STATEMENT OF
JOHN D. DAIGH, JR., M.D., CPA
ASSISTANT INSPECTOR GENERAL
FOR HEALTHCARE INSPECTIONS
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS' AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
HEARING ON
"#BETHERE: WHAT MORE CAN BE DONE
TO PREVENT VETERAN SUICIDE?"

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Mr. Chairman, Ranking Member Tester, and Members of the Committee, thank you for the opportunity to discuss the Office of Inspector General's (OIG) recent work on VA's efforts to prevent veteran suicide. Suicide is a serious public health concern. Beyond the loss of life to the victim, suicide takes a profound toll on survivors, caregivers, and the community. Likewise, incomplete suicides, taking the form of suicide attempts, gestures, and other acute self-destructive behaviors, are associated with injury, an emotional toll, and personal and societal financial burdens. Therefore, prevention initiatives and interventions that might reduce suicidal behaviors are of enormous importance.

Since 2006, the Veterans Health Administration (VHA) has implemented several initiatives aimed at suicide prevention, including the appointment of a National Suicide Prevention Coordinator (SPC), the establishment of the suicide prevention hotline (Veterans Crisis Line (VCL)), the development of a patient record flagging system to identify high-risk patients, and the creation of suicide prevention programs in each facility. In addition, VHA expanded facility SPC roles, requiring them to participate in community outreach activities. The purpose of these initiatives was to reduce the stigma surrounding mental health (MH) conditions, provide access to MH services, and promote public awareness of suicide.

Recognizing the importance of this issue, the OIG has focused resources in conducting oversight of VHA's suicide prevention efforts. My statement today focuses on some of our more recent reviews highlighting opportunities where VHA can strengthen its suicide prevention efforts.

OVERVIEW OF VA SUICIDE PREVENTION EFFORTS AND DATA COLLECTION [1]

Our objective for this recent report was to answer several questions regarding VA's suicide prevention programs:

- How do you know if the programs are working?
- What percent of veterans who die by suicide have been under the care of VHA?
- Are data on suicides turned over to MH providers in real time?
- What risk factors associated with higher veteran suicides are being explored in depth, and by whom?
- What ways can be identified to gather more reliable suicide data?

How do you know if VA's suicide prevention programs are working?

Whether or not suicide prevention specific policies, programming, and strategies are having a positive effect may be ultimately reflected in outcome measures, specifically in identification of sustained downward trends in completed suicide rates, suicide attempt rates, and suicide re-attempt rates. There are limitations to determining the outcome measures of VHA's suicide prevention programs. The limitations included that VHA staff were not always notified when a veteran died by or attempted suicide, and suicide data were only as reliable as the information provided on the death certificate.

Population Based Measurement

We found that VHA staff tracked suicide rates of all veterans and other VHA users by matching suicide deaths from the National Death Index (NDI).[2]

When VHA leaders set up the VHA suicide prevention program, it was based on the hypothesis that improving access to high quality, evidence-based MH care, supplemented by specific suicide prevention programming, would affect suicide rates. However, capturing the impact of suicide prevention programming is challenging. While access and process measures identified variations in implementation of, or adherence to, MH and suicide prevention specific policies and programming, quantifying the impact of suicide prevention programming was more difficult.

Several VHA initiatives may have been simultaneously ongoing, thereby creating difficulties in teasing out individualized programmatic or operational impact at the individual facility and Veterans Integrated Service Network (VISN) level. In addition to not having a large enough population size to address global effect and co-occurring programming initiatives, site-to-site variability in population size, demography, and other variables rendered site-to-site comparisons problematic. For these reasons, evaluation of whether VHA efforts were working was most amenable to a national (or population

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[1] *Healthcare Inspection – Overview of VA Suicide Prevention Efforts and Data Collection,* https://www.va.gov/oig/pubs/VAOIG-16-00349-369.pdf, September 19, 2017.

[2] The NDI, a self-supporting service of National Center for Health Statistics (NCHS), is a component of the National Vital Statistics System. NDI is a centralized database of death record information compiled from state vital statistics offices. NCHS website, www.cdc.gov/nchs/data/factsheets/factsheet_ndi.htm. Accessed January 19, 2017.

level) analysis of the trend of suicide rates over time as a reflection of the impact of the portfolio of MH and targeted suicide prevention programming.

On a facility level, site-to-site variability impacted the accuracy in program evaluation-outcome analysis. This limitation may in part be circumvented by comparing intra-facility (same facility to itself) suicide rates over a several year period, or alternatively through use of predictive analytics based risk-modeling.

VHA Staff Measures Completed Suicide and Attempt Rates

The development and expansion of the joint VA/Department of Defense (DOD) Suicide Data Repository allowed for identification of suicide rates within the U.S. veteran population and other VHA users. VHA staff calculated completed suicide and attempt