower 2** also voiced concerns about the lack of support for staff after a patient commits suicide. He wanted to seek help dealing with a patient's suicide and reported that he was not aware of the EAP until early October 2014, when one of his patients committed suicide.

Findings

VA Handbook 5019/5 Part VI, *Occupational Health Services*, January 23, 2015, outlines EAPs, which are voluntary, work-based programs that offer free and confidential assessments, short-term counseling, referrals, and follow-up services to employees who have personal or work-related problems. EAPs address a broad and complex body of issues affecting mental and emotional well-being, such as alcohol and other substance abuse, stress, grief, family problems, and psychological disorders. EAP counselors also work in a consultative role with managers and supervisors to address employee and organizational challenges and needs.¹¹ EAP is discussed during new employee orientation.

The Substance Abuse Clinic conducted a group counseling session after this patient's suicide that occurred in October 2014, during which they discussed dealing with a patient's suicide. The whistleblower did not feel that this meeting was enough, and so his supervisor provided information about EAP. With the exception of the whistleblower, all other staff were aware of the EAP program since starting their employment with VA.

Additional Conclusions **Whistleblower 2** April 17, 2015 allegations

- VA did not substantiate that patients were abandoned after the Medical Center discontinued the Motivation for Change program.
- VA did not substantiate a Medical Center lack of support for staff dealing with patient loss.

Recommendation to the Medical Center

8. Continue to highlight the availability of EAP for MH staff especially for those whose patients have committed suicide.

Additional allegations raised by **Whistleblower 2** June 8, 2015

Whistleblower 2 raised concerns about scheduling overtime for ED SW coverage.

¹¹ <http://www.opm.gov/policy-data-oversight/worklife/employee-assistance-programs/>

Whistleblower 2 made allegations related to a news report of a Veteran, [Veteran 4], who committed suicide in a Veterans Benefit Administration parking lot, where he "wonders if the Veteran stopped by the ED in the weeks leading up to his suicide....and if they were unable to fill [his opioid prescriptions]?"

Findings

The VA team reviewed the provided documentation in the email, employee work schedules, and interviewed the Chief of SW with regard to this allegation. The allegation specifies overtime work done to ensure weekend coverage of the ED by SWs. As provided by our HR SME, the American Federation of Government Employees contract states in article 21 section 3d, "employees shall not be required to report to work unless they have had at least 12 hours of off duty time between work hours. Exceptions may be made by mutual agreement between employees and supervisor." The SW supervisor advertised for volunteers to cover several shifts needed to ensure 24-hour coverage of the ED by SWs. One volunteer agreed to cover the shifts, and this was mutually agreed to by the volunteer and the supervisor. All shifts were covered. There were no reported concerns with the SW coverage during this time, and the age of the provider was not relevant.

The VA team reviewed the EHR of Veteran 4. He was a 53-year-old male, who on August 29, 1998, registered at the Medical Center. He was also registered at the Puget Sound VA Health Care System, where he had no recorded clinical visits. Veteran 4 was rated as 10-percent disabled due to his service-connected condition, bronchial asthma. His other health conditions included refraction disorder NOS, hyperlipidemia, hypercholesterolemia, tendinitis, pain in limb, calculus of ureter, hip pain, diabetes mellitus, tinea, impacted cerumen, dental abscess, allergic rhinitis, and impaired dentition. He was followed in primary care and was seen 21 times from May 25, 2001, to January 20, 2015, with 10 MH screenings completed during that time. His last screen for PTSD, January 20, 2015, was negative, and his last screening for depression and alcohol abuse, September 29, 2014, were both negative. The Veteran had never been seen by, nor referred to, any MH services at the Medical Center and was not flagged as high risk for suicide or referred to the Suicide Prevention Team. The EHR indicated that he committed suicide by gunshot wound, although he had in the past denied to his VA providers that he had access to a gun.

With regards to Whistleblower 2 wondering "if Veteran 4 had stopped by the ED in the weeks leading up to his suicide... and if they were unable to fill his opioid prescriptions," there is no evidence of visits to the ED with concerns about suicide, or opioid prescriptions. The last time Veteran 4 had filled an opioid prescription at the Medical Center was in 2013. The Arizona, New Mexico, and Texas state prescription drug monitoring programs report no record of this Veteran having received non-VA fills of controlled medications.

