



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

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OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS, U.S. HOUSE OF REPRESENTATIVES
HEARING ON
CARING FOR VETERANS IN CRISIS:
ENSURING A COMPREHENSIVE HEALTH SYSTEM APPROACH
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Chairman Takano, Ranking Member Roe, and members of the Committee, thank you for the opportunity to discuss the Office of Inspector General's (OIG's) oversight of the mental health care and services provided by the Department of Veterans Affairs (VA) at Veterans Health Administration (VHA) facilities. The mission of the OIG is to oversee the efficiency and effectiveness of VA's programs and operations through independent audits, inspections, evaluations, reviews, and investigations. For many years, the OIG has conducted reviews and inspections that have identified concerns with veterans' access to quality health care, including mental health care, provided at VHA facilities. Recent reports have identified ongoing concerns with the timeliness and delivery of quality mental health care, the challenges associated with the coordination of that care, the proactive measures that could reduce suicides, and the physical environment in which veterans receive mental health care.

Although veterans are a tremendously diverse community, they have a culture, set of experiences, and sense of duty associated with military service that can differ dramatically from civilians. Some veteran experiences can contribute to and challenge the management of often complex mental health needs. According to research, veterans experience mental health and substance abuse disorders, posttraumatic stress, and traumatic brain injury at rates disproportionately high when compared to their civilian counterparts.¹ This underscores the magnitude of responsibility VHA assumes in supporting the needs of this population. Responding effectively to their needs requires a holistic approach focused on each veteran's successful reintegration into civilian life. A truly integrated approach, while veteran-centric in design, can be effective only if families, caregivers, healthcare providers, and communities work together to support veterans' whole health. Perhaps most urgent is the need to mitigate the risk of suicide. VHA must continue to focus attention on outreach efforts that educate and provide all

¹ Terri Tanielian et al., "Invisible Wounds: Mental Health and Cognitive Care Needs of America's Returning Veterans," (Santa Monica, CA: RAND Corporation, 2008), https://www.rand.org/pubs/research_briefs/RB9336.html; National Alliance on Mental Illness, "You Are Not Alone," <https://nami.org/mhstats>, accessed on January 27, 2020.

stakeholders with evidence-based tools that not only help identify high-risk veterans, but also encourage those veterans to engage in the care they need.

VHA has implemented several initiatives aimed at reducing the stigma surrounding mental health conditions, providing access to mental health services, and promoting public awareness of suicide. The focus on suicide prevention has included appointing a National Suicide Prevention Coordinator, establishing the Veterans Crisis Line, developing a patient record system to identify high-risk patients, and creating suicide prevention programs in each facility. In addition, VHA expanded facility suicide prevention coordinator roles, requiring them to participate in community outreach activities.

VHA's efforts in suicide prevention, including the Veterans Crisis Line, have been largely directed at crisis intervention. According to the medical literature, the opportunity for intervention between the decision to complete suicide and the attempt itself is extremely narrow, as short as one hour in over 70 percent of all suicide attempts.² Additionally, 69 percent of veteran suicide deaths are by the more likely lethal means of firearms, compared to 48 percent of civilian suicide deaths.³ To significantly reduce suicide and improve the lives of veterans, prompt and effective behavioral health treatment must be paired with a wide range of additional approaches. For example, VA has promoted firearm safety by urging veterans to secure guns with locks, removing firing pins, or storing firearms where they are not easily and quickly accessed. The VA Suicide Prevention Program's Acting Director was recently quoted as saying, "The safety measures can slow a person's ability to follow through on suicidal thoughts and preempt an irrevocable choice."⁴ It is being presented as just one element of a plan, in the hope that clinicians can include this topic as an aspect of self-care. Lethal-means safety counseling offers clinicians an evidence-based opportunity to erect a barrier to suicidal impulsivity. VHA has several current projects that address lethal-means safety, but each project requires additional resources to develop their concepts and evaluate effectiveness in the veteran community. VHA must take every opportunity—from the time of a servicemembers' transition to the community and throughout the veterans' life—to identify and address behavioral health conditions.

Despite VHA's recent efforts, there are significant challenges ahead. The OIG has published numerous reports in recent years that detail veterans' experiences with obstacles accessing and receiving high-quality mental health care within VHA. Tragic events such as suicides are the most publicized and typically understood to be the result of unrecognized, untreated, or undertreated mental health disorders. The OIG's focus, however, has also included the timely care and management of the wide variety of mental health needs for which veterans seek care. Report recommendations are meant to assist VHA in

² E.A. Deisenhammer et al., "The Duration of the Suicidal Process: How Much Time Is Left for Intervention Between Consideration and Accomplishment of a Suicide Attempt?" *Journal of Clinical Psychiatry*, 70(1), 19–24.

³ Department of Veterans Affairs, "VA National Suicide Data Report 2005–2016," VA Office of Mental Health and Suicide Prevention, September 2018.

⁴ Martin Kuz, "Can Veterans Lead the Way on Preventing Suicide," *Christian Science Monitor*, December 31, 2019, <https://www.csmonitor.com/USA/Military/2019/1231/Can-veterans-lead-the-way-on-preventing-suicide>.

its efforts to be responsive at all levels to addressing the complex mental health care needs of veterans. The goal, ultimately, is to improve veterans' quality of life (as well as the lives of their families and caregivers) and to reduce the rate of veteran suicide.

