



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Inadequate Emergency
Department Care and
Physician Misconduct at the
Washington DC VA Medical
Center



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Executive Summary

The VA Office of Inspector General (OIG) conducted an inspection to assess the validity of allegations related to the care provided to a patient in the Washington DC VA Medical Center (facility) Emergency Department prior to the patient's death by suicide six days later. The complaint included an allegation of poor medical care and a facility Emergency Department physician's (physician 2) statement to the effect of "[the patient] can go shoot [themselves]. I do not care."¹

The OIG substantiated that the patient presented to the Emergency Department with suicidal ideation and died six days later. The medical examiner's office determined that the patient died by suicide by self-inflicted gunshot wound. The OIG also found that Emergency Department and consulting psychiatry staff failed to complete required suicide prevention planning prior to the patient's discharge.² Emergency Department staff's failure to manage this patient's care, according to Veteran Health Administration (VHA) suicide prevention policies, contributed to an inadequate assessment of suicide risk.

The patient was in their 60s at the time of death by suicide. The patient had a long history of panic attacks, benzodiazepine and opioid dependence, benzodiazepine withdrawal seizures, osteoarthritis, and a remote history of multiple surgeries related to a motor vehicle accident. In 2014, a facility primary care provider referred the patient to the facility Primary Care Behavioral Health psychiatry resident physician for symptoms of benzodiazepine withdrawal. The Primary Care Behavioral Health psychiatry resident physician referred the patient to a community-based outpatient clinic psychiatrist. The community-based outpatient clinic psychiatrist planned a taper of the patient's benzodiazepine medication and initiated an antidepressant medication to address anxiety and insomnia. However, the patient was unable to tolerate outpatient benzodiazepine tapering; the psychiatrist documented that the patient's detoxification was complicated and best suited for inpatient treatment. The patient was admitted to the facility inpatient medical service for detoxification in summer 2014. The patient briefly attended outpatient substance abuse treatment but dropped out of substance abuse treatment and outpatient mental health treatment

¹ The original allegation identified physician 2's statement as "[the patient] can go shoot [themselves]. I do not care." Other individuals reported physician 2's statement with similar content but varying language; the OIG uses the singular form of they in this instance for privacy purposes.

² VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017. VA Assistant Deputy Under Secretary for Health for Clinical Operations Memorandum, *Suicide Prevention in Emergency Departments (SPED): Suicide Safety Planning and Follow Up Interventions*, September 7, 2018. Deputy Undersecretary for Health for Operations and Management Memorandum, *Eliminating Veteran Suicide: Implementation of Suicide Risk Screening and Evaluation*, November 2, 2018.

because the patient did not identify with having a substance abuse diagnosis and disagreed with the psychiatrist's plan of benzodiazepine tapering.

The patient's next contact with the facility occurred in early 2019, when the patient called the medical advice line with a complaint of worsening lower back pain and having run out of prescribed pain medication. The medical advice line nurse documented that the patient planned to come to the Emergency Department. The following day, the patient, accompanied by a family member, presented to the Emergency Department and complained of alprazolam and oxycodone withdrawal and being unable to sleep.³ The Emergency Department resident physician documented the patient's desire for inpatient admission for detoxification from opioid and benzodiazepine medications, recommended outpatient psychiatry follow-up, and the Emergency Department attending physician (physician 1) documented agreement with the "assessment, management and disposition." An Emergency Department social worker scheduled the patient for a same-day outpatient psychiatry evaluation.

The patient and family member reported dissatisfaction with care to a Veteran Experience Specialist, reiterating a request for admission for detoxification.⁴ The Veteran Experience Specialist described escorting the patient and family member back to the Emergency Department and informing an Emergency Department staff member of the patient's preference for admission. Following the contact with the Veteran Experience Specialist, the patient presented to the outpatient psychiatry appointment as instructed.

An outpatient psychiatrist assessed the patient as being at moderate risk for suicide and recommended either an inpatient medicine admission for management of opioid and benzodiazepine withdrawal or an inpatient psychiatry admission for management of withdrawal, insomnia, and anxiety. The outpatient psychiatrist escorted the patient back to the Emergency Department for evaluation and reportedly provided a verbal hand-off directly and through an alert in the electronic health record to physician 1.⁵ The patient's family member left the facility with the expectation that the patient was being admitted.

³ Merck Manual, Professional Version, *Alprazolam*. Alprazolam is a benzodiazepine medication prescribed for anxiety. <https://www.merckmanuals.com/professional/resources/brand-names-of-some-commonly-used-drugs>. (The website was accessed on August 9, 2019.) Merck Manual, Professional Version. *Oxycodone*. Oxycodone is an opioid medication used for pain management. <https://www.merckmanuals.com/professional/resources/brand-names-of-some-commonly-used-drugs>. (The website was accessed on August 9, 2019.)

⁴ Veteran Experience Specialists work in the facility's Office of Patient Experience and Advocacy and help resolve patient issues that are unable to be resolved at the department or service level. Facility Patient Experience and Advocacy Office. https://www.washingtondc.va.gov/services/Patient_Advocate_Office.asp. (The website was accessed on March 3, 2020.)

⁵ U.S. Department of Health and Human Services, Patient Safety Network, "Handoffs and Signouts," January 2019. For the purpose of this report, "hand-off" encompasses both the process of transferring responsibility for a patient's care and transmitting information about a patient from one provider to another when transferring responsibility for a patient's care. <https://psnet.ahrq.gov/primers/primer/9/handoffs-and-signouts>. (The website was accessed on August 9, 2019.)

A physician assistant (physician assistant 1) documented the patient was to be admitted to inpatient psychiatry and paged the consulting psychiatry resident physician for an admission evaluation. Physician assistant 1 provided a verbal hand-off to the oncoming physician assistant (physician assistant 2). The consulting psychiatry resident physician assessed the patient's suicide risk as "mild" and documented that the patient denied suicidal ideation and denied "safety concerns." The consulting psychiatry resident physician recommended discharge to home. The patient's discharge instructions included follow up with the Mental Health Clinic, although the instructions did not include information about when to follow up, if the clinic was a walk-in clinic, or if the patient needed a scheduled appointment.

When informed of the discharge plan, the patient refused to leave. A second Emergency Department attending physician (physician 2) documented that the patient was "clearly malingering" and "ranting" and called VA police to escort the patient from the Emergency Department. After being escorted from the building, the patient wanted to return to the Emergency Department to address knee pain. Staff members reported that when informed of the patient's plan to return, physician 2 dismissed the patient's reported symptoms and shouted, "[the patient] can go shoot [themselves]. I do not care."⁶ While the OIG confirmed that at least three facility staff members heard the statement, the OIG could not confirm that the patient heard this statement. The patient was picked up by the family member and left the facility.

The patient navigated two transitions between the Emergency Department and outpatient Mental Health Clinic and saw seven providers over the course of 12 hours. The lack of collaboration between Emergency Department and inpatient mental health providers, deficiencies in the hand-off process, and the Emergency Department and inpatient mental health providers' failure to read the outpatient psychiatrist's notes led to a compromised understanding of the patient's treatment needs and a failure to enact the outpatient psychiatrist's recommended treatment plan.

Two days after the patient presented to the Emergency Department, the outpatient psychiatrist entered a consult for the outpatient substance use treatment program indicating that the patient was informed of the appointment date and time of early 2019 (five days after the Emergency Department visit), at 8:00 a.m. However, the OIG found no evidence that staff informed the patient of the appointment date and time. An outpatient nurse closed the consult and added a comment that the patient was to report to the outpatient substance use treatment program five days after the Emergency Department visit, at 8:00 a.m. However, contrary to VHA policy, the nurse explained that an appointment was not scheduled because it was not program procedure

⁶ The original allegation identified physician 2's statement as "[the patient] can go shoot [themselves]. I do not care." However, other individuals reported physician 2's statement with similar content but varying language. Department of Veterans Affairs, 38 CFR, Part 0, Federal Register Volume 77, Number 135, *Care Values and Characteristics of the Department*, July 13, 2012. VA defines its core values as ICARE: Integrity, Commitment, Advocacy, Respect, and Excellence. "The Values represent VA's beliefs and provide a baseline for the standards of behavior expected of all VA employees." Facility Policy PM-05-13, *Abuse and Neglect of Patients, Residents, or Employees*, January 5, 2018.

at the time to schedule consult appointments. The nurse erroneously thought that the patient was already in treatment with the outpatient psychiatrist. Because the patient had no scheduled appointment, staff did not follow up with the patient as required for missed appointments. The patient's family member called the facility's medical advice line and informed the medical advice line nurse that the patient died at home in early 2019 (six days after the patient presented to the Emergency Department).

The OIG substantiated that Emergency Department staff were initially aware of the patient's reported history of withdrawal seizures and that the patient ran out of opioid and benzodiazepine medications and discharged the patient with a same-day outpatient psychiatry appointment. The OIG also found that upon the patient's return to the Emergency Department, providers failed to document a review of the patient's withdrawal seizure history or evaluate the patient's risk for adverse consequences related to withdrawal from prescribed opioid and benzodiazepine medications.

The OIG found that facility providers failed to reevaluate the patient's vital signs and despite the patient's withdrawal risk, Emergency Department staff discharged the patient without a thorough understanding of the patient's withdrawal management needs. The providers' lack of systematic assessments, of either the patient's risk factors for moderate to severe withdrawal or the patient's expressed suicidal thoughts related to withdrawal symptoms, contributed to a failure to properly assess the patient's risk for significant harm, including death by suicide and benzodiazepine withdrawal.

The OIG found that the outpatient psychiatrist transferred care of the patient to physician 1 by person-to-person contact as preferred by facility policy.⁷ However, the OIG determined that physician assistant 2, the consulting psychiatry resident physician, and physician 2 failed to document review of the relevant patient history to inform medical decision-making. The OIG opines that the three providers failed to evaluate the patient's overall psychiatric and medical needs but rather focused on discharging the patient based on a narrow perspective of the patient's presentation. The failure to adequately consider the outpatient psychiatrist's assessment from earlier that day may have resulted in the patient's discharge without consideration of identified suicide and medical risk factors.

The OIG further substantiated that physician 2 made a statement to the effect of "[the patient] can go shoot [themselves]. I do not care." While this statement was inconsistent with VHA patient care tenets and suggested a high level of insensitivity to the patient's needs, it could also be

⁷ Facility Policy PM-11-13, *Patient Hand-off Communication*, January 5, 2018. In independent OIG team interviews, the outpatient psychiatrist and physician 1 described person-to-person contact in the patient's transfer of care.

considered misconduct according to VA policy and patient abuse according to facility policy.⁸ Facility and contracted staff failed to adhere to facility policy regarding reporting of employee misconduct and patient abuse and did not receive required annual abuse and neglect policy education. Physician 2 had a history of verbal misconduct including in fall 2018 toward the Chief, Emergency Department and another facility physician and in spring 2019 toward VA police.

The Chief of Staff told the OIG that physician 2's clinical outcomes were very good and acknowledged problems with physician 2's attitude. The Chief of Staff noted ongoing review and "scrutiny" of physician 2; however, physician 2 was not immediately removed from the contract. In fall 2019, the Chief of Staff told the OIG that if leaders received one more complaint about physician 2, they would consider not renewing physician 2's privileges that were up for review six months later. Despite facility leaders' awareness by late spring 2019 of physician 2's inappropriate statement regarding the patient and physician 2's prior pattern of misconduct, the OIG found that facility leaders did not conduct a formal fact-finding or administrative investigation as required by VA.⁹ The OIG opines that the Chief of Staff focused on physician 2's overall positive clinical outcomes, and that the Chief of Staff and the Facility Director believed that clinical reviews of the patient's care were sufficient, and therefore, did not pursue formal administrative reviews related to physician 2's pattern of verbal misconduct.

In fall 2019, after receiving another report of verbal misconduct by physician 2 directed toward an Emergency Department nurse, the Chief, Emergency Department, expressed concerns to the Chief of Staff about physician 2's conduct. A few days later, the Facility Director reported concerns about physician 2's conduct to the Contract Officer and requested that physician 2 be "replaced as a contract provider at this facility."¹⁰ The Facility Director told the OIG that physician 2's last day in the Emergency Department was late 2019, and a Medical Faculty Associates Risk Manager reported that physician 2 resigned from Medical Faculty Associates, Inc. three days later.