Newspaper articles referenced by Whistleblower 2 reported that Veteran 4 had problems with his housing situation. This Veteran was not in a VA homeless program

but was in stable subsidized housing. VA confirmed that he had received a late payment notice for missing one monthly payment; however, he had not received an eviction notice as reported in the press.

Additional Conclusions RE: Whistleblower 2 allegations, June 8, 2015

- With regard to the ED SW overtime scheduling, although VA does not find it ideal to schedule a provider for multiple shifts in a short period of time, there was no violation of policy, law, rule or regulations, in scheduling such shifts.
- VA **did not substantiate** that Veteran 4 had presented to the Medical Center's ED for care related either to suicide ideation or pain management.

Recommendation to the Medical Center

9. Ensure adequate staffing to cover SW shifts in the ED to limit the use of overtime.

Summary Statement

VA has developed this report in consultation with other VHA and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, OGC has provided a legal review, and OAR has examined the issues from a HR perspective to establish accountability, when appropriate, for improper personnel practices. VA found no violation or apparent violation of any law, rule, or regulation. VA found evidence of violations of VA and VHA policy that were being addressed prior to this investigation. Therefore, as a result of this investigation, there are no changes in rules, regulations, or policy planned, and no additional accountability actions warranted except as noted above.

Attachment A

Documents Reviewed in Addition to the Electronic Medical Record:

VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 1.0, June 2013

VHA Handbook 1162.06, *Health Care for Re-entry Veterans (HCRV) Program*, April 9, 2010

VA Handbook 5019/5 Part VI, *Occupational Health Services*, January 23, 2015

Medical Center Policy Memorandum No. 122-19, *Suicide and Suicide Related Behavior*, November 13, 2014

VHA Directive 2010-008, *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities*, February 22, 2010

Medical Center Policy Memorandum No.11-98, *Suicidal/Homicidal Ideation and Other High-Risk Patient Management in the Emergency Department*, July, 2, 2007

Medical Center ED Suicide Risk Assessment Template

Medical Center Emergency Department Information System Reports for Missed Opportunities and Patients Seen for March 2014–March 2015

Medical Center Motivation for Change Phases Overview

Medical Center Safety Observer training

Medical Center ED staffing schedules

VA Police ED elopement reports

Medical Center SARRTP Program Description

Medical Center Policy Memorandum No. 3, (Psychiatry Service/116A), *Substance Abuse Residential Rehabilitation Treatment Program (SARRTP) Standard Operating Procedure (SOP): Managing Suicidal Patients*, July 24, 2014

Medical Center staff competency records

Medical Center Psychology Service Standard of Operation policies

Medical Center Policy Memorandum No. MH & BSS 116A-07, *Processing Involuntary Psychiatric Patients*, December 18, 2011

Medical Center Policy Memorandum, No. 132-13, *Management of Wandering and Missing Patients*. April 28, 2011

Medical Center Social Work Service Staff Meeting minutes

Attachment B



DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
VHA Privacy Office (10P2C1)
810 Vermont Avenue, NW
Washington, DC 20420

In Reply Refer To: 10P2C1

March 23, 2015

Whistleblower 2

Whistleblower 2

This letter is in response to your privacy complaint received on January 8, 2015 where you allege that a note by Employee 1 was deleted from your health record, and that you received conflicting information about the status of your privacy complaint and lastly, that your health records were inappropriately accessed on June 25, 2014 at 13:53pm by your co-worker Employee 1. We have thoroughly investigated your complaint. This letter addresses each of your complaints.

Complaint #1: Regarding your inquiry as to whether or not Employee 1 authored a note in your health record that was subsequently deleted, we have no information or evidence to substantiate that a Computerized Patient Record System (CPRS) progress note was entered in and/or removed by Employee 1 or any other staff member at the Phoenix Veterans Affairs Medical Center (VAMC). Please be advised that the entry of progress notes into the VistA/CPRS health record is governed by VA business rules for user classes and person classes and by health record documentation requirements. This information can be found within the CPRS Text Integrated Utilities technical and user manuals and also within VHA Handbook 1907.01. We have determined that the allegations of a progress note being entered into your record and subsequently removed cannot be substantiated.

Complaint #2: Regarding your complaint that you received conflicting information in December 2014 on the status of your privacy complaint, we are unable to investigate this issue neither are we able to determine the accuracy of the information you were provided without additional factual information. Based on our documentation review, the response letter to your complaint was dated December 18, 2014. If you have concerns on the local process we advise that you schedule a meeting with the Privacy Officer to obtain further clarification.