Recognizing the importance of suicide prevention as VA's—and this Committee's—top clinical priority, the OIG has focused significant resources on conducting oversight of VHA's mental health treatment programs and other suicide prevention efforts.⁵ This statement focuses on some of the more recent OIG reviews highlighting opportunities where VHA can strengthen its efforts to improve the quality and coordination of care as well as the environment in which veterans receive that care.

DEFICIENCIES IN VHA MENTAL HEALTH COORDINATION OF CARE

The OIG has reviewed a number of reported suicides and mental healthcare-related concerns that occurred on VA campuses. These involved veterans who were receiving, seeking, or may have needed mental health care from VHA providers. These reviews found deficiencies in care delivery that resulted in negative outcomes for patients experiencing a mental health crisis. The OIG's findings in this area can be categorized as deficiencies in coordination of care in the following contexts:

- Within a mental health treatment team
- With non-mental health providers
- During the discharge process
- By care providers with the patients or their family/surrogate

The OIG found inadequate coordination of care to be an underlying theme in every one of its recently conducted reviews. Relevant examples from these reports are discussed below.

Coordination of Care Within a Mental Health Treatment Team

Typically, a mental health treatment team is multidisciplinary and may involve a psychiatrist, a psychologist, mental health nurses, mental health social workers, mental health clinical pharmacists, and suicide prevention coordinators. Coordination within the team is vital to provide the patient with synchronized and complementary services. Failures in communication could result in conflicting information or gaps in care that may result in harm to the patient. The following reports involve deficiencies in coordination of care within a mental health team.

⁵ Department of Veterans Affairs, "The VA is Making Real Progress on Suicide Prevention for Veterans," January 14, 2019, <https://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=5177>; House Veterans Affairs Committee, "Chairman Takano Announces New Compromise on Legislation to Address Veteran Suicide," December 3, 2019, https://veterans.house.gov/news/press-releases/_chairman-takano-announces-new-compromise-on-legislation-to-address-veteran-suicide.

Alleged Deficiencies in Mental Health Care Prior to a Death by Suicide at the VA San Diego Healthcare System

The OIG conducted a healthcare inspection in response to allegations that staff failed to provide mental health care to a patient who subsequently died by suicide.⁶ The OIG did not substantiate that the system failed to provide mental health care when the patient sought help. However, the OIG team found deficits in the decision-making process to deactivate a patient's High Risk for Suicide Patient Record Flag (PRF).⁷ The assigned suicide prevention coordinator chose to deactivate the patient's PRF in spring 2018 without consulting the treatment team. In addition, the patient did not have any scheduled future appointments and had not been engaged in any mental health services for more than two months. VHA does not have clearly delineated requirements for the decision-making process to deactivate the High Risk for Suicide PRF; however, the then Executive Director of the Suicide Prevention Program told the OIG that there is an expectation that the suicide prevention coordinator will consult with the patient's treatment team, provide evidence of decreased suicide risk factors, and document rationale for clinical judgment about mental health conditions and behaviors. The OIG recommended the Under Secretary for Health expedite the development of a National Suicide Prevention Program policy and procedure to delineate the deactivation process of High Risk for Suicide PRFs and monitor compliance.⁸ The VHA action plan projected completion date was December 2019. OIG staff will monitor VA's progress until the proposed action is complete.⁹

The September 2018 Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide in the Minneapolis VA Health Care System

In September 2018, the OIG reported on the care of a patient who was admitted to the inpatient mental health unit and subsequently died from a self-inflicted gunshot wound less than 24 hours after

⁶ [*Alleged Deficiencies in Mental Health Care Prior to a Death by Suicide at the VA San Diego Healthcare System, California*](#), August 7, 2019.

⁷ VHA established the High Risk for Suicide Patient Record Flag to alert staff to patients with immediate clinical safety concerns and is therefore only activated for those patients assessed at high risk for suicide and only for the duration of the increased risk. The suicide prevention coordinator works with the patient's clinicians to determine if the flag is needed, monitors its continued application, and deactivates the flag when the patient no longer has an elevated risk.

⁸ The recommendations directed to the Under Secretary for Health are submitted to the Executive in Charge, who has the authority to perform those functions and duties.

⁹ VA provides implementation plans and determines their projected dates for implementation when providing comments on OIG draft reports. At quarterly intervals starting 90 days after report issuance, OIG staff requests the VA office provide an accounting of actions taken to implement open recommendations, as well as whether the VA office believes a recommendation may be closed. After receiving the VA office's report, OIG staff reviews the materials and provides a final determination whether any recommendations have been satisfactorily implemented and can be closed. The decision to close a recommendation is based on a review of VA's supporting documentation or independent information obtained by OIG that indicates the corrective action has occurred and is sustained or progressed enough to show recommendation implementation.

discharge.¹⁰ The OIG determined that the inpatient interdisciplinary treatment team failed to appropriately coordinate with the patient's outpatient treatment team. Specifically, inpatient mental health staff did not identify an outpatient prescriber and schedule an outpatient medication management follow-up appointment. Additionally, the system's suicide prevention coordinator did not collaborate with the inpatient interdisciplinary treatment team during admission. The OIG was unable to determine that identified deficits, alone or in combination, were a causal factor in the patient's death. However, the OIG did make recommendations related to interdisciplinary team collaboration, which are now closed.