⁸ The original allegation identified physician 2's statement as "[the patient] can go shoot [themselves]. I do not care." However, other individuals reported physician 2's statement with similar content but varying language. Department of Veterans Affairs, 38 CRF, Part 0, Federal Register Volume 77, Number 135, *Core Values and Characteristics of the Department*, July 13, 2012. VA defines its core values as ICARE: Integrity, Commitment, Advocacy, Respect, and Excellence. "The Values represent VA's beliefs and provide a baseline for the standards of behavior expected of all VA employees." Facility Policy PM-05-13, *Abuse and Neglect of Patients, Residents, or Employees*, January 5, 2018. VA Handbook 5021/25, *Employee/Management Relations*, December 28, 2017.

⁹ VA Handbook 5021/25.

¹⁰ Through a contract, George Washington University Medical Faculty Associates, Inc. provides Emergency Department physician and physician assistant services to the facility. Medical Faculty Associates, Inc. proposed providing 14 physicians and physician assistants to fulfil contractual requirements and 8 additional physicians and physician assistants for back-up coverage.

VHA requires organizational leaders to file a report with the State Licensing Board and National Practitioner Data Bank when a provider has issues of professional competence or conduct.¹¹ Facility leaders did not report physician 2 to the State Licensing Board or National Practitioner Data Bank. Facility leaders' failure to consider administrative investigation or disciplinary action resulted in physician 2 continuing to provide patient care for nine months after the events occurred with the patient in early 2019. During those nine months, there were two additional documented accounts of physician 2's misconduct toward other facility employees. Failure to follow VHA and facility policy in response to incidents of employee misconduct and patient abuse undermines the public interest and presents an ongoing risk to VHA patients and staff. As discussed above, the OIG opines that the Chief of Staff's focus on physician 2's overall positive clinical outcomes contributed to a failure to notify the State Licensing Board or National Practitioner Data Bank.

The OIG found that the facility's Suicide Prevention Coordinator failed to complete the suicide behavior report following notification of the patient's death by suicide, as required by VHA.¹² In an interview with the OIG team, the Suicide Prevention Coordinator was unable to locate a suicide behavior report and acknowledged that failure to complete it was an oversight. Failure of staff to consistently complete suicide behavior reports compromises the accuracy of VHA's suicide-related events data that may be used to identify trends of self-directed violence behaviors and determine suicide prevention efforts.

The OIG further found that the facility's Emergency Department failed to meet VHA's requirements for a safe and secure evaluation area for patients seeking mental health services. Lack of a safe and secure area for patients presenting with emergent mental health needs, including a psychiatric evaluation room, may result in privacy violations and an inability to adequately evaluate and monitor patients at risk of elopement or suicidal behaviors. Due to limited physical space, the Emergency Department did not contain a psychiatric intervention room for patients presenting with mental health needs. Beginning in 2009, facility leaders have pursued a renovation project that included three mental health examination rooms.¹³ In 2019, facility leaders submitted a request for Veteran Integrated Service Network (VISN) approval to expand the Emergency Department and several months later, the VISN approved the request. As of April 7, 2020, the VISN Deputy Quality Management Officer reported the bid was obtained

¹¹ VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005. The National Practitioner Data Bank is a web-based tool for reporting healthcare practitioners' adverse actions. U.S. Department of Health and Human Services, "National Practitioner Data Bank." <https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp>. (The website was accessed on January 27, 2020.) VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009.

¹² VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

¹³ Starting in 2009, proposals for Emergency Department renovation were pursued with multiple reasons for halting including structural issues and cost.

and process in place for awarding the contract. On May 11, 2020, the VISN Capital Asset Manager reported that VA Contracting and Office of General Counsel decided to resolicit the project given the time lapsed and cost limit increase approval in March 2020 and cited an anticipated award date of September 30, 2020.

Facility leaders told the OIG that in response to their review of this patient's care, mental health leaders implemented revised inpatient mental health admission procedures to include a warm hand-off between outpatient and inpatient mental health providers to discuss rationale for admission.

The OIG made one recommendation to the Veterans Integrated Service Network Director related to leadership and supervisory response to allegations of employee misconduct and patient abuse, and 10 recommendations to the Facility Director related to suicide prevention, assessment of withdrawal symptoms, education on policies related to employee misconduct and patient abuse, State Licensing Board and National Practitioner Data Bank reporting, and hand-off processes. Recommendations also focused on reconciliation of diagnostic and care plan information, family member involvement in care plan development, suicide behavior and overdose reporting, consult scheduling, and ensuring a safe and secure Emergency Department area for evaluation of mental health patients.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes A and B). The OIG considers all recommendations open and will follow up on the planned and recently implemented actions to allow time for the Veterans Integrated Service Network and facility to submit documentation of actions taken and to ensure that they have been effective and sustained.



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Abbreviations

OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted an inspection to assess the validity of the allegations related to the care provided to a patient in the Washington DC VA Medical Center (facility) Emergency Department prior to the patient’s death by suicide six days later. The complaint included an allegation of poor medical care and a facility Emergency Department physician’s (physician 2) statement to the effect of “[the patient] can go shoot [themselves]. I do not care.”¹⁴

Background

The facility, part of the Veteran Integrated Service Network (VISN) 5, offers comprehensive primary and specialty care in medicine, surgery, neurology, and psychiatry. The facility provides specialized services including cardiology, home-based primary care, women’s health, interventional radiology, renal care, trauma services, homeless outreach, compensated work therapy, substance abuse treatment, and telehealth and virtual services. The facility operates six community-based outpatient clinics. From October 1, 2018, through September 30, 2019, the facility served 80,953 patients and had a total of 265 hospital operating beds, including 175 inpatient beds, and 90 community living center beds. The facility has affiliations with the George Washington University Medical Center, Georgetown University Medical School, Howard University, and Uniformed Services University of the Health Sciences. Through a contract, George Washington University Medical Faculty Associates, Inc. provides Emergency Department physician and physician assistant services to the facility.¹⁵

Prior OIG Reports

A 2018 report, *Critical Deficiencies at the Washington DC VA Medical Center*, found deficits related to failures in leadership. The report was issued in response to a confidential complaint regarding supply and financial mismanagement. The OIG found that although problems at the facility reached the awareness of responsible facility officials, “actions taken did not effectively remediate the conditions.” Additionally, VISN leaders were also aware of problems at the facility but did not ensure adequate corrective action on the part of facility leaders.¹⁶ The

¹⁴ The original allegation identified physician 2’s statement as “[the patient] can go shoot [themselves]. I do not care.” However, other individuals reported physician 2’s statement with similar content but varying language; the OIG uses the singular form of they in this instance for privacy purposes.

¹⁵ Medical Faculty Associates, Inc. proposed providing 14 physicians and physician assistants to fulfil the contractual requirements and eight additional physicians and physician assistants for back-up coverage.

¹⁶ VA Office of Inspector General, *Critical Deficiencies at the Washington DC VA Medical Center*, Report No. 17-02644-130, March 7, 2018.

associated recommendations were specific to sterile processing and there was a different Facility Director at the time of the prior inspection. However, the issue of facility leaders not taking immediate action upon learning of significant concerns remains relevant to the current inspection.¹⁷

Allegations and Related Concerns

On February 20, 2019, the OIG received a complaint related to the conduct of a facility Emergency Department physician and the care provided to a patient in the Emergency Department prior to the patient's death by suicide. On March 5, 2019, the OIG reviewed the complaint and requested a response from the facility. The Facility Director responded on May 31, 2019, and the OIG requested additional information. A VISN contact provided a response to the OIG on August 2, 2019. The OIG determined that the facility's response was inadequate and opened a hotline inspection.

The purpose of the inspection was to determine the validity of the following allegations:

1. Facility staff were aware that the patient had suicidal ideation, discharged the patient home, and the patient later died by suicide.
2. Facility staff were aware that the patient was out of medications, at risk for opioid and benzodiazepine withdrawal, and discharged the patient home.
3. Physician 2 stated "[the patient] can go shoot [themselves]. I do not care."¹⁸

The OIG team identified and reviewed four additional concerns:

4. Failed communication and discharge processes
5. Deficiencies in suicide behavior reporting
6. Noncompliance with consult scheduling process
7. Inadequate physical space and safety in the Emergency Department

¹⁷ The current Facility Director was appointed on October 14, 2018. U.S. Department of Veterans Affairs, "Washington DC VA Medical Center Leadership Team," July 29, 2019. <https://www.washingtondc.va.gov/about/leadership.asp>. (The website was accessed on January 7, 2020.)

¹⁸ The original allegation identified physician 2's statement as "[the patient] can go shoot [themselves]. I do not care." However, other individuals reported physician 2's statement with similar content but varying language.

Scope and Methodology

The OIG conducted site visits from October 15, 2019, through October 17, 2019, and on October 29, 2019.

The OIG team interviewed the patient's family member, facility leaders, VA police; and staff from the Emergency Department, outpatient mental health, patient safety and risk management, patient advocate office, and Medical Faculty Associates, Inc. The OIG team toured the Emergency Department. The OIG team reviewed the patient's electronic health record for the time period of early 2019.

The OIG team reviewed Veterans Health Administration (VHA) directives, handbooks, memoranda; facility policies and procedures; and a facility contract in effect in early 2019.

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

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Patient Case Summary

The patient was in their 60s at the time of death by suicide in early 2019. The patient had a long history of [panic attacks](#), [benzodiazepine](#) and [opioid dependence](#), benzodiazepine [withdrawal seizures](#), [osteoarthritis](#), and remote history of multiple surgeries related to a motor vehicle accident. The patient's first documented contact with VHA was at the facility's primary care clinic in late spring 2005. The primary care provider documented the patient's complaints of anxiety and knee pain and that the patient received benzodiazepine and opioid medications from a non-VA physician. The provider submitted an orthopedic consult and in summer 2005, the patient declined the orthopedic consultant's offer to provide non-opioid injections.

The patient was next evaluated by a facility Primary Care Behavioral Health psychiatry resident physician for symptoms of benzodiazepine withdrawal in summer 2014. The resident physician documented that a non-VA provider prescribed pain medications and [alprazolam](#) for the prior 15 years. The Primary Care Behavioral Health psychiatry resident physician scheduled the patient for an appointment with an outpatient psychiatrist at a community-based outpatient clinic. At the patient's first visit in summer 2014, the community-based outpatient clinic psychiatrist planned a taper of the patient's alprazolam and initiated an antidepressant medication to address [anxiety](#) and [insomnia](#). A week later, the patient presented with withdrawal symptoms. The patient declined the psychiatrist's offer of inpatient detoxification, and the psychiatrist postponed the taper due to the patient's severity of withdrawal symptoms. One week later, the psychiatrist further postponed the patient's alprazolam taper due to the patient's elevated heart rate and advised the patient that the treatment plan was to continue the taper "with stable vital signs in future."

A few days later, the community-based outpatient clinic psychiatrist documented that the patient requested inpatient detoxification and that the patient presented with "a very complicated detox [detoxification] process and is best suited for inpatient treatment." The patient was admitted to the facility's inpatient medical service for seven days in summer 2014 for detoxification due to the complexity of the medication regimen and severe withdrawal symptoms. As scheduled, the patient presented to the facility's outpatient substance abuse recovery program the day after discharge; four days later, the patient reported that the program was not "necessary or beneficial" and discontinued treatment.

In fall 2014, the primary care provider documented that the patient stopped seeing the community-based outpatient clinic psychiatrist because "all [the psychiatrist] wants to do is take me off the [alprazolam]." The patient reportedly had a scheduled appointment with a non-VA physician the following month. The patient returned to the Emergency Department in fall 2014, with increased anxiety and tremors, and requested alprazolam. The Emergency Department physician contacted psychiatry services, prescribed "a few [alprazolam] for home," and recommended the patient follow up with psychiatry.

From early 2015 through late 2018, the patient received opioid pain medication and alprazolam from a non-VA outpatient clinic. The patient's next contact with the facility occurred in early 2019, when the patient called the facility medical advice line and reported worsening back pain after a fall and "ran out of [the patient's] pain medications" prescribed by a non-VA physician. The medical advice line nurse documented that the patient planned to come to the Emergency Department.

In early 2019, the patient, accompanied by a family member, presented to the Emergency Department. At 10:30 a.m., a nurse documented the patient's chief complaint as alprazolam and [oxycodone](#) withdrawal and being unable to sleep. The patient's blood pressure and pulse rate were elevated. The patient and family member told the Emergency Department resident physician about being prescribed alprazolam and oxycodone, having recently changed pain management providers, and running out of medication three days prior. The Emergency Department resident physician ordered a single dose of alprazolam and recommended outpatient psychiatry follow-up for evaluation. After administration of the alprazolam, the patient's blood pressure and heart rate decreased. An Emergency Department social worker scheduled the patient for a same-day outpatient psychiatry evaluation at 3:00 p.m. The Emergency Department resident physician documented the patient's desire for inpatient admission for detoxification from opioid and benzodiazepine medications and the Emergency Department attending physician (physician 1) documented agreement with the "assessment, management and disposition."