Complaint #3: Regarding your complaint as to the validity of the investigation and whether or not it was conducted in an unbiased manner, we have determined that the investigation of your complaint was conducted appropriately by the Privacy Officer. All employees are responsible for reporting known privacy complaints and/or violations

to the Privacy Officer and/or Information Security Officer for logging and investigation. After your privacy complaint is submitted, the Privacy Officer will:

- a) Speak to you about your privacy complaint and obtain any additional information necessary to review and examine your privacy complaint;
- b) Conduct a thorough interview of VA staff involved in the matter surrounding your privacy complaint;
- c) Review your records in question, as necessary, to assist in the review of the privacy complaint; and
- d) Provide a written response to your privacy complaint outlining the results and findings of the review, including whether or not your privacy complaint is valid and a privacy violation occurred.

The Privacy Officer cannot share any details on any disciplinary action that may result from a privacy complaint that is determined to be a privacy violation. For example, the Privacy Officer cannot inform you that a specified VHA employee has been suspended or otherwise disciplined as a result of your complaint. This information is subject to specific restrictions on disclosure or use and is protected by federal privacy laws and regulations.

Per VA Policy, a Privacy Security Event Tracking System (PSETS) ticket was entered on November 10, 2014 by the Privacy Officer, and the classification of the ticket was entered appropriately as an "incident". A privacy incident is defined as a privacy or security-related event in which PII may have been exposed through either unauthorized access or disclosure. Access to your health record by Employee constitutes a privacy incident and triggers additional reviews by the VA Data Breach Core Team (DBCT) and/or the VA Incident Resolution Team (IRT).

Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, privacy incidents are presumed to be a reportable data breach, unless after a risk assessment there is a low probability that the protected health information (PHI) has been compromised. The risk assessment takes multiple factors into account in determining the risk including the type of information involved, who the information was disclosed to and whether the VA has been able to mitigate the risk.

Please be advised that the DBCT and IRT are considered the authoritative sources within VA for determining whether or not a data breach has occurred. As a result of the review, it was determined on December 18, 2014 by the IRT that your privacy complaint does not constitute a data breach under the HIPAA Privacy Rule criteria.

Based on our investigation there is still no information that would lead VA to believe that there was further use or disclosure of your record in a manner that is not permitted by VA policy. When reviewing the December 18, 2014 facility response letter,

we have determined that the specific language listed below did not constitute a clear explanation and delineation of what is considered an incident of a privacy violation versus a data breach.

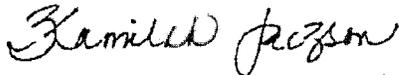
"The Privacy Officer at the Phoenix VA Health Care System has thoroughly investigated your complaint and we have determined the extent of the complaint. We are pleased to inform you that your medical information was not impermissibly accessed or disclosed. This was determined to be an unintentional chart access without chart documentation or disclosure. In conclusion, no violation was found."

The VHA Privacy Office has communicated our findings to the Privacy Officer. This letter supersedes the initial facility determination letter dated December 18, 2014. Please be advised that our final determination is that no data breach occurred meeting the HHS breach criteria. In reviewing the HIPAA Privacy Rule and Privacy Act authority for workforce members' access to PHI/PII we have determined that **Employee 1** in the performance of her official VA job duties has appropriate access to CPRS, however that the inadvertent access to your health record during the course of case review of mutual patients, was still impermissible. All employees are reminded to take caution when accessing health records. Appropriate actions have been taken by the facility; therefore no additional follow-up will be conducted. Finally, at the conclusion of our investigation we are unable to substantiate your allegations that **Employee 1** access to your health record was done with malicious intent for re-disclosure nor that a specific subset of information was reviewed.

We take the privacy concerns of our Veterans very seriously and hope that you will continue to bring privacy related matters to our attention. We apologize for the delay in responding to your privacy complaint. If you feel this letter inadequately addresses your privacy complaint or your concerns you may also file your complaint with the Department of Health and Human Services (HHS).

You may contact HHS at 1-800-368-1019 or through the following website, <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>. You will find a fact sheet that gives you step by step instructions on how to file a complaint. A copy of your original privacy complaint is attached.

Sincerely,



Kamilah Jackson, MS, RHIA, CHPS, CIPP/US, CIPP/G
VHA Privacy Specialist
VHA Privacy Office (10P2C1)

Enclosure (Privacy Complaint Letter, 4-pages)

Cc: Privacy Officer, Phoenix VAMC