Review of Two Mental Health Patients Who Died by Suicide at the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin

The review team assessed the care of a patient who committed suicide less than 48 hours after being discharged from the VA facility.¹¹ The OIG found that the mental health clinical pharmacists informally collaborated with facility psychiatrists but did not appropriately refer patients with complex mental health issues whose treatment was beyond the pharmacists' scope of practice. Specifically, mental health clinical pharmacists acted outside of their scope of practice in changing diagnoses and providing psychotherapy. The collaborations were insufficient to meet the requirements of mental health clinical pharmacists' scope of practice. Their independent decision-making without sufficient psychiatrist collaboration or supervision may have contributed to deficient mental health care. The OIG also identified similar deficiencies by a mental health clinical pharmacist in the care of another patient that died by suicide 13 months before the first patient's death. The OIG made recommendations related to prescribing practices, including the use of collaborative agreements, the assignment of prescribers for patients with complex mental health needs, and strengthening mental health clinical pharmacists' supervision processes. Based on a review of VA's corrective actions, the OIG has closed all report recommendations.

Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities

The seriousness of the risks identified in the prior report led the OIG to initiate a broader review of clinical pharmacists' practice in mental health outpatient care settings. The OIG assessed VHA facilities' use of clinical pharmacists who work under a scope of practice in a mental health outpatient care setting.¹²

Clinical pharmacists have advanced specialized education and training that allows them to provide comprehensive medication management that includes resolving patient medication nonadherence and

¹⁰ [*Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide, Minneapolis VA Health Care System, Minnesota*](#), September 25, 2018.

¹¹ [*Review of Two Mental Health Patients Who Died by Suicide, William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin*](#), August 1, 2018.

¹² [*Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities*](#), June 27, 2019.

assisting patients in achieving medication-related therapeutic goals. Clinical pharmacists are not licensed independent practitioners and therefore must collaborate with licensed independent practitioners who have prescriptive authority, as outlined in a collaborative practice agreement. Each clinical pharmacist requests the types of services he or she will provide, which are reviewed and recommended by the relevant facility's service chiefs and executive committee of the medical staff, and then approved by the medical facility director.

The role of clinical pharmacists with a scope of practice in the mental health specialty practice area has been a focus of expansion for VHA in recent years. As VHA expands and increases its use of mental health clinical pharmacists, it is imperative that there are collaborating agreements in place and that scopes of practice clearly delineate duties and are standardized to maximize patient safety.

The OIG's review found that mental health clinical pharmacists' independence levels were not clearly identified by staff or facilities' bylaws. Guidance provided conflicting instructions regarding the requirements for collaborating agreements and lacked provisions for oversight by a specific physician. Facilities' scopes of practice were inconsistent in describing delegated duties that were specific to mental health. VHA policy also was insufficient to ensure the chief of mental health conducts reviews and endorses mental health clinical pharmacists' scopes of practice. Referral processes were not clear or standardized regarding how diagnoses were conveyed to mental health clinical pharmacists or whether involvement of a licensed independent practitioner with prescriptive authority was considered to determine appropriateness for patients' referrals. VHA policy does not require a defined process to consider a patient's clinical complexity. Policies lacked guidance on instructing mental health clinical pharmacists on when or how to refer patients to a higher level of care. The OIG made nine recommendations to the VHA Under Secretary for Health related to autonomy, collaborating agreements, working with licensed independent practitioners with prescribing authority, scopes of practice, and referrals. Recommendations are to be completed no later than May 2020, according to VHA action plans. OIG staff will monitor VA's progress until all proposed actions are complete.

Coordination of Care with Non-Mental Health Providers

Patients' mental health care must be managed together with any other medical conditions. Patients with complex medical histories require coordination between mental health and non-mental health care providers. Failures in communication may result in harm resulting from medication side effects or interactions or worsening of the underlying medical conditions. The following OIG reports found issues with the coordination of care between mental health and non-mental health care providers.

The January 2020 Report Deficiencies in Care Coordination and Facility Response to Another Patient Suicide in Minneapolis

In January 2020, the OIG released a healthcare inspection report assessing care coordination for a patient who died by suicide while admitted to an inpatient medicine unit at the facility.¹³ The patient was assessed as at a heightened but not imminent risk for suicide. Facility emergency department staff failed to report the patient's suicidal ideation to the facility's suicide prevention coordinator. Two consulting staff members and an inpatient registered nurse completed required suicide prevention training but failed to involve clinicians when the patient verbalized suicidal thoughts and warning signs. Two of the three staff documented the patient's suicidal thoughts and warning signs in consult results notes, but the OIG did not find documentation that the inpatient medicine resident reviewed or acted on the consult results. The OIG made recommendations to the facility's director related to improving emergency department staff's notification to the suicide prevention coordinator when a patient presents with suicidal ideation. The recommendations also called on the facility director to ensure that inpatient consult results are acted upon by the responsible care provider or appropriate designee. All recommendations are to be completed no later than July 2020, according to VHA action plans. OIG staff will monitor VA's progress until the proposed actions are complete.

Alleged Deficiencies in Oncology Psychosocial Distress Screening and Root Cause Analysis Processes at a Facility in Veterans Integrated Service Network 15

In a December 2019 healthcare inspection report, OIG staff examined a Veterans Integrated Service Network (VISN) 15 medical facility in response to concerns identified in a June 2019 OIG healthcare inspection.¹⁴ In part, this inspection evaluated the oncology service staff's adherence to the facility's psychosocial distress screening standard operating procedure in the care of two patients who died by suicide. The OIG team found that facility oncology service staff demonstrated compliance with psychosocial distress screening standard operating procedures. However, the OIG was unable to determine if a mental health evaluation completed prior to one of the patients' leaving the clinic would have changed the patient's outcome. Completion of a mental health evaluation may have identified additional risk factors and provided greater opportunity for suicide prevention interventions before the patient left the clinic. The OIG recommended that the facility director conduct an evaluation of radiation oncology clinic mental health consultation and treatment program needs and adjust mental health provider coverage as warranted. The VHA action plan projected completion date is May 2020. OIG staff will monitor VA's progress until the proposed actions are complete.