In the outpatient Mental Health Clinic, the patient screened positive for depression and suicide risk, reporting thoughts of self-harm or being better off dead nearly every day for the past two weeks. The patient told the outpatient psychiatrist that the patient "has a low mood in the setting of withdrawal" from opioids and benzodiazepines. The patient described not sleeping for four days following discontinuation of medicine, "terrible" appetite and concentration, and feelings of hopelessness and helplessness. The outpatient psychiatrist documented that the patient was "worried about going home and would feel suicidal if not admitted for detox" and assessed the patient as being at moderate risk for suicide. The patient further described chronic daily anxiety and panic attacks multiple times per week. Based on the patient's presentation, as well as the patient's and family member's reports, the outpatient psychiatrist recommended either an inpatient medicine admission for management of opioid and benzodiazepine withdrawal or an inpatient psychiatry admission for management of withdrawal, insomnia, and anxiety. The outpatient psychiatrist escorted the patient and family member back to the

Emergency Department for evaluation, and reportedly provided a verbal hand-off directly and through an alert in the electronic health record to physician 1.¹⁹

On return to the Emergency Department, the patient's blood pressure and heart rate were slightly elevated. The patient denied suicidal ideation to an Emergency Department triage nurse at 4:37 p.m., and then expressed suicidal ideation to the Emergency Department physician assistant (physician assistant 1) at 5:31 p.m. Physician assistant 1 documented the patient was to be admitted to inpatient psychiatry and paged the consulting psychiatry resident physician at 5:36 p.m.²⁰ The patient's vital signs were checked shortly after 7:00 p.m. and the patient's blood pressure was further elevated. At 7:05 p.m., physician assistant 1 ordered a dose of alprazolam to be given immediately. Physician assistant 1, whose shift ended at 8:00 p.m., provided a verbal hand-off to the oncoming physician assistant (physician assistant 2). At 9:39 p.m., the consulting psychiatry resident physician assessed the patient's suicide risk as "mild" and documented that the patient denied suicidal ideation and denied "safety concerns." The consulting psychiatry resident physician informed the patient that benzodiazepine and opioid withdrawal "in the absence of other mental health symptoms" did not meet criteria for inpatient psychiatric admission. The consulting psychiatry resident physician recommended discharge to home with follow-up in the walk-in Mental Health Clinic the following morning. The on-call attending psychiatrist documented discussion of the case with the consulting psychiatry resident physician and concurrence with the assessment and treatment plan. Physician assistant 2 documented that psychiatry cleared the patient for discharge to home with follow-up in the walk-in Mental Health Clinic the following day. When informed of the discharge plan, the patient refused to leave. Between 10:00 p.m. and 10:30 p.m., a second Emergency Department attending physician (physician 2) documented that the patient was "clearly malingering" and "ranting;" and called VA police to escort the patient from the Emergency Department. Immediately following discharge, the patient wanted to return to the Emergency Department to address knee pain. Physician 2 documented informing staff at the front desk, triage nurse, and security that the patient "was not to be registered again tonight, [the patient] is to be seen in [the Mental Health Clinic] tomorrow morning as a walk-in." At approximately 11:00 p.m., the patient was picked up by a family member and left the facility.

The patient did not present to the Mental Health Clinic as advised in the written discharge instructions. Two days after the patient presented to the Emergency Department, the outpatient psychiatrist entered an outpatient substance use treatment program consult indicating that the

¹⁹ U.S. Department of Health and Human Services, Patient Safety Network, "Handoffs and Signouts," January 2019. For the purpose of this report, "hand-off" encompasses both the process of transferring responsibility for a patient's care and transmitting information about a patient from one provider to another when transferring responsibility for a patient's care. <https://psnet.ahrq.gov/primers/primer/9/handoffs-and-signouts>. (The website was accessed on August 9, 2019.)

²⁰ Physician assistants may admit or discharge patients in consultation with, or on behalf of, collaborating physicians. VHA Directive 1063, *Utilization of Physician Assistants (PA)*, December 24, 2013.

patient was provided an appointment date and time of early 2019 (five days after the Emergency Department visit), at 8:00 a.m. An outpatient substance use disorder nurse closed the consult the same day indicating that the patient was to report to the substance abuse treatment program five days after the Emergency Department visit, at 8:00 a.m. The patient did not present to the substance abuse treatment program in early 2019. The patient's family member called the facility medical advice line and informed the medical advice line nurse that the patient died at home in early 2019 (six days after the presenting to the Emergency Department).

Inspection Results

1. Patient's Emergency Department Discharge and Subsequent Death by Suicide

The OIG substantiated that the patient presented to the Emergency Department with suicidal ideation and died six days later. The medical examiner's office determined that the patient died by suicide by self-inflicted gunshot wound. The OIG also found that Emergency Department and consulting psychiatry staff failed to complete required suicide prevention planning prior to the patient's discharge.²¹

VHA requires on-site mental health coverage from 7:00 a.m. to 11:00 p.m., and either on-site or on-call mental health coverage by a licensed mental health provider or psychiatry resident who has appropriate supervision during all hours of emergency department operation.²² VHA also requires that emergency department staff screen all patients for suicide, alert the facility Suicide Prevention Coordinator of any patient presenting with suicidal ideation, and place any patient who screened positive for suicide risk on one-to-one observation.²³

In September 2018, VHA implemented the Suicide Prevention in Emergency Departments program, which required that all patients, who were assessed as at risk for suicide and safe to discharge home, complete or update a safety plan and that facility staff complete outreach to "facilitate engagement in outpatient mental health care" upon discharge.²⁴ In November 2018,

²¹ VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017. VA Assistant Deputy Under Secretary for Health for Clinical Operations Memorandum, *Suicide Prevention in Emergency Departments (SPED): Suicide Safety Planning and Follow Up Interventions*, September 7, 2018. Deputy Undersecretary for Health for Operations and Management Memorandum, *Eliminating Veteran Suicide: Implementation of Suicide Risk Screening and Evaluation*, November 2, 2018.

²² VHA Directive 1101.05(2). VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. The licensed mental health provider may be a psychiatrist, psychologist, social worker, physician assistant, or advanced nurse practitioner. This mental health coverage requirement is applicable to 1a level complexity VA medical centers, such as the facility.

²³ VHA Directive 1101.05(2).

²⁴ VA Assistant Deputy Under Secretary for Health for Clinical Operations Memorandum.

VHA further implemented a comprehensive suicide risk evaluation process in emergency departments, which included an initial screen, secondary screen, and comprehensive suicide risk evaluation.²⁵

In early 2019, physician assistant 1 evaluated the patient and documented that the patient had suicidal ideation. However, physician assistant 1 failed to alert the Suicide Prevention Coordinator, initiate one-to-one observation of the patient (or document rationale for not initiating one-to-one), or complete further suicide risk assessment. Facility providers told the OIG that the practice of Emergency Department staff was to obtain an evaluation from the after-hours consulting psychiatry resident physician to determine if a patient required inpatient mental health admission. The consulting psychiatry resident physician then reviewed the patient's case with the on-call attending psychiatrist by phone. Consistent with this practice, physician assistant 1 submitted a consult for a psychiatry evaluation at 5:30 p.m., with the expectation that the patient would be admitted to the inpatient psychiatry unit. In an interview with the OIG, physician assistant 1 reported not contacting the Suicide Prevention Coordinator because (1) physician assistant 1 thought the patient was being admitted, and (2) if the patient was going to be discharged, physician assistant 1 would have contacted a psychiatric social worker to complete safety planning.

The Acting Chief of Psychiatry told the OIG that the consulting psychiatric provider is responsible for completing the suicide prevention safety plan with the patient or delegating that responsibility to a mental health social worker. In an interview with the OIG, the consulting psychiatry resident physician recalled reviewing the outpatient psychiatrist's evaluation from earlier the same day. The consulting psychiatry resident physician evaluated the patient as "mild" risk of suicide and recommended discharging the patient home with a plan for the patient to follow up the next day in the walk-in Mental Health Clinic.

Consistent with VHA and non-VA physician resident supervision requirements, the on-call attending psychiatrist documented discussion of the case with the consulting psychiatry resident physician and concurrence with the assessment and treatment plan.²⁶ Physician assistant 2 then documented that psychiatry services cleared the patient for discharge and discharged the patient to home with Veterans Crisis Line information and written instructions to follow up in the Mental Health Clinic. The OIG determined that staff did not contact a social worker to complete required suicide prevention planning prior to the patient's discharge because of staff's failure to

²⁵ Deputy Undersecretary for Health for Operations and Management Memorandum.

²⁶ VHA Handbook 1400.04, *Supervision of Associated Health Trainees*, March 19, 2015. Accreditation Council for Graduate Medical Education Program Requirements for Graduate Medical Education in Psychiatry, effective July 1, 2019. The Accreditation Council for Graduate Medical Education Program Requirements for Graduate Medical Education in Psychiatry was amended July 1, 2019. Accreditation Council for Graduate Medical Education, *Common Program Requirements Section VI, Table of Implementation Dates*, May 2017. The 2017 program requirements and the 2019 requirements contain the same or similar language regarding resident physician supervision although some requirements were not subject to citation until July 1, 2019.

reconcile the prior moderate suicide risk with the subsequent mild risk assessment and psychiatry's clearance of the patient for discharge. Physician 2 documented agreement with physician assistant 2's plan of care and added physician assistant 1's initial assessment with instruction for the patient "to be seen in [the Mental Health Clinic] tomorrow morning as a walk-in." The patient's discharge instructions included follow up with the Mental Health Clinic although the instructions did not include information about when to follow up, if the clinic was a walk-in clinic, or if the patient needed a scheduled appointment. Emergency Department staff's failure to manage this patient's care according to VHA suicide prevention policies contributed to an inadequate assessment of suicide risk.

Facility leaders told the OIG that in response to their review of this patient's care, mental health leaders implemented revised inpatient mental health admission procedures to include a warm hand-off between outpatient and inpatient mental health providers to explain rationale for admission. Additionally, only the Chief of Staff can reverse the outpatient mental health provider's recommendation for a patient's admission.

2. Emergency Department Staff Discharge Despite Patient's Withdrawal Risk

The OIG substantiated that initially Emergency Department staff were aware of the patient's reported history of withdrawal seizures and that the patient ran out of opioid and benzodiazepine medications and discharged the patient with a same-day outpatient psychiatry appointment. The OIG also found that upon the patient's return to the Emergency Department, providers failed to document a review of the patient's withdrawal seizure history or evaluate the patient's risk for adverse consequences related to withdrawal from prescribed opioid and benzodiazepine medications.

VHA facilities must conduct systematic assessment of withdrawal symptoms and risk of adverse consequences related to withdrawal.²⁷ Emergency care includes evaluation by "qualified personnel with the knowledge and skills appropriate to treat those seeking emergency care."²⁸ Withdrawal may be managed on an ambulatory basis and, when needed, inpatient withdrawal management must also be available.²⁹ Severe withdrawal seizures may result in coma or death,

²⁷ VHA Handbook 1160.01.

²⁸ VHA Directive 1101.05(2).

²⁹ VHA Handbook 1160.01.

and management of withdrawal seizures should include inpatient hospitalization for stabilization.³⁰

Approximately five years earlier, the patient presented to the facility with a non-VA prescribed benzodiazepine and opioid medication regimen that was similar to the patient's medication protocol upon 2019 presentation. At that time, following a failed attempt at outpatient medication tapering, a community-based outpatient clinic psychiatrist determined that the patient's withdrawal, related to benzodiazepine and opioid medication, was "complicated" and "best suited for inpatient treatment." The patient was successfully detoxified on the inpatient medical unit. The patient's family member described the patient as being treated well during the 2014 episode of care. The patient discontinued outpatient substance use treatment and declined further follow-up when offered during a subsequent Mental Health Clinic visit.

In early 2019, the patient, accompanied by a family member, presented to the Emergency Department seeking detoxification after reportedly running out of opioid and benzodiazepine medications. The patient's family member told the OIG that they went to the VA because they thought they would get help although they did not want to overburden the system. An Emergency Department resident physician documented that the patient had a history of seizures following benzodiazepine withdrawal and that the patient reported "seizure like symptoms" the prior evening. Approximately 20 minutes after the initial assessment, physician 1 discharged the patient after a single dose of benzodiazepine and with a scheduled same-day outpatient Mental Health Clinic follow-up.