¹³ [*Deficiencies in Care Coordination and Facility Response to a Patient Suicide at the Minneapolis VA Health Care System, Minnesota*](#), January 7, 2020.

¹⁴ [*Alleged Deficiencies in Oncology Psychosocial Distress Screening and Root Cause Analysis Processes at a facility in Veterans Integrated Service Network 15*](#), December 11, 2019; [*Delay in Diagnosis and Subsequent Suicide at a Veterans Integrated Service Network 15 Medical Facility*](#), June 26, 2019.

Coordination of Care During the Discharge Process

When patients transition between providers—whether this is due to changes in levels of care (inpatient to outpatient) or to changes in treatment settings (patient is moving or a provider leaving)—ethical care demands a transfer of information about the patient (or “handoff”) between providers to facilitate continuity of medical and mental health care. Failure to provide such a handoff may lead to patient harm related to interruptions in treatment. It may also result in inappropriate repetition of previously completed testing or inappropriate medication because of the gaps in transferred information about previous intolerance or medication interactions. The following reports involve issues with coordination in the discharge process.

Deficiencies in Discharge Planning for a Mental Health Inpatient Who Transitioned to the Judicial System from a Veterans Integrated Service Network 4 Medical Facility

An OIG team responded to allegations related to the discharge of a patient from an inpatient mental health unit at a VISN 4 medical facility, and subsequent transfer to a federal detention center where the patient died shortly after discharge and while incarcerated.¹⁵ The OIG team determined that VA facility inpatient mental health staff failed to engage in proper discharge planning and proper treatment planning processes. The VA facility staff did not contact the receiving care providers at the detention center to provide any clinical information on a patient with serious chronic mental illness and severe medical comorbidities. Specifically, the OIG team determined that inpatient mental health staff neglected to provide clinical hand-off information to the patient’s receiving mental health providers, and to assign a mental health treatment coordinator responsible for overall care and discharge planning coordination. The OIG made a recommendation to ensure the provision of a complete medical and psychiatric diagnostic summary to receiving providers. That recommendation remains open and the OIG will continue to follow-up with the facility until it is fully implemented.

The September 2018 Review of Mental Health Care Provided Prior to a Veteran’s Death by Suicide in Minneapolis

In addition to the deficiencies in coordination of care with consultants and other non-mental health care providers previously mentioned, the September 2018 report also found issues related to discharge planning. The OIG team determined that VA’s inpatient mental health staff failed to include the patient’s outpatient treatment team in discharge planning, did not identify an outpatient prescriber, and neglected to schedule an outpatient medication management follow-up appointment. The OIG team noted that the system’s suicide prevention coordinator did not collaborate with the patient’s interdisciplinary treatment team during admission or participate in discharge planning. The OIG made a recommendation to the facility director to strengthen processes that will help ensure mental health interdisciplinary collaboration across levels of care in treatment planning, provision of clinical services,

¹⁵ [*Deficiencies in Discharge Planning for a Mental Health Inpatient Who Transitioned to the Judicial System from a Veterans Integrated Service Network 4 Medical Facility*](#), July 2, 2019.

and discharge planning that includes medication management, as required by VHA. Based on a review of VA's corrective actions, the OIG has closed the recommendation.

Coordination of Care With the Patient or With the Patient's Family/Surrogate

Patient-centered care requires that providers involve the patient or a patient's family (or decision-making surrogate) in all treatment determinations. VA requires informed consent for all treatment options across all disciplines. Failure to coordinate treatment decision-making with patients or family represents a failure of ethical care. The following reports involving deficiencies in coordinating care with the patient or the patient's family or surrogate.

Two Patient Suicides, a Patient Self-Harm Event, and Mental Health Services Administrative Deficiencies at the Alaska VA Healthcare System in Anchorage

An OIG healthcare inspection reviewed allegations of deficiencies in quality of care and administrative processes that contributed to two patients' deaths by suicide and one patient's self-harm at the facility's Social and Behavioral Health Services.¹⁶ Patient 1, who was assigned a High Risk for Suicide PRF, visited the same-day access clinic and noted on the triage form experiencing high anxiety, depression, and hopelessness, but denied suicidal thoughts or plans. The patient left the clinic without being seen by a mental health care provider. The OIG team substantiated that same-day access clinic staff failed to adhere to VHA and facility missing patient policies after this at-risk patient left without being seen. However, the OIG team was unable to determine that facility staff's lack of timely search and outreach to the patient directly contributed to the patient's death by suicide approximately one week later. Other potential contributing factors were unknown.

The OIG team substantiated that Patients 2 and 3 did not have appointments scheduled after visiting the same-day access clinic, as evidenced in the lack of providers' clinically indicated date, and return to clinic orders, respectively. Failure to schedule a follow-up appointment with a patient having active psychiatric symptoms can place a patient at risk for adverse outcomes. The OIG team, however, was unable to determine that the unscheduled appointments contributed directly to Patient 2's self-harm and Patient 3's death by suicide.

The OIG made recommendations related to the Behavioral Health Service's policies and procedures, same-day access clinic coverage, and scheduling processes. All 11 recommendations are currently open and OIG staff will monitor VA's progress until the proposed actions are complete.

¹⁶ [*Two Patient Suicides, a Patient Self-Harm Event, and Mental Health Services Administrative Deficiencies at the Alaska VA Healthcare System, Anchorage, Alaska*](#), November 19, 2019.

Deficiencies in Discharge Planning for a Mental Health Inpatient Who Transitioned to the Judicial System from a Veterans Integrated Service Network 4 Medical Facility

This previously discussed report also had findings related to inadequate coordination of care during discharge planning. The OIG team found that the VISN 4 facility staff did not obtain consent for voluntary admission from the patient’s surrogate as required for patients who lack decision-making capacity or are subject to the state law involuntary commitment options. Additionally, facility staff did not discuss or consider issues such as guardianship, competency, surrogacy, or alternative placements for the patient who may have lacked decision-making ability. The family was not allowed to participate in treatment team meetings and was not informed about discussions that took place during these meetings despite numerous attempts to obtain information regarding the patient’s treatment and discharge plan. Finally, although facility staff knew of the patient’s pending arrest one day prior to the discharge, staff did not inform the patient, nor contact the patient’s family member until after the patient had been removed from the facility and transported to the prison. The OIG made a recommendation to the facility director to strengthen inpatient mental health unit processes to include the patient, family members, or surrogate in treatment and discharge planning decisions. That recommendation remains open and the OIG will continue to follow-up with the facility until it is fully implemented.

DEFICIENCIES IN VHA’S MENTAL HEALTH ENVIRONMENT OF CARE

While most suicides occur in the community, some do occur in the hospital, most commonly by hanging. In 2017, The Joint Commission noted that approximately 425 suicides within healthcare settings (not just VA facilities) had been reported over the previous five years.¹⁷ For 2012 through 2017, VHA’s National Center for Patient Safety told OIG staff there were 37 inpatient suicides at VA facilities, including two in locked mental health units. A patient suicide in a healthcare facility is a “never event,” a largely preventable tragic event of deep concern to both the public and healthcare providers.

OIG Hotline Reviews Related to Mental Health Environment of Care

OIG’s hotline reviews are inspections of VA facilities to review specific allegations or concerns that have been submitted to the OIG, or that are discovered during the course of other OIG oversight projects.¹⁸ Many hotline reviews focus on vulnerabilities in the healthcare environment and are meant to identify and report on ways that VHA can reduce and control environmental hazards that can help prevent accidents, injuries, and suicide for patients, staff, and visitors. The most recent OIG report (2019) related to the environment of care examined a patient suicide at the West Palm Beach VA

¹⁷ The Joint Commission, “Special Report: Suicide Prevention in Health Care Settings,” *Joint Commission Perspectives*, November 2017, 37(11):1 and 3–7.

¹⁸ The OIG operates a hotline that accepts any complaints, concerns, or allegations related to VA. The hotline website can be accessed at <https://www.va.gov/oig/hotline/>.

Medical Center. It highlights the facility’s failure to maintain a safe environment for patients with mental illnesses and to take adequate steps to mitigate physical risks.¹⁹

Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center in Florida

In August 2019, the OIG reported on its review of the care provided to a patient who died by suicide while in the locked mental health unit at the West Palm Beach VA Medical Center.²⁰ The inspection examined whether there were deficient conditions, and if so, their effect. The patient (who previously received VA outpatient treatment) was placed on “close” observation status after being involuntarily admitted to the medical center’s inpatient unit, requiring observation every 15 minutes. Over the stay of several days, the patient was cooperative and engaged in activities. By day four, the patient was planned to be discharged to visit a family member, after first returning home, and was updated as “low risk” of suicide. That afternoon, the psychiatrist told the patient that because staff had been unable to contact the spouse, the patient’s discharge would be delayed. The patient became significantly agitated. An hour later, after declining medication to decrease agitation, the patient was in the day room using the telephone, denied having suicidal ideations, and hopeful of discharge the next day. The patient was noted as being in their room for the rest of the afternoon.

At 5:45 p.m., a nursing assistant documented seeing the patient, who refused dinner due to lack of appetite. The staff reportedly did not enter the room. At approximately 6 p.m., a fellow inpatient went to the patient’s room, found the door closed, and encountered resistance when trying to open it. A nursing assistant was called and found the patient unresponsive with a garment tied around the neck—the other end of which was wedged over the top of the door. After lifesaving efforts, the patient was declared dead at 6:37 p.m. Inpatient mental health unit staff care for some of the most high-risk patients with serious mental illnesses, which requires special safety measures to prevent harm. Given the need for those measures, the Mental Health Environment of Care Checklist (MHEOCC) was designed to help VHA facilities identify and address environmental risks for suicide and suicide attempts for patients in acute inpatient mental health units. It consists of criteria applicable to all rooms on the unit, as well as specific criteria for areas such as bedrooms, bathrooms, seclusion rooms, and staff work stations. The checklist was implemented in 2007 and research has associated it with a substantial decrease in the rate of inpatient suicides.²¹ The OIG team found that while the medical center did conduct risk assessment

¹⁹ Prior OIG reports demonstrate that concerns with a safe environment for mental health patients are not new. For example, in 2013, the OIG substantiated allegations that the leadership at the Atlanta VA Health Care System in Decatur, Georgia, did not have effective policies and did not properly monitor inpatients at that mental health unit. [Mismanagement of Inpatient Mental Health Care, Atlanta VA Medical Center, Georgia](#), April 17, 2013.