The patient and a family member then met with a Veteran Experience Specialist and reported dissatisfaction with care and wanting inpatient admission for detoxification.³¹ In an interview with the OIG team, the Veteran Experience Specialist described escorting the patient and family member to the Emergency Department and informing an Emergency Department staff member of the patient's preference for admission. Following the contact with the Veteran Experience Specialist, the patient presented to the outpatient psychiatry appointment as instructed.

³⁰ Hu, X, "Benzodiazepine withdrawal seizures and management," *Journal of the Oklahoma State Medical Association*, 104 (2), (February 2011): 62–65. <https://www.ncbi.nlm.nih.gov/pubmed/21815323>. (The website was accessed on December 5, 2019.) Puening, SE, Wilson, MP, and Nordstrom, K, "Psychiatric Emergencies for Clinicians: Emergency Department Management of Benzodiazepine Withdrawal," *The Journal of Emergency Medicine*, 52(1), (2017): 66–69. <https://www.clinicalkey.com#!/content/playContent/1-s2.0-S0736467916301652?returnurl=https:%2F%2Flinkinghub.elsevier.com%2Fretrieve%2Fpii%2FS0736467916301652%3Fshowall%3Dtrue&referrer=https:%2F%2Fwww.ncbi.nlm.nih.gov%2Fpubmed%2F27687167>. (The website was accessed on April 23, 2020.)

³¹ Veteran Experience Specialists work in the facility's Office of Patient Experience and Advocacy and help resolve patient issues that are unable to be resolved at the department or service level. Facility Patient Experience and Advocacy Office, https://www.washingtondc.va.gov/services/Patient_Advocate_Office.asp. (The website was accessed on March 3, 2020.)

The outpatient psychiatrist documented that the patient ran out of medications four days prior. The outpatient psychiatrist told the OIG that a review of the Prescription Drug Monitoring Program at that time indicated that the patient's report was accurate regarding a benzodiazepine prescription obtained from a non-VA provider.³² The outpatient psychiatrist further documented that the patient's family member corroborated the patient's history of withdrawal seizures and that the patient denied current suicidal ideation but indicated increased risk of suicidality if not admitted for detoxification. Additionally, the outpatient psychiatrist documented that the patient was at a moderate risk of suicide and escorted the patient and a family member to the Emergency Department for consideration of medical or psychiatric inpatient admission. The patient's family member told the OIG that the outpatient psychiatrist told them that the patient was going to be admitted to detoxification or the psychiatry unit.

Physician assistant 1 documented the patient's chief complaint as anxiety, documented the patient's suicidal ideation, and placed a psychiatry consult to evaluate the patient for inpatient admission. The consulting psychiatry resident physician and attending psychiatrist determined the patient was at mild risk of suicide and did not meet criteria for inpatient admission. Physician assistant 2, in consultation with physician 2, discharged the patient home with unscheduled follow-up at the outpatient Mental Health Clinic. The consulting psychiatry resident physician told the OIG that the patient "had the impression that [the patient] was admitted to the hospital." Physician 2 told the OIG, "well, this wasn't, to me this wasn't a [detoxification] situation."

In the second Emergency Department visit, the three Emergency Department providers (physician 2 and physician assistants 1 and 2) and two consulting psychiatry providers failed to document a review of the patient's withdrawal seizure history or consideration of the outpatient psychiatrist's documentation, assess the patient's history of withdrawal symptoms, or evaluate the patient's risk for adverse consequences related to withdrawal from prescribed opioid and benzodiazepine medications. The OIG concluded that the Emergency Department providers and consultants attributed the patient's presentation to mental health symptoms rather than benzodiazepine and opioid withdrawal symptoms. Therefore, the providers did not consider an inpatient medical unit admission.

Following the patient's second Emergency Department visit, staff discharged the patient without scheduled follow-up care or medication for potential withdrawal symptoms at home. The OIG determined that the providers failed to review documentation and discharged the patient without a thorough evaluation for a variety of reasons including (1) physician 2 conceptualized the patient as having primarily mental health problems and did not believe the patient required

³² "A [Prescription Drug Monitoring Program] is a statewide database that collects designated data on controlled substances dispensed to patients within that state." "This helps to promote safety of controlled substance use and to decrease drug diversion and substance use disorders among patients nationwide." VHA Directive 1306(1), *Querying State Prescription Drug Monitoring Programs (PDMP)*, October 19, 2016. The directive was amended on October 21, 2019.

medical management; (2) the consulting psychiatry resident physician understood the consultation request to establish clearance for the patient's discharge rather than conduct an evaluation for admission; and (3) the attending psychiatrist relied on the consulting psychiatry resident physician's report.

The patient's long history of prescribed opioid and benzodiazepine usage, current prescription for a benzodiazepine with a short half-life, and abrupt discontinuation of the medications placed the patient at high risk for withdrawal symptoms.³³ The patient presented with signs of benzodiazepine withdrawal (elevated blood pressure and heart rate) throughout the extended episode of care. As would be expected, the patient's blood pressure and heart rate decreased after receiving benzodiazepine medication in the Emergency Department in the morning. By evening, the patient's increased blood pressure required immediate repeat administration of benzodiazepine medication. Given the patient's history of long-term benzodiazepine use and withdrawal and presenting withdrawal symptoms, the OIG would have expected staff to reassess the patient's vital signs after the evening medication administration to determine if the patient required outpatient or inpatient medication management of benzodiazepine withdrawal. The OIG found that facility providers failed to reevaluate the patient's vital signs and despite the patient's withdrawal risk, Emergency Department staff discharged the patient without a thorough understanding of the patient's withdrawal management needs. The providers' lack of systematic assessments of either the patient's risk factors for moderate to severe withdrawal or the patient's expressed suicidal thoughts related to withdrawal symptoms contributed to a failure to properly assess the patient's risk for significant harm, including death by suicide and benzodiazepine withdrawal.

3. Physician 2's Misconduct and Facility Leaders' Response

The OIG substantiated that physician 2 made a statement to the effect of "[the patient] can go shoot [themselves]. I do not care." While this statement was inconsistent with VHA patient care

³³ Puening, SE, Wilson, MP, and Nordstrom, K, "Psychiatric Emergencies for Clinicians: Emergency Department Management of Benzodiazepine Withdrawal," *The Journal of Emergency Medicine*, 52(1), (2017): 66–69. <https://www.clinicalkey.com/#!/content/playContent/1-s2.0-S0736467916301652?returnurl=https:%2F%2Flinkinghub.elsevier.com%2Fretrieve%2Fpii%2FS0736467916301652%3Fshowall%3Dtrue&referrer=https:%2F%2Fwww.ncbi.nlm.nih.gov%2Fpubmed%2F27687167>. (The website was accessed on April 23, 2020.) Half-life is the amount of time it takes for one-half of a medication to be metabolized. Stedman's Medical Dictionary. "Half-Life". (Lippincott Williams & Wilkins, 2016). STATRef Online Electronic Medical Library, <http://online.statref.com/document/Emgwzd9P4QVPrXbr00rPNj>. (The website was accessed on January 21, 2020.) This is an internal VA website and not available to the general public. Alprazolam has a short half-life of 14 hours as compared with other benzodiazepines like clonazepam (40 hours) or diazepam (40 hours). Alan F. Schatzberg and Charles DeBattista, *Schatzberg's Manual of Clinical Psychopharmacology*, 9th ed. American Psychiatric Association Publishing, October 8, 2019. Chapter 6: Antianxiety Agents, <https://psychiatryonline.org/doi/book/10.1176/appi.books.9781615372997>. (The website was accessed on April 30, 2020.) This is an internal VA website and not available to the general public.

tenets suggested a high level of insensitivity to the patient's needs, it could also be considered misconduct according to VA policy and patient abuse according to facility policy.³⁴ Facility and contracted staff failed to adhere to facility policy regarding reporting of employee misconduct and patient abuse and did not receive required annual abuse and neglect policy education. Despite facility leaders' awareness by late spring 2019 of physician 2's inappropriate statement regarding the patient and physician 2's prior pattern of misconduct, the OIG found that facility leaders did not conduct a formal fact-finding or administrative investigation as required by VA.³⁵ Additionally, facility leaders did not report physician 2 to the State Licensing Board or National Practitioner Data Bank.³⁶

Misconduct: VA and Facility Policy Requirements

In a 2017 policy update, VA required that employees maintain high standards of integrity and conduct and that corrective actions are prompt when these standards are not met. VA defined "disrespectful, insulting, abusive, insolent, or obscene language or conduct to or about supervisors, other employees, patients, or visitors" as general misconduct with a maximum penalty of removal.³⁷ VHA leaders who receive reports of VA employee misconduct are required to "inquire into the matter sufficiently to determine whether a full administrative investigation is needed."³⁸ The supervisor must begin an inquiry as soon as possible, including gathering information from the employee who was alleged to have engaged in misconduct as well as from other individuals with relevant information, and document inquiry results. In determining appropriate action, supervisors should consider multiple factors including the seriousness and frequency of the offense.³⁹

³⁴ The original allegation identified physician 2's statement as "[the patient] can go shoot [themselves]. I do not care." However, other individuals reported physician 2's statement with similar content but varying language. Department of Veterans Affairs, 38 CFR, Part 0, Federal Register Volume 77, Number 135, *Core Values and Characteristics of the Department*, July 13, 2012. VA defines its core values as ICARE: Integrity, Commitment, Advocacy, Respect, and Excellence. "The Values represent VA's beliefs and provide a baseline for the standards of behavior expected of all VA employees." Facility Policy PM-05-13, *Abuse and Neglect of Patients, Residents, or Employees*, January 5, 2018. VA Handbook 5021/25, *Employee/Management Relations*, December 28, 2017.

³⁵ VA Handbook 5021/25.

³⁶ VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005. The National Practitioner Data Bank is a web-based tool for reporting healthcare practitioners' adverse actions. U.S. Department of Health and Human Services, *National Practitioner Data Bank*. <https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp>. (The website was accessed on January 27, 2020.) VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009.

³⁷ VA Handbook 5021/25. Removal is defined as "the involuntary separation of a non-probationary employee for disciplinary or non-disciplinary reasons."

³⁸ VA Handbook 0700, *Administrative Investigations*, July 31, 2002.

³⁹ VA Handbook 5021/25.

Facility policy defined patient abuse as “intimidation” or “harassment or ridicule of a patient.”⁴⁰ Facility policy also required that all staff, including contract clinicians, complete annual patient abuse education. Service chiefs are responsible for providing annual education on required conduct, and employees have a duty to report any instance of suspected patient abuse to a supervisor or management official. When an employee becomes aware of an instance of patient abuse, the employee should enter an incident report, notify the supervisor, and submit a written report of contact before the end of the tour of duty. Supervisors are to immediately notify “the responsible physician, Quality Management, Patient Safety and Leadership.”⁴¹ Facility policy stated that the penalty for patient abuse or failure to report patient abuse is removal.⁴²

Facility Response: Internal Actions

Two facility police officers and physician assistant 2 told the OIG that, in early 2019, they witnessed physician 2 make a statement to the effect of “[the patient] can go shoot [themselves]. I do not care.” which constituted misconduct and patient abuse according to VA and facility policy, respectively.⁴³ While the OIG confirmed these staff members heard the statement, the OIG could not confirm that the patient also heard this statement. The staff members who witnessed physician 2’s patient abuse told the OIG they did not report the incident to a supervisor or submit an incident report or a written report of contact prior to the end of the tour of duty as required by facility policy.⁴⁴ The facility leaders did not provide education on the facility policy, and the staff members who witnessed the statement did not define the behavior as patient abuse at the time of the event.

The facility’s Patient Safety Manager told the OIG that an internal review was initiated upon learning of the patient’s death in early 2019. During the internal review process, the Patient Safety Manager learned of physician 2’s alleged misconduct. At around the same time, the OIG requested facility leaders to respond to two allegations, including the allegation that an Emergency Department physician made an inappropriate comment about the patient.

The Patient Safety Manager and a facility nurse told the OIG team that in early spring 2019, physician 2 did not deny making an inappropriate statement and the Patient Safety Manager brought the misconduct to the attention of facility leaders.

⁴⁰ Facility Policy PM-05-13.

⁴¹ Facility Policy PM-05-13.

⁴² Facility Policy PM-05-13.

⁴³ VA Handbook 5021/25; Facility Policy PM-05-13.

⁴⁴ One of the staff members was with a supervisor when they both witnessed physician 2’s statement and therefore, the staff member would not be expected to inform the supervisor.