²⁰ [Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center, Florida](#), August 22, 2019.

²¹ Bradley Watts et al., “Sustained Effectiveness of the Mental Health Environment of Care Checklist to Decrease Inpatient Suicide,” *Psychiatric Services* 2017, 68:4, 405–407.

rounds of the unit every six months, per VHA policy, the medical center was not handling other responsibilities:

- The facility did not meet VHA expectations by designating an Interdisciplinary Safety Inspection Team to identify environmental hazards and develop abatement plans.
- Facility leaders failed to ensure that Mental Health Environment of Care team members and other responsible staff received the relevant checklist training. Staff members who are permanently assigned to or have responsibilities on the mental health unit must be trained, including housekeepers, chaplains, outpatient providers, and police officers.
- Facility staff did not consistently identify noncompliant or unsafe environmental conditions. Staff did not identify that corridor doors were a risk, claiming that prior oversight inspections did not cite the doors. While true, that does not eliminate a need for critical thought and risk mitigation. A proper inspection team is expected to consider hazards beyond the checklist.
- The facility did not complete the waiver process for issues such as lack of seclusion room flooring cushions and cameras to mitigate seclusion room blind spots. The OIG found no waiver requests from the facility on these issues.
- Oversight and follow-up did not consistently occur at the facility, VISN, and VHA central office levels.

The report also presented findings and related recommendations in four other areas regarding clinical care, risk mitigation, unit staffing, and leadership responsiveness.²² Of particular concern, the medical center's Police Chief, Associate Director, Associate Director for Patient Care Services, and Assistant Director told OIG staff that they were unaware of the facility's requirement for cameras. Leaders did not understand the risks associated with the unit's corridor doors. One leader told OIG that the facility was going "above and beyond" to prevent further incidents by counting eating utensils, which, in fact, is a long-standing, basic safety requirement.

The current Patient Safety Manager reported to facility leaders in a group forum that some of the unit's physical environment conditions represented an "immediate threat to life." The Associate Director

²² Additionally, the OIG found (1) the patient received reasonable screening, clinical care, and level of observation given the circumstances, although the patient's record did lack a unifying treatment plan with measurable goals as required; (2) risk mitigation findings included that no documentation was found in the unit's rounding sheets that identified the corridor doors as a risk, patient observation rounds were not conducted and documented in a manner that could reasonably assure patient safety, and cameras, while installed, were nonfunctional for years; (3) unit staffing was sufficient on the day of the suicide, but one of the nursing assistants assigned to conduct 15-minute safety rounds also performed other duties during that time, contrary to protocol described by the unit nurse manager; and (4) OIG staff found that facility leaders and managers knew, or should have known, about lapses in the unit's physical environment, staff training, and the MHEOCC inspections. Further, there was no indication they took steps to educate themselves on these issues or solve them, and leaders and staff accepted noncompliance and unsafe conditions. While the OIG team determined that the facility responded promptly after the patient's suicide, the actions only occurred after this "never event."

reportedly cautioned the Patient Safety Manager that using the term “immediate threat to life” was “strong” and to “be careful what you say.”

The OIG made 11 recommendations. One recommendation was to the Under Secretary for Health to ensure that the MHEOCC work group reviews and ranks hazards in mental health units and monitors abatement plans or waiver requests. Another recommendation focused on ensuring VISN-appropriate staff comply with semiannual report reviews and follow up on abatement of issues identified in the checklist assessment. The other nine recommendations were directed to the facility to improve compliance with VHA’s guidelines for inspections, operations, safety, and training.

The Under Secretary for Health, the VISN director, and the medical center director concurred with the recommendations and provided acceptable action plans for implementation. All recommendations were to be completed no later than September 2019, according to the action plans. The OIG will follow up and review implementation actions to determine if the recommendations can be closed in accordance with OIG policy.

Inpatient Mental Health Clinical Operations Concerns at the Phoenix VA Health Care System

The OIG conducted a healthcare inspection in response to allegations received in 2016 and 2017 related to the clinical operations of the inpatient mental health unit regarding patients admitted with a diagnosis of dementia.²³ Among other concerns, the OIG substantiated that inpatient mental health unit staff did not consistently follow the facility’s patient safety observer policy that outlined one-to-one care. The OIG reviewed patients requiring one-to-one care during January 2017 and found patient safety observer -to-patient ratios were not one-to-one, patient safety observers did not maintain constant visual observation of patients, and documentation was inconsistent. Additionally, due to the facility’s incomplete documentation, the OIG was unable to determine whether nurse staffing was adequate to meet patient care needs.

In 2017, the OIG team substantiated that the inpatient mental health unit was not a therapeutic environment due to the absence of cleanliness and interior updates, patients not wearing personal clothes, and a noncompliant patient advocacy program. In 2018, the OIG team noted a satisfactory improvement in the cleanliness after the facility contracted with an external company that provided cleaning services.

The OIG made seven recommendations to the facility. The OIG has closed the recommendations related to patient safety observer policy compliance, inpatient mental health unit nurse staffing methodology, the cleanliness of the inpatient mental health unit, and use of the Patient Advocate Tracking System.

²³ [*Inpatient Mental Health Clinical Operations Concerns at the Phoenix VA Health Care System, Arizona*](#), May 7, 2019.

While six of the seven recommendations are closed, the OIG continues to monitor compliance with training and improvements to the therapeutic environment of the unit.