The following month, the Chief, Emergency Department asked physician 2 about the patient's treatment and whether physician 2 made an inappropriate statement about the patient. Physician 2 responded, "I do not recall exactly what I said, but given what was likely misinterpreted, if I had to guess, I probably said something along the lines of "unless [the patient] says [they are] suicidal, I don't care, [the patient] can be seen tomorrow.'" Facility leaders did not conduct a formal fact-finding or an administrative investigation despite facility staff reports of physician 2's misconduct and patient abuse. The Facility Director reported not initiating an administrative investigation because of the assumption that it would have been covered by the peer review.⁴⁵

In late spring 2019, the Facility Director informed the OIG that an internal review "substantiated" that physician 2 made an inappropriate statement and that leaders implemented a new emergency department and psychiatry hand-off process, completed a root cause analysis, and initiated a peer review.⁴⁶ The Facility Director reported requesting the Chief of Staff have physician 2 removed from the contract for Emergency Department physicians with George Washington University at that time. The OIG team obtained electronic mail beginning in summer 2019 in which the Chief of Staff requested Medical Faculty Associates, Inc. start the process of recruiting a physician to replace physician 2 in the Emergency Department. The Chief of Staff told the OIG that physician 2's clinical outcomes were very good and acknowledged problems with physician 2's attitude. The Chief of Staff noted ongoing review and "scrutiny" of physician 2, however physician 2 was not immediately removed from the contract. In fall 2019, the Chief of Staff told the OIG that if leaders received one more complaint about physician 2, they would consider not renewing physician 2's privileges that were up for review six months later. However, the OIG found that leaders did not consider immediate termination or other disciplinary action.

When asked by the OIG team in fall 2019, physician 2 denied making an inappropriate statement about the patient. In fall 2019, the OIG team again informed the Facility Director of concerns about physician 2's ongoing care of patients without an internal review of the reported potential misconduct and patient abuse. The next day, after receiving another report of verbal misconduct by physician 2 directed toward an Emergency Department nurse, the Chief, Emergency Department expressed concerns to the Chief of Staff about physician 2's conduct. A few days later, the Facility Director reported concerns about physician 2's conduct to the Contract Officer and requested that physician 2 be "replaced as a contract provider at this facility." The Facility

⁴⁵ VA Handbook 0700, *Administrative Investigations*, July 31, 2002. An administrative investigation is conducted to evaluate allegations of significant employee misconduct, neglect of duty, prohibited personnel practices, suspected threats, abuse, or deliberate injury to patients.

⁴⁶ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. A root cause analysis is a focused review with a multidisciplinary team approach to identify system and process factors (rather than individual performance) that contribute to healthcare-related adverse events. VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. Peer review "is intended to promote confidential and non-punitive assessments of care at the individual clinician level."

Director told the OIG that physician 2's last day in the Emergency Department was late fall 2019, and a Medical Faculty Associates Risk Manager reported that physician 2 resigned from Medical Faculty Associates, Inc. three days later.

The OIG substantiated physician 2 made an inappropriate statement about the patient that constituted employee misconduct and patient abuse according to VA and facility policy, respectively. Further, physician 2 had a history of misconduct including in fall 2018, toward the Chief, Emergency Department and another facility physician and in spring 2019, toward VA police. Facility and contracted staff failed to adhere to facility policy regarding employee misconduct and patient abuse and did not receive required annual abuse and neglect policy education. Facility leaders failed to conduct formal fact-finding and an administrative investigation, as required by VA to maintain standards of integrity, conduct, and service to the public.⁴⁷ The OIG opines that the Chief of Staff focused on physician 2's overall positive clinical outcomes and that the Chief of Staff and the Facility Director believed that internal clinical reviews of the patient's care were sufficient; and therefore, did not pursue formal administrative reviews related to physician 2's pattern of verbal misconduct.

Facility Response: External Reporting Requirements

VHA requires organizational leaders to file a report with the State Licensing Board and National Practitioner Data Bank when a provider has issues of professional competence or conduct.⁴⁸ VHA leaders must consider reporting a provider to the State Licensing Board whose behavior or clinical practice "substantially failed to meet generally-accepted standards of clinical practice as to raise [a] reasonable concern for the safety of patients," "as well as the moral and ethical behavior necessary to carry out those [professional] responsibilities." The behavior of concern does not have to be directly related to the provision of health care.⁴⁹ VHA leaders are required to report a provider to the National Practitioner Data Bank when the provider's services (and associated medical staff appointment and clinical privileges) are terminated from a contractor employee under a continuing contract for improper professional conduct.⁵⁰

Facility leaders did not report physician 2 to the State Licensing Board or National Practitioner Data Bank.⁵¹ Although facility leaders did not conduct a formal investigation, they removed physician 2 from the VA contract for the provision of Emergency Department services, and therefore, facility leaders had a duty to report physician 2 to the State Licensing Board and National Practitioner Data Bank, per VHA requirements.⁵² The OIG opines that the Chief of

⁴⁷ VA Handbook 0700; VA Handbook 5021/25.

⁴⁸ VHA Handbook 1100.18; VHA Handbook 1100.17.

⁴⁹ VHA Handbook 1100.18.

⁵⁰ VHA Handbook 1100.17.

⁵¹ VHA Handbook 1100.18; VHA Handbook 1100.17.

⁵² VHA Handbook 1100.18; VHA Handbook 1100.17.

Staff's focus on physician 2's overall positive clinical outcomes contributed to a failure to pursue formal administrative actions related to physician 2's pattern of misconduct including removal from the contract and notification to the State Licensing Board or National Practitioner Data Bank.

Facility leaders' failure to consider administrative investigation or disciplinary action resulted in physician 2 continuing to provide patient care for nine months after the events with the patient in early 2019. During those nine months, there were two additional documented accounts of physician 2's misconduct. Failure to follow VA and facility policy in response to incidents of employee misconduct and patient abuse undermines the public interest and continued risk to VA patients and staff.

4. Communication and Discharge Process Failures

Hand-Off

The OIG found that the outpatient psychiatrist transferred care of the patient to physician 1 by person-to-person contact as preferred by facility policy.⁵³ However, the OIG determined that physician assistant 2, the consulting psychiatry resident physician, and physician 2 failed to document review of the relevant patient history to inform medical decision-making.

Facility policy required all providers to utilize a standardized hand-off format when transferring a patient from one setting or level of care to another, at change of shift, and when transferring responsibility from one provider to another. The receiving provider should review the hand-off information including relevant patient history.⁵⁴

Consistent with the outpatient psychiatrist's assessment, physician assistant 1 documented that the patient presented with suicidal ideation and was brought to the Emergency Department from the Mental Health Clinic for medical clearance for inpatient admission; physician assistant 2 and physician 2 signed the note. Although the outpatient psychiatrist's assessment was available in the patient's electronic health record, the OIG did not find documentation that indicated physician assistant 2, the consulting psychiatry resident physician, and an on-call attending psychiatrist reviewed the assessment from earlier the same day that identified the patient's risks for suicide and severe withdrawal symptoms if not admitted for detoxification. Physician assistant 2 did not recall reviewing the patient's documentation when speaking with the OIG team. The consulting psychiatry resident physician told the OIG that although there was not much time to do so, the patient's documentation was reviewed.

⁵³ Facility Policy PM-11-13, *Patient Hand-off Communication*, January 5, 2018. In independent OIG team interviews, the outpatient psychiatrist and physician 1 described person-to-person contact in the patient's transfer of care.

⁵⁴ Facility Policy PM-11-13.

In an interview with the OIG, physician 2 reported not reviewing the outpatient psychiatrist's assessment documentation at the time of the patient's care. Further, the OIG found that physician 2 documented in the patient's electronic health record that two physicians had assessed the patient, but they had never interacted with the patient. However, the OIG determined that physician assistant 2, the consulting psychiatry resident physician, and physician 2 failed to document review of the relevant patient history to inform medical decision making. The OIG opines that the three providers failed to evaluate the patient's overall psychiatric and medical needs but rather focused on discharging the patient based on a narrow perspective of the patient's presentation. The failure to review the outpatient psychiatrist's assessment from earlier that day, may have resulted in the patient's discharge without consideration of identified suicide and medical risk factors.

A standardized hand-off process allows providers to share "crucial clinical patient data" and improves patient safety.⁵⁵ The failure of providers to review patient information including disposition and history can result in care deficits and may contribute to adverse patient outcomes, as occurred in the care of the patient.

The Patient Safety Manager told the OIG that a facility internal review identified hand-off deficits related to the patient's care. As a result, facility managers implemented a new procedure to strengthen the Emergency Department hand-off processes including documentation of standardized hand-off communication. As of January 2020, facility leaders were revising the policy to reflect the new Emergency Department procedures. The Chief Nurse, Critical Care and Operations, told the OIG team that the Emergency Department Nurse Manager was responsible for daily audits to determine whether a shift change hand-off meeting occurred. The OIG found that the audits conducted from April through December 2019 only included daytime but not the evening shift change hand-off process and did not monitor the quality of the hand-off process, such as interdisciplinary team member attendance or adherence to the newly established hand-off communication requirements. Without monitoring team member attendance, Emergency Department leaders would be unable to ensure that the responsible clinicians are providing and receiving hand-off communication during each shift change. Further, failure to monitor the quality of the hand-off communication limits Emergency Department leaders' identification of areas for improvement in hand-off communication.

⁵⁵ Facility Policy PM-11-13. This facility policy requires providers to use the standardized ISBAR format that includes: **I**dentification of the provider, patient, and current situation; **S**ituation of the patient; **B**ackground including the patient's history and physical and treatment course; **A**ssessment of the patient's present state; and **R**ecommendations for the patient's treatment.

Documentation

“VHA, by statute, must maintain complete, accurate, timely, clinically-pertinent, and readily-accessible patient health records, which contain sufficient recorded information to serve as a basis to plan patient care, support diagnoses, [and] warrant treatment.”⁵⁶ The OIG found that the patient’s electronic health record contained inconsistent reports of the patient’s chief complaint and presentation that staff did not reconcile prior to the patient’s discharge. The OIG also determined physician 2 did not document an understanding of the outcomes of other providers’ evaluations or a review of the patient’s electronic health record to inform the medical decision-making that led to the patient’s discharge. The OIG found that facility staff failed to document consistent information in the patient’s discharge progress notes and discharge instructions, as required by VHA.⁵⁷

Upon the patient’s initial admission to the Emergency Department, providers noted chief complaints including “detox,” withdrawal, and not being able to sleep. The outpatient psychiatrist also documented withdrawal as the chief complaint; however, upon the patient’s return to the Emergency Department, a provider and a nurse documented a chief complaint of anxiety. Further, physician assistant 1 documented anxiety as the patient’s chief complaint but told the OIG that the patient was seen for benzodiazepine and opioid withdrawal. Physician assistant 1 documented the patient’s mental status as “alert.” An Emergency Department registered nurse told the OIG that the patient was “slumped” in a chair and that they did not complete the nursing assessment because the patient was medicated and “it would not have been an appropriate assessment.” In contrast, physician 2 later documented that the patient was “ranting.” Clinicians’ documentation of the patient’s presentation throughout the patient’s two Emergency Department visits varied significantly, and providers did not document reconciliation of these differences or a conceptualization to support diagnoses and plan patient care.

The OIG also identified discrepancies between information physician 2 told the OIG and the care documented in the patient’s electronic health record. For example, physician 2 reported to the OIG evaluating the patient “multiple times.” However, in physician 2’s addenda to physician assistant 1’s progress note, physician 2 only documented “I was onsite available for consultation” and that the patient was “seen by” three other physicians earlier in the day. However, two of the three physicians that physician 2 specifically identified in the patient’s electronic health record had not seen the patient. OIG determined that although physician 2 documented other providers evaluated the patient, physician 2 did not document an understanding of the outcomes of those evaluations or a review of the patient’s electronic health record to inform the medical decision-making that led to the patient’s discharge. Further, the

⁵⁶ VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

⁵⁷ VHA Handbook 1907.01.

OIG would have expected physician 2 to document the medical decision-making or clinical reasoning for the patient's discharge and follow up treatment plan.

VHA requires that "The information contained in the Discharge Progress Note, Discharge Instructions, Discharge Summary and related documents must be consistent."⁵⁸ Physician 2 documented agreement with physician assistant 2's plan to discharge the patient and added physician assistant 1's initial assessment with instruction for the patient "to be seen in [the Mental Health Clinic] tomorrow morning as a walk-in." The patient's discharge instructions included follow up with the Mental Health Clinic although the instructions did not include information about when to follow up, if the clinic was a walk-in clinic, or if the patient needed a scheduled appointment. The patient's family member told the OIG that no facility staff contacted them as part of the discharge process or any time prior to the patient's death, and described the staff's treatment of the patient as deplorable. Further, the patient's family member told the OIG that nobody would help. Given the patient's distress about discharge, the OIG would have expected facility staff to attempt to contact the patient's family member to ensure continuity of care. Staff's failure to provide the patient with a clear and specific discharge plan, or to include the patient's family member in discharge planning probably diminished the patient's likelihood of following up at the facility after discharge and likely contributed to the family member's opinion that the ball was totally dropped.

Discharge Process

VHA describes VA care as patient-centered and asserts that patients should be active partners in the development of a care plan and have a clear understanding of diagnoses and treatment plans.⁵⁹ Facility policy states that the patient, and any person the patient chooses, will be involved in all healthcare decisions.⁶⁰ The OIG concluded that Emergency Department providers failed to (1) develop a clear understanding of the patient's diagnoses, and (2) deliver patient-centered care that engaged the patient as an active partner in a care plan, as expected by VHA.⁶¹ Further, providers did not include the patient and the patient's family member in healthcare decisions, as required by facility policy.⁶²

The outpatient psychiatrist documented a comprehensive biopsychosocial assessment and treatment plan with input and feedback from the patient and the patient's family member. The outpatient psychiatrist escorted the patient and family member to the Emergency Department,

⁵⁸ VHA Handbook 1907.01.

⁵⁹ U.S. Department of Veterans Affairs, VA National Center for Patient Safety. *VA Care is Patient-Centered*, <https://www.patientsafety.va.gov/veterans/patient-centered.asp>. (The website was accessed on February 8, 2020.)

⁶⁰ Facility Policy PM-002-08, *Patient Rights and Responsibilities*, May 17, 2016.

⁶¹ U.S. Department of Veterans Affairs, "VA National Center for Patient Safety," *VA Care is Patient-Centered*, <https://www.patientsafety.va.gov/veterans/patient-centered.asp>. (The website was accessed on February 8, 2020.)

⁶² Facility Policy PM-002-08.

and both the outpatient psychiatrist and physician 1 told the OIG that they consulted about the recommendation of admission. In an interview with the OIG, the outpatient psychiatrist acknowledged telling the patient that the patient would not be “going home tonight.” based on the consultation with physician 1. However, physician 1 did not recall guaranteeing the patient’s admission to the outpatient psychiatrist when asked by the OIG team. Following the outpatient psychiatrist’s evaluation and the patient’s return to the Emergency Department, the patient’s family member left the facility at approximately 5:00 p.m., with the expectation that the patient was being admitted.

Consistent with the plan for admission, the patient reported to physician assistant 1 of the need to be admitted and expected to be evaluated for medical clearance. The patient’s family member told the OIG that the patient had a bag of clothes in preparation for admission. Based on the similar circumstances in 2014 that resulted in an inpatient admission and the patient’s and family member’s understanding of the outpatient psychiatrist’s plan, the OIG concluded that the patient’s expectation for admission was reasonable.

The consulting psychiatry resident informed the patient that the patient “did not meet criteria for inpatient psychiatric hospitalization due to withdrawal in the absence [*sic*] of other mental health symptoms” and deferred medical care planning to Emergency Department providers. Physician assistant 2 later documented that the patient was cleared for discharge but did not document consideration of medical admission or discussion of discharge care plans with the patient. In an interview with the OIG, physician assistant 2 reported not remembering a discussion about whether to admit the patient to a medical unit. Physician assistant 2 told the OIG that discussion about discharge with the patient after psychiatry clearance was their only interaction.

An Emergency Department registered nurse (nurse) documented that the patient was upset about being discharged, refused to leave, and had no means of getting home. The nurse told the OIG that the patient called the family member, and the nurse explained to the family member that the admission was up to the provider. The nurse told the OIG that [they] did not complete an assessment on the patient because the patient was medicated and “it would not have been an appropriate assessment.” The nurse also reported not thinking the patient was at risk of suicide but was uncomfortable about discharging the patient at that time and therefore, talked to physician assistant 2. The nurse and physician assistant 2 told the OIG that physician assistant 2 apologized to the patient and said that psychiatry cleared the patient for discharge.

Physician 2 documented reliance on Emergency Department medical clearance 10 to 11 hours earlier and did not document discussion with the patient or family member regarding disposition prior to the patient’s discharge. Physician 2 told the OIG that “in any situation; however, the buck stops with me. The [Emergency Department] doctor makes all the decisions.” Based on this statement and information provided to the OIG by physician assistant 2, the OIG determined that physician assistant 2 discharged the patient on behalf of physician 2’s decision. As discussed

earlier in this report, although the psychiatry resident cleared the patient for discharge, providers did not further assess the patient for medical admission.

Despite the patient's benzodiazepine withdrawal symptoms, understandable expectation of admission, distress, and the absence of documented evidence of evaluations by physician 2, physician assistant 2, and the nurse, the patient was discharged. The OIG concluded that Emergency Department providers failed to (1) develop a clear understanding of the patient's diagnoses, and (2) deliver patient-centered care that engaged the patient as an active partner in a care plan, as expected by VHA.⁶³ Further, providers did not include the patient and the patient's family member in healthcare decisions, as required by facility policy.⁶⁴

5. Deficits in Suicide Behavior Reporting

The OIG found that the facility's Suicide Prevention Coordinator failed to complete the suicide behavior report following notification of the patient's death by suicide, as required by VHA.⁶⁵ VHA also required clinical staff to complete a suicide behavior report when they became aware of any self-directed violence that occurred within 12 months of the notification.⁶⁶

In early 2019, the patient's family member informed the Suicide Prevention Coordinator of the patient's death.⁶⁷ In an interview with the OIG team, the Suicide Prevention Coordinator was unable to locate a suicide behavior report and acknowledged that failure to complete it was an oversight.⁶⁸ VHA uses suicide behavior report data to track suicide-related events nationally. Failure of staff to consistently complete suicide behavior reports compromises the accuracy of VHA's suicide-related events data that may be used to identify trends of self-directed violence behaviors and determine suicide prevention efforts.

⁶³ U.S. Department of Veterans Affairs, VA National Center for Patient Safety, *VA Care is Patient-Centered*. <https://www.patientsafety.va.gov/veterans/patient-centered.asp>. (The website was accessed on February 8, 2020.)

⁶⁴ Facility Policy PM-002-08.

⁶⁵ VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

⁶⁶ VA Deputy Under Secretary for Health Operations and Management Memorandum, *High Risk for Suicide Patient Record Flag Changes*, October 3, 2017.

⁶⁷ The patient's family member contacted the facility's medical advice line nurse, who transferred the call to the Suicide Prevention Coordinator.

⁶⁸ At the time of the patient's death, VHA required a Suicide Behavior Report. In April 2019, VHA changed the requirement to a Suicide Behavior and Overdose Report. VA Deputy Under Secretary for Health Operations and Management Memorandum, *VA Deputy Under Secretary for Health for Operations and Management Memorandum, Suicide Behavior and Overdose Report Computerized Patient Record System (CPRS) Note Template Implementation*, April 8, 2019.

6. Consult Processes Noncompliance

The OIG found that a nurse closed the outpatient psychiatrist's outpatient substance use disorder treatment consult request without a scheduled appointment, contrary to VHA policy.⁶⁹

In June 2017, VHA updated scheduling and consult requirements to facilitate timeliness of consult responses. The receiving service must review and schedule an appointment within two business days of receiving a consult request.⁷⁰ Two days after the patient presented to the Emergency Department, the outpatient psychiatrist entered a consult for the outpatient substance use treatment program indicating that the patient was informed of the appointment date and time of early 2019 (five days after the Emergency Department visit), at 8:00 a.m. However, the OIG found no evidence that staff informed the patient of the appointment date and time. An outpatient nurse closed the consult and added a comment that the patient was to report to the outpatient substance use treatment program five days after the Emergency Department visit, at 8:00 a.m. However, contrary to VHA policy, the nurse explained about not scheduling the appointment because it was not program procedure at the time to schedule consult appointments, and the nurse erroneously thought that the patient was already in treatment with the outpatient psychiatrist. Because the patient had no scheduled appointment, staff did not follow up with the patient as required for missed appointments. The staff's failure to work collaboratively with the patient and the patient's family to schedule an appointment and engage the patient in treatment may have contributed to the patient not accessing facility treatment resources prior to completing suicide.

The outpatient substance use disorder treatment program manager told the OIG that facility managers implemented consult procedure changes in response to the gaps identified as a result of the review of the patient's care. The new process ensures that an appointment is scheduled for every consult. The program manager told the OIG that with a scheduled appointment, a patient receives follow-up outreach if the patient misses the appointment.

7. Inadequate Physical Space and Safety in the Emergency Department

The OIG found that the facility's Emergency Department failed to meet VHA's requirements for a safe and secure evaluation area for patients seeking mental health services. Lack of a safe and secure area for patients who present with emergent mental health needs, including a psychiatric

⁶⁹ VHA Directive 1232 (2), *Consult Processes and Procedures*, August 24, 2016. Deputy Under Secretary for Health for Operations and Management Memorandum, *Scheduling and Consult Policy Updates*, June 5, 2017.

⁷⁰ Deputy Under Secretary for Health for Operations and Management Memorandum, *Scheduling and Consult Policy Updates*, June 5, 2017.

evaluation room, may result in privacy violations and an inability to adequately evaluate and monitor patients at risk of elopement or suicidal behaviors.

VHA emergency departments must have a safe and secure area to evaluate and observe patients presenting with mental health needs, including at least one psychiatric intervention room.⁷¹ Due to limited physical space, the Emergency Department did not contain a psychiatric intervention room for patients presenting with mental health needs. Due to the space constraints, patients in need of mental health services were placed in chairs in the Emergency Department hallway unless the patient had a co-occurring medical condition. During the patient's early 2019 Emergency Department visit, the patient was placed in the hallway, which may not have supported the patient's psychological safety and security and may have diminished the likelihood of the patient's self-reflection and self-disclosure of thoughts of self-harm.

Beginning in 2009, facility leaders have pursued a renovation project that included three mental health examination rooms.⁷² In 2019, facility leaders submitted a request for VISN approval to expand the Emergency Department and several months later, the VISN approved the request. As of April 7, 2020, the VISN Deputy Quality Management Officer reported the bid was obtained and a process was in place for awarding the contract. On May 11, 2020, the VISN Capital Asset Manager reported that VA Contracting and Office of General Counsel decided to resolicit the project given the time lapsed and cost limit increase approval in March 2020; and cited an anticipated award date of September 30, 2020.

Conclusion

The OIG substantiated that the patient presented to the Emergency Department with suicidal ideation and died six days later. The medical examiner's office determined that the patient died by suicide by self-inflicted gunshot wound. The OIG also found that Emergency Department and consulting psychiatry staff failed to complete required suicide prevention planning prior to the patient's discharge.⁷³ Emergency Department staff's failure to manage this patient's care according to VHA suicide prevention policies contributed to an inadequate assessment of suicide risk. The patient, who had a history of complicated withdrawal from benzodiazepines, navigated two transitions between the Emergency Department and outpatient Mental Health Clinic and saw seven providers over the course of 12 hours. The lack of collaboration between Emergency Department and inpatient mental health providers, deficiencies in the hand-off process, and the

⁷¹ A psychiatric intervention room is where a seriously disturbed, agitated, or intoxicated patient can be taken immediately to provide a suitable environment for evaluation of dangerously unstable situations. VHA Directive 1101.05(2).

⁷² Starting in 2009, proposals for Emergency Department renovations were pursued with multiple reasons for halting including structural issues and cost.

⁷³ VHA Directive 1101.05(2); VA Assistant Deputy Under Secretary for Health for Clinical Operations; Deputy Undersecretary for Health for Operations and Management Memorandum.

Emergency Department and inpatient mental health providers' failure to read the outpatient psychiatrist's notes led to a compromised understanding of the patient's treatment needs and a failure to enact the outpatient psychiatrist's recommended treatment plan.

Facility leaders told the OIG that in response to their review of this patient's care, mental health leaders implemented revised inpatient mental health admission procedures to include a warm hand-off between outpatient and inpatient mental health providers to explain rationale for admission. Additionally, only the Chief of Staff can reverse the outpatient mental health provider's recommendation for a patient's admission.