Inpatient Security, Safety, and Patient Care Concerns at the Chillicothe VA Medical Center in Ohio

The OIG reviewed the care of a patient who fell to his death from a window at the Chillicothe VA Medical Center in 2017.²⁴ The OIG determined that there were not adequate security and safety measures in place, and these deficiencies contributed to the patient's death. The OIG also found that the facility's attempts to provide an institutional disclosure to the family were inadequate. Although the patient was not cared for in an inpatient mental health unit because of other medical conditions, generally the patient received appropriate care.

The OIG found, however, that the inpatient unit's external windows were not secured shut or limited in their opening width, in violation of VHA policy. Each VHA facility is required to conduct an Annual Workplace Evaluation with occupational safety and health staff examining safety and industrial hygiene issues. VHA experts had previously sent out guidance on installing brackets to limit opening width, and the facility took no action to resolve this issue despite a previous attempt by a patient to jump out of a window that opened fully. In this case, the patient had been placed on special observation, where the observer must remain within arm's length of the patient at all times. The observer lost sight of the patient and, in a few moments, the patient climbed out of the bathroom window after entering the bathroom and closing and locking the bathroom door. The observer attempted to grab and rescue the patient, but the patient's fall resulted in death. The OIG determined that staff did not adhere to the facility's observer policy related to the content, frequency, and hand-off documentation requirements. Moreover, facility leaders failed to monitor staff compliance with the special observer documentation requirements. The OIG also reviewed training records and found unit staff did not complete the Prevention and Management of Disruptive Behavior training, the special observer competencies, and other required trainings. The OIG found that facility leaders' failure to ensure that staff were trained in key competencies likely contributed to staff being unaware of the guidelines and duties.

The OIG made four recommendations to the facility director regarding exterior windows being made compliant with VHA's guidelines, compliance with observation policies and training competencies, and reviewing the discussion of the institutional disclosure that took place with the next of kin. All recommendations have been closed.

The OIG's Comprehensive Healthcare Inspection Program Focus on Inpatient Mental Health Units' Environment of Care

The OIG uses its Comprehensive Healthcare Inspection Program (CHIP) to provide cyclical, focused evaluations of the quality of care delivered in the inpatient and outpatient settings of VA facilities. OIG

²⁴ [*Inpatient Security, Safety, and Patient Care Concerns at the Chillicothe VA Medical Center, Ohio*](#), September 12, 2018.

CHIP teams evaluate areas of clinical and administrative operations that reflect quality patient care, with focused review areas changing every fiscal year.²⁵ These inspections are one element of the overall efforts of the OIG to ensure that the nation’s veterans receive high-quality and timely VA healthcare services.

OIG staff determine whether facilities maintain a clean and safe healing, recovery-oriented environment, particularly in selected areas often associated with higher risks of harm to patients, such as in locked mental health units.

Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018

In fiscal year (FY) 2018, OIG staff completed 51 CHIP inspections, with the results summarized in a report that, among other topics, highlighted inpatient mental health units’ environment of care deficiencies at those facilities inspected from April to September 2018.²⁶ Generally, VA facilities met requirements associated with infection prevention, general safety, privacy, and availability of supplies. Construction and Nutrition and Food Services areas, locked mental health units, and emergency management programs met many of their respective requirements. However, the OIG identified concerns with environmental cleanliness, installation and testing of panic alarms in high-risk areas, seclusion rooms in locked mental health units, and emergency management processes.

In FY 2018, VA inspected 27 mental health units that yielded the following findings:

- Twenty-three had evidence of monthly alarm system testing, but only 17 of those 23 documented evidence of VA police response times.
- Four had dirty ventilations grills and/or floors.
- Five of 19 applicable locked mental health units with seclusion rooms lacked flooring made of a material that provides cushioning.

In FY 2019, during continued physical inspections of 27 additional VA inpatient mental health units’ environment of care, OIG staff found these deficiencies:

- Four of the 27 units did not document evidence of panic alarm testing. Of the 23 units that had evidence of panic alarm testing, three did not include VA police response times.
- Five units had cleanliness issues.

²⁵ The nine areas for FY 2018 were leadership and organizational risks; quality, safety, and value; credentialing and privileging; environment of care; medication management; mental health; long-term care; women’s health; and high-risk processes. For FY 2019, medical staff privileging was substituted for credentialing and privileging. FY 2020 is the same as FY 2019 except care coordination was substituted for long-term care.

²⁶ [Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018](#), October 10, 2019.

- Four of 22 applicable units' seclusion rooms did not have flooring made of a material that provides cushioning. Facility managers reported a lack of awareness of these requirements and admitted to their lack of oversight in ensuring a safe environment of care.

The FY 2018 Summary Report made four recommendations to the Under Secretary for Health to improve the environment of care nationally, based upon aggregate data collected during the related CHIP site visits. VHA, VISN, and facility leaders concurred with OIG recommended improvements and set their completion timeframes to accomplish and monitor compliance with the following:

- Ensure that facility managers maintain a clean and safe environment (June 2020 projected completion date).
- Confirm that VA police test panic alarms and document response times to alarm testing in locked mental health units and high-risk outpatient clinic areas (November 2019 projected completion date).
- Make certain that facility managers install floor cushioning in locked mental health unit seclusion rooms (June 2020 projected completion date).
- Verify that facility managers annually review emergency operations plans and resource and asset inventories (November 2020 projected completion date).

OIG staff will monitor VA's progress.

Other OIG Work Related to VHA Mental Health Care Experience

The OIG has released reports on other issues that can directly affect VHA's ability to provide effective mental health care. The following recent reports highlight areas within VHA that require attention to help ensure a supportive environment and appropriate coordination for effective mental health care.