The OIG substantiated that initially Emergency Department staff were aware of the patient's reported history of withdrawal seizures and that the patient ran out of opioid and benzodiazepine medications and discharged the patient with a same-day outpatient psychiatry appointment. The OIG also found that upon the patient's return to the Emergency Department, providers failed to document a review of the patient's withdrawal seizure history or evaluate the patient's risk for adverse consequences related to withdrawal from prescribed opioid and benzodiazepine medications.

The OIG found that facility providers failed to reevaluate the patient's vital signs and despite the patient's withdrawal risk, Emergency Department staff discharged the patient without a thorough understanding of the patient's withdrawal management needs. The providers' lack of systematic assessments of either the patient's risk factors for moderate to severe withdrawal or the patient's expressed suicidal thoughts related to withdrawal symptoms contributed to a failure to properly assess the patient's risk for significant harm, including death by suicide and benzodiazepine withdrawal.

The OIG substantiated that physician 2 made a statement to the effect of "[the patient] can go shoot [themselves]. I do not care." While the OIG confirmed that at least three facility staff members heard the statement, the OIG could not confirm that the patient heard this statement. While this statement was inconsistent with VHA patient care tenets and suggested a high level of insensitivity to the patient's needs, it could also be considered misconduct according to VA policy and patient abuse according to facility policy.⁷⁴ Facility and contracted staff failed to adhere to facility policy regarding reporting of employee misconduct and patient abuse and did not receive required annual abuse and neglect policy education. Despite facility leaders' awareness by late spring 2019 of physician 2's inappropriate statement regarding the patient and

⁷⁴ The original allegation identified physician 2's statement as "[the patient] can go shoot [themselves]. I do not care." However, other individuals reported physician 2's statement with similar content but varying language. Department of Veterans Affairs, 38 CFR, Part 0, Federal Register Volume 77, Number 135. VA defines its core values as ICARE: Integrity, Commitment, Advocacy, Respect, and Excellence. "The Values represent VA's beliefs and provide a baseline for the standards of behavior expected of all VA employees." Facility Policy PM-05-13; VA Handbook 5021/25.

physician 2's prior pattern of misconduct, the OIG found that facility leaders did not conduct a formal fact-finding or administrative investigation as required by VA.⁷⁵ The OIG opines that the Chief of Staff focused on physician 2's overall positive clinical outcomes and that the Chief of Staff and the Facility Director believed that internal clinical reviews of the patient's care were sufficient; and therefore, did not pursue formal administrative reviews related to physician 2's pattern of verbal misconduct.

Additionally, facility leaders did not report physician 2 to the State Licensing Board or National Practitioner Data Bank.⁷⁶ Facility leaders' failure to consider administrative investigation or disciplinary action resulted in physician 2 continuing to provide patient care for nine months after the events occurred with the patient in early 2019. During those nine months, there were two additional documented accounts of physician 2's misconduct. Failure to follow VHA and facility policy in response to incidents of employee misconduct and patient abuse undermined the public interest and continued risk to VA patients and staff.

The OIG found that the outpatient psychiatrist transferred care of the patient to physician 1 by person-to-person contact as preferred by facility policy.⁷⁷ However, the OIG determined that physician assistant 2, the consulting psychiatry resident physician, and physician 2 failed to review the relevant patient history to inform medical decision making. The OIG opines that the three providers failed to evaluate the patient's overall psychiatric and medical needs but rather focused on discharging the patient based on a narrow perspective of the patient's presentation. The failure to review the outpatient psychiatrist's assessment from earlier that day may have resulted in the patient's discharge without consideration of identified suicide and medical risk factors.

The Patient Safety Manager told that OIG that a facility internal review identified hand-off deficits related to the patient's care. As a result, facility managers implemented a new procedure to strengthen the Emergency Department hand-off processes including documentation of standardized hand-off communication. Additionally, the Chief Nurse, Critical Care and Operations, told the OIG team that the Emergency Department Nurse Manager was responsible for daily audits to determine whether a shift change hand-off meeting occurred. The OIG found that audits conducted from spring through late 2019 only included monitoring daytime but not the evening shift change hand-off process and did not monitor the quality of the hand-off process, such as interdisciplinary team member attendance or adherence to the newly established

⁷⁵ VA Handbook 5021/25.

⁷⁶ VHA Handbook 1100.18. The National Practitioner Data Bank is a web-based tool for reporting healthcare practitioners' adverse actions. U.S. Department of Health and Human Services, "National Practitioner Data Bank," <https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp>. (The website was accessed on January 27, 2020.); VHA Handbook 1100.17.

⁷⁷ Facility Policy PM-11-13. In independent OIG team interviews, the outpatient psychiatrist and physician 1 described person-to-person contact in the patient's transfer of care.

hand-off communication requirements. Without monitoring team member attendance, Emergency Department leaders would be unable to ensure that the responsible clinicians are providing and receiving hand-off communication during each shift change. Further, failure to monitor the integrity of the hand-off communication limits Emergency Department leaders' identification of areas for improvement in hand-off communication.

The OIG found that the patient's electronic health record contained inconsistent reports of the patient's chief complaint and presentation that staff did not reconcile prior to the patient's discharge. The OIG also determined physician 2 did not document an understanding of the outcomes of other providers' evaluations or a review of the patient's electronic health record to inform the medical decision making that led to the patient's discharge. The OIG found that facility staff failed to document consistent information in the patient's discharge progress notes and discharge instructions, as required by VHA.⁷⁸ Given the patient's distress about being discharged, the OIG would have expected that facility staff would have attempted to contact the patient's family member to ensure continuity of care. Staff's failure to provide the patient with a clear and specific discharge plan, or to include the patient's family member in planning probably diminished the patient's likelihood of following up at the facility after discharge.

The OIG concluded that Emergency Department providers failed to (1) develop a clear understanding of the patient's diagnoses and (2) deliver patient-centered care that engaged the patient as an active partner in a care plan, as expected by VHA.⁷⁹ Further, providers did not include the patient and the patient's family member in healthcare decisions, as required by facility policy.⁸⁰

The OIG found that the facility's Suicide Prevention Coordinator failed to complete the suicide behavior report following notification of the patient's death by suicide, as required by VHA.⁸¹ Failure of staff to consistently complete suicide behavior reports compromises the accuracy of VHA's suicide-related events data that may be used to identify trends of self-directed violence behaviors and determine suicide prevention efforts.

The OIG found that a nurse closed the outpatient psychiatrist's outpatient substance use disorder treatment consult request without scheduling an appointment, contrary to VHA policy.⁸² The staff's failure to work collaboratively with the patient and the patient's family to schedule an appointment and engage the patient in treatment may have contributed to the patient not accessing facility treatment resources prior to completing suicide. The outpatient substance use

⁷⁸ VHA Handbook 1907.01.

⁷⁹ U.S. Department of Veterans Affairs, VA National Center for Patient Safety, VA Care is Patient-Centered, <https://www.patientsafety.va.gov/veterans/patient-centered.asp>. (The website was accessed on February 8, 2020.)

⁸⁰ Facility Policy PM-002-08.

⁸¹ VHA Directive 2008-036.

⁸² VHA Directive 1232 (2). Deputy Under Secretary for Health for Operations and Management Memorandum, *Scheduling and Consult Policy Updates*, June 5, 2017.

disorder treatment program manager told the OIG that facility managers implemented consult procedure changes in response to the gaps identified as a result of the review of the patient's care. The new process ensured that an appointment is scheduled for every consult. The program manager told the OIG that with a scheduled appointment, a patient receives follow-up outreach if the patient misses the appointment.

The OIG found that the facility's Emergency Department failed to meet VHA's requirements for a safe and secure evaluation area for patients seeking mental health services. Lack of a safe and secure area for patients presenting with emergent mental health needs, including a psychiatric evaluation room, may result in privacy violations and an inability to adequately evaluate and monitor patients at risk of elopement or suicidal behaviors. Due to limited physical space, the Emergency Department did not contain a psychiatric intervention room for patients presenting with mental health needs. Beginning in 2009, facility leaders have pursued a renovation project that included three mental health examination rooms.⁸³ In 2019, facility leaders submitted a request for VISN approval to expand the Emergency Department and several months later, the VISN approved the request. As of April 7, 2020, the VISN Deputy Quality Management Officer reported the bid was obtained, and a process was in place for awarding the contract. On May 11, 2020, the VISN Capital Asset Manager reported that VA Contracting and Office of General Counsel decided to resolicit the project given the time lapsed and cost limit increase approval in March 2020; and cited an anticipated award date of September 30, 2020.

Recommendations 1–11

1. The Washington DC VA Medical Center Director ensures that Emergency Department staff adhere to Veterans Health Administration suicide prevention policies and monitors compliance.
2. The Washington DC VA Medical Center Director ensures that patients are adequately assessed for withdrawal risk and provided with appropriate disposition for management of withdrawal.
3. The Washington DC VA Medical Center Director ensures staff education of the Veterans Health Administration and Washington DC VA Medical Center policies related to employee misconduct and patient abuse, and monitors compliance.
4. The VA Capitol Health Care Network Director reviews Washington DC VA Medical Center leadership and supervisory response to allegations of employee misconduct and patient abuse to determine if administrative action is warranted and takes action as appropriate.

⁸³ Starting in 2009, proposals for Emergency Department renovation were pursued with multiple reasons for halting including structural issues and cost.

5. The Washington DC VA Medical Center Director determines leaders' authority and duty to report physician 2's behavior to the State Licensing Board and National Practitioner Data Bank and takes action as indicated.
6. The Washington DC VA Medical Center Director establishes comprehensive quality monitoring of the required hand-off communication processes, including interdisciplinary participation and monitors compliance.
7. The Washington DC VA Medical Center Director makes certain that Emergency Department staff reconcile diagnostic and care plan information that may vary across providers and shifts when determining a patient's final disposition.
8. The Washington DC VA Medical Center Director ensures that Emergency Department staff include the patient and family members, in the development of a care plan as appropriate, and monitor compliance.
9. The Washington DC VA Medical Center Director ensures that facility staff complete Suicide Behavior and Overdose reports as required.
10. The Washington DC VA Medical Center Director establishes quality monitoring of consult scheduling procedures and monitors compliance.
11. The Washington DC VA Medical Center Director expedites Emergency Department renovations to ensure a safe and secure area for evaluation of mental health patients.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 18, 2020

From: Director, VA Capitol Health Care Network (10N05)

Subj: Healthcare Inspection— Inadequate Emergency Department Care and Physician Misconduct at Washington DC VA Medical Center

To: Director, Mental Health Programs, Office of Healthcare Inspections (54MH00)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. I have reviewed and concur with the findings and recommendations in the Office of Inspector General's (OIG's) draft report entitled – Inadequate Emergency Department Care and Physician Misconduct at the Washington DC VA Medical Center.
2. I have reviewed the attached comments provided by the Medical Center Director, Washington DC VA Medical Center, and concur with the responses and actions to the ten (10) facility recommendations.
3. Attached is the VISN response to the one (1) VISN recommendation including actions to focus on continuous performance improvement.
4. Should you require any additional information please contact VISN 5 network office at 410-691-1321.

(Original signed by:)

Robert M. Walton, FACHE
Director, VA Capitol Health Care Network

VISN Director Response

Recommendation 4

The VA Capitol Health Care Network Director reviews Washington DC VA Medical Center leadership and supervisory response to allegations of employee misconduct and patient abuse to determine if administrative action is warranted and takes action as appropriate.

Concur.

Target date for completion: September 30, 2020

Director Comments

The VA Capitol Health Care Network Director will review the Medical Center's reassessment of the professional conduct of Provider 2 in this case. The VA Capitol Health Care Network Director will review Washington DC VA Medical Center leadership and supervisory responses to allegations of employee misconduct and patient abuse over a period of at least six months and will take administrative action if appropriate.

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 17, 2020

From: Director, Washington DC VA Medical Center, Washington DC (688/00)

Subj: Healthcare Inspection— Inadequate Emergency Department Care and Physician Misconduct at the Washington DC VA Medical Center

To: Director, VA Capitol Health Care Network (10N05)

1. Thank you to the Office of the Inspector General's team that conducted this thorough review of the processes in the Medical Center. I have reviewed the draft report and concur with findings and recommendations.
2. Attached are the facility responses to the ten (10) recommendations including actions to correct the identified opportunities for improvement.

(Original signed by:)

Michael S. Heimall

Director, Washington DC VA Medical Center

Facility Director Response

Recommendation 1

The Washington DC VA Medical Center Director ensures that Emergency Department staff adhere to Veterans Health Administration suicide prevention policies and monitors compliance.

Concur.