OIG Determination of VHA's Occupational Staffing Shortages, FY 2019

Since January 2015, the OIG has reported on VHA clinical staffing shortages as required by the *Veterans Access, Choice, and Accountability Act of 2014* (PL 113-146).²⁷ Although the 2018 report was the fifth OIG report on staffing shortages within VHA, it was the first report that included facility-specific data reported by leaders at 140 VA medical centers. Users can examine the particular self-reported needs of an individual facility as opposed to only national data.

It was also the first report to include nonclinical positions, such as police and custodial personnel, as required by the *VA Choice and Quality Employment Act of 2017* (PL 115-46).²⁸ These nonclinical occupations also can affect the ability of VHA facilities to provide quality and timely patient care in a

²⁷ OIG Determination of Veterans Health Administration's Occupational Staffing Shortages reports were previously published on June 14, 2018; September 27, 2017; September 26, 2016; September 1, 2015; and January 30, 2015.

²⁸ [*OIG Determination of VHA's Occupational Staffing Shortages, FY 2019*](#), September 30, 2019.

safe and clean environment. The results of the review underscore the extent to which mental health care and related shortages are a widespread issue across VHA.

Medical center directors most commonly cited the need for medical officers and nurses, which is consistent with the OIG's five previous VHA staffing reports. The data showed that 131 of 140 facilities listed the medical officer occupational series (or a related VHA assignment code) as experiencing a shortage, with the psychiatry and primary care positions being the most frequently reported. Of the 140 facilities, 102 listed the nurse occupational series (or a related VHA assignment code) as experiencing a shortage, with practical nurse and staff nurse as the most frequently reported. Within nonclinical occupations, the OIG found that police occupations, general engineering, and custodial workers were among the most often cited as shortages. Overall, 99 out of 140 VHA facility directors reported at least one severe shortage in mental health occupations.²⁹

Inadequate Governance of the VA Police Program at Medical Facilities

The safety of VA personnel, veterans and their families, and visitors to VA facilities is not just a responsibility for clinical and administrative VHA personnel but also VA's police service. Veterans may have interactions with VA police during their care at a VA facility—in some cases it may be the first interaction they have upon entering a facility. These interactions underscore the importance of an appropriately governed, well trained, and adequately staffed VA police service, particularly when they interact with veterans experiencing a mental health crisis.

The OIG in this report did not focus on VA police encounters with individuals in mental health crisis. It examined the effectiveness of the police program governance structure and the challenges in staffing and overseeing its police workforce.³⁰ Accordingly, there is some concern about how overall governance and police staffing might affect a broad array of facility duties, including those related to mental health concerns.

ONGOING OIG WORK RELATED TO VHA MENTAL HEALTH CARE

In addition to the recent work highlighted in this statement, the OIG has many other ongoing and planned projects related to VHA mental health care. The OIG recognizes the tremendous importance of mental health care and suicide prevention and is coordinating and focusing efforts across the OIG to ensure effective oversight of VHA's efforts. For example, the OIG is conducting an audit to determine whether suicide prevention coordinators are effectively managing crisis line referrals to connect at-risk veterans with needed services. Specifically, the audit will assess whether VHA provided oversight and

²⁹ Mental health occupations include Psychiatry; Registered Nurses – Inpatient and Outpatient Mental Health; Nurse Practitioner – Mental Health/Substance Use Disorder; Clinical Nurse Specialist – Mental Health/Substance Use Disorder; Social Science/Licensed Professional Mental Health Counselor; Psychology; Psychology Aid and Technician.

³⁰ [*Inadequate Governance of the VA Police Program at Medical Facilities*](#), December 13, 2018.

established processes for suicide prevention coordinators to ensure veterans are reached to assess their needs.

Additionally, the OIG is in the final stages of developing a focused review that will evaluate the quality of care provided at Readjustment Counseling Services clinics, also known as Vet Centers. The review will cover key clinical and administrative processes at Vet Centers that are associated with promoting quality care such as effective governance, appropriate environment of care, VHA care coordination and collaboration, and suicide prevention. The OIG also has ongoing reviews of recent incidents in which there are allegations that veterans experiencing a mental health crisis did not receive appropriate or adequate care. This includes incidents that have occurred at VA medical centers and at the Veterans Crisis Line. The OIG hotline continually works with expert staff to triage incoming information and remains vigilant to issues that could undermine appropriate and timely mental health care, and investigate thoroughly allegations of patient harm, suicide, and related concerns at VHA facilities.

CONCLUSION

This Committee and VA have made it a priority to improve the mental health care and suicide prevention capabilities of VHA. All OIG staff share your sense of urgency in addressing these issues. Recent OIG work has detailed the challenges some veterans face accessing and receiving high-quality mental health care within VHA. However, we should not lose sight of the good work that dedicated mental health care providers and other professionals are doing within VA. There are tremendous numbers of patients and providers who have had positive experiences that should be valued and applauded. The reports highlighted in this statement show that there are still considerable challenges however, particularly regarding deficiencies in the environment and coordination of mental health care that have persisted and led to negative outcomes for veterans experiencing mental health crises. The OIG is committed to providing recommendations that flow from our oversight work to help VHA improve its programs and veterans' experiences. The OIG will continue to monitor the many aspects of mental health care and suicide prevention provided by VHA to help ensure the improvements sought by this Committee and our nation are realized.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or other members of the Committee may have.