Target date for completion: December 31, 2020

Director Comments

The Washington DC VA Medical Center Emergency Room leadership has instituted a comprehensive educational program for clinical staff working in the Emergency Room to ensure staff's understanding of the Veterans Health Administration's local policies surrounding suicide prevention. Additionally, the Emergency Department (ED) leadership has implemented the Safety Planning in the Emergency Department (SPED) initiative. ED leadership has designated the ED Nurse Manager and Assistant Nurse Manager as the facility SPED Points of Contact (POCs). The POCs will be the primary point of contact to monitor the SPED program which allows the facility to monitor patients who have presented to the Emergency Room with suicidal thoughts to ensure a safety plan is completed before discharge. Additionally, the SPED POCs will conduct randomized chart audits of 20% of all patient Emergency Room encounters weekly where the patient expressed suicidal thoughts to ensure that the care provided was consistent with VHA and local policies. Evidence of training compliance will include the submission of training records for the Emergency Room clinical staff and Mental Health ED staff with an 80% compliance of completing the training by July 31, 2020. All new staff will be assigned the training during their orientation phase. Evidence of compliance for the completed audits will be 90% compliance with all elements of the VHA and local policies for a minimum of two quarters.

Recommendation 2

The Washington DC VA Medical Center Director ensures that patients are adequately assessed for withdrawal risk and provided with appropriate disposition for management of withdrawal.

Concur.

Target date for completion: December 31, 2020

Director Comments

The Washington DC VA Medical Center has implemented the use of evidence-based assessment tools (Clinical Institute Withdrawal Assessment for Alcohol (revised version) (CIWA-AR),

Clinical Institute Withdrawal Scale - Benzodiazepines (CIWA-B) for providers and Alcohol Use Disorders Identification Test (AUDIT-C) and Clinical Opioid Withdrawal Scale (COWS) for both providers and nurses) to properly determine a patient's withdrawal symptoms and subsequent risk associated with the symptoms the patient is experiencing. The implementation of these evidence-based tools allows the clinicians in the Emergency Room to more accurately assess a patient's clinical status and subsequently develop a more comprehensive disposition plan. The results of these assessments are placed on the Emergency Department Integration Software (EDIS) Tracking Board to increase communication among all members of the treatment team. The Medical Center will conduct randomized chart audits of 20% of all patient Emergency Room encounters monthly where the patient had symptoms of withdrawal to ensure that the patient was provided with an appropriate disposition plan. Evidence of compliance will be a 90% compliance with the patient's disposition plan being clinically appropriate for a minimum of two quarters.

Recommendation 3

The Washington DC VA Medical Center Director ensures staff education of the Veterans Health Administration and Washington DC VA Medical Center policies related to employee misconduct and patient abuse, and monitors compliance.

Concur.

Target date for completion: September 30, 2020

Director Comments

The Emergency Department has implemented a comprehensive educational program for all staff in the department on the Veterans Health Administration and Washington DC VA Medical Center policies regarding employee misconduct and patient abuse. Evidence of compliance will include the submission of training records for the Emergency Room clinical staff with an 80% compliance of completing the training by July 31, 2020. All new staff will be assigned the training during their orientation phase.

Recommendation 5

The Washington DC VA Medical Center Director determines leaders' authority and duty to report physician 2's behavior to the State Licensing Board and National Practitioner Data Bank and takes action as indicated.

Concur.

Target date for completion: June 30, 2020

Director Comments

The Medical Center Director reviewed the findings and recommendations of the Medical Executive Committee related to the standard of care provided by multiple providers involved in the care of this Veteran and determined no provider warranted reporting to the National Practitioner Data Bank (NPDB) or a State Licensing Board (SLB) under the criteria outlined in paragraph 8 of VHA Handbook 1100.17, National Practitioner Data Bank (NPDB) reporting or VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards. The Medical Center will reconsider review the professional conduct of Provider 2 in this case and determine if Provider 2's professional conduct in this matter warrants reporting to the NPDB under provisions of paragraph 9, VHA Handbook 1100.17 or VHA Handbook 1100.18.

OIG Comment

The OIG considers this recommendation open and will follow up on the recently implemented actions provided by the Washington DC VA Medical Center Director to allow time for the facility to submit documentation of actions taken and to ensure that corrective actions have been effective and sustained.

Recommendation 6

The Washington DC VA Medical Center Director establishes comprehensive quality monitoring of the required hand-off communication processes, including interdisciplinary participation and monitors compliance.

Concur.

Target date for completion: December 31, 2020

Director Comments

The Washington DC VA Medical Center Emergency Department has implemented a multidisciplinary team huddle at the time of change of shift in the Emergency Department to ensure that the clinical care and planned disposition for the patients is appropriately handed-off from one shift to another. The Medical Center will conduct audits on 20% of the total patient encounters where the patient had a mental health concern and there was documentation in the electronic health record from another clinician outside of the Emergency Department on the same day as the Emergency Department encounter. Evidence of compliance will be that 80% of records audited will document the continuity of the primary clinical concerns and the provider recommendations in the Emergency Department Record. The Medical Center will monitor two quarters of data for compliance.

Recommendation 7

The Washington DC VA Medical Center Director makes certain that Emergency Department staff reconcile diagnostic and care plan information that may vary across providers and shifts when determining a patient's final disposition.

Concur.

Target date for completion: December 31, 2020

Director Comments

The ability to synthesize data and information from the various clinical aspects of a patient's record is the heart of the clinical judgment that providers make during each patient encounter. To ensure the continuity of care during a telephone hand-off from a care environment external to the Emergency Department, the Medical Center will implement a process that requires the receiving Emergency Department provider to acknowledge the receipt of the hand-off through documentation in the electronic health record. The Medical Center will conduct audits on 20% of the total patient encounters where the patient had a mental health concern. The audits will assess for the documentation of the receipt of hand-off in the Emergency Department's note and the audit will examine and apply clinical judgment from the auditor determining if the same clinical assessment and disposition would be maintained. Evidence of compliance will be 80% concurrence with the clinical assessment and disposition for two quarters and 90% compliance with documentation of the hand-off of care in the electronic health record for two quarters.

Recommendation 8

The Washington DC VA Medical Center Director ensures that Emergency Department staff include the patient and family members in the development of a care plan as appropriate, and monitor compliance.

Concur.

Target date for completion: December 31, 2020

Director Comments

The Washington DC VA Medical Center Emergency Department has updated the nursing and provider discharge documentation to ensure there is a section in the templated note where clinicians can document patient and family member involvement in the plan of care. The Medical Center will conduct audits on 20% of the total patient encounters where the patient had a mental health concern and subsequently discharged to home. Evidence of compliance will be 80% compliance with documentation of the involvement of patients and families in the disposition plan for a minimum of two quarters.

Recommendation 9

The Washington DC VA Medical Center Director ensures that facility staff complete Suicide Behavior and Overdose reports as required.

Concur.

Target date for completion: December 31, 2020

Director Comments

All licensed independent staff at the Washington DC VA Medical Center are responsible for completion of the suicide behavior and overdose reports for completed suicides at the facility. The Medical Center has reinforced this requirement to the medical staff. The Suicide Prevention team will conduct a comprehensive audit of all completed suicide cases to ensure 100% compliance of completion of the suicide behavior overdose report. Evidence of compliance will be two quarters worth of data.

Recommendation 10

The Washington DC VA Medical Center Director establishes quality monitoring of consult scheduling procedures and monitors compliance.

Concur.

Target date for completion: December 31, 2020

Director Comments

The Washington DC VAMC follows the Veterans Health Administration directive on the management of consults. As such, the Medical Center will monitor 20% of all Mental Health consults generated from the Emergency Department for adherence to VHA requirements. Evidence of compliance will be that 80% of the consults audited will meet VHA requirements for a minimum of two quarters.

Recommendation 11

The Washington DC VA Medical Center Director expedites Emergency Department renovations to ensure a safe and secure area for evaluation of mental health patients.

Concur.

Target date for completion: September 30, 2020

Director Comments

As per the OIG's report, the Washington DC VAMC anticipates an award to be issued for the renovations of the Emergency Department by September 30, 2020. In the interim, the Medical Center has approved modifications to the Emergency Department's existing physical environment to improve the safety of mental health patients in the Emergency Department. This plan requires some construction but at a significantly smaller scale than the full renovation project planned for the Emergency Department. Evidence of compliance will be the implementation of the interim plan to increase the safety of the mental health patient in the Emergency Department by September 30, 2020.

Glossary

alprazolam. A benzodiazepine medication prescribed for anxiety.⁸⁴

anxiety. An expected part of life that involves worry or fear. In individuals with an anxiety disorder, it can worsen over time and can interfere with daily activities to include job performance, schoolwork, and relationships.⁸⁵

benzodiazepine dependence. Sedative, hypnotic, or anxiolytic medications may produce tolerance and withdrawal even when prescribed by a physician, depending on the dose and instructions. If these drugs are prescribed and used appropriately, “the resulting tolerance or withdrawal does not meet the criteria for diagnosing a substance use disorder.” Dependence is defined by evidence of tolerance and withdrawal “in an individual who has abruptly discontinued use of benzodiazepines,” including those prescribed at prescribed and therapeutic doses.⁸⁶

insomnia. “A common sleep disorder that can make it hard to fall asleep, hard to stay asleep, or cause you to wake up too early and not be able to get back to sleep.”⁸⁷

malinger. To pretend or exaggerate incapacity or illness.⁸⁸

opioid dependence. Opioid medications may be prescribed for medical purposes, and depending on the regimen, these drugs may produce tolerance and withdrawal. If these drugs are prescribed and used appropriately, the resulting tolerance or withdrawal does not meet the criteria for diagnosing a substance use disorder. Dependence is defined by evidence of tolerance and

⁸⁴ Merck Manual, Professional Version, *Alprazolam*. <https://www.merckmanuals.com/professional/resources/brand-names-of-some-commonly-used-drugs>. (The website was accessed on August 9, 2019.)

⁸⁵ National Institute of Mental Health, *Anxiety Disorders*. <https://www.nimh.nih.gov/health/index.shtml>. (The website was accessed on December 9, 2019.)

⁸⁶ Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, American Psychiatric Association (online), *Substance -Related and Addictive Disorders*. <https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm16#CHDGIHGB>. (The website was accessed on August 12, 2019.) NIH National Institute on Drug Abuse, *Is there a difference between physical dependence and addiction?* <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/there-difference-between-physical-dependence>. (The website was accessed on May 4, 2020.)

⁸⁷ Mayo Clinic, *Insomnia*. <https://www.mayoclinic.org/diseases-conditions/insomnia/symptoms-causes/syc-20355167>. (The website was accessed on December 9, 2019.)

⁸⁸ Merriam-Webster, *Definition of malingering*. <https://www.merriam-webster.com/dictionary/malingering>. (The website was accessed on December 9, 2019.)

withdrawal in the absence of a diagnosis of an opioid use disorder in an individual who has abruptly discontinued use of opioids.⁸⁹

osteoarthritis. The most common form of arthritis. “It occurs when the protective cartilage that cushions the ends of your bones wears down over time.”⁹⁰

oxycodone. An opioid medication used for pain management.⁹¹

panic attacks. “A sudden episode of intense fear that triggers severe physical reactions when there is no real danger or apparent cause.”⁹²

withdrawal seizures. Potentially life-threatening seizures that may occur in the first 1-12 days after abrupt discontinuation of benzodiazepines. Dosage of benzodiazepine should be reduced over several weeks to minimize the risk of seizures.⁹³

⁸⁹ Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, American Psychiatric Association (online), “Substance-Related and Addictive Disorders,” <https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm16#CHDGIHGB>. (The website was accessed on August 12, 2019.) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, American Psychiatric Association 2000 (print), “Substance-Related Disorders,” <https://dsm.psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890420249.dsm-iv-tr>. (The website was accessed on February 26, 2020.)

⁹⁰ Mayo Clinic, *Osteoarthritis*. <https://www.mayoclinic.org/search/search-results?q=Arthritis,%20osteoarthritis>. (The website was accessed on December 9, 2019.)

⁹¹ Merck Manual, Professional Version. <https://www.merckmanuals.com/professional/resources/brand-names-of-some-commonly-used-drugs>. (The website was accessed on August 9, 2019.)

⁹² Mayo Clinic, *Panic Attacks and Panic Disorder*. <https://www.mayoclinic.org/search/search-results?q=panic%20attacks>. (The website was accessed on December 9, 2019.)

⁹³ Jonathan Brett and Bridin Murnion, “Management of benzodiazepine misuse and dependence,” *Australian Prescriber*, 38, no. 5, (October 2015): 152–155. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4657308/pdf/austprescr-38-152.pdf>. (The website was accessed on December 16, 2019.)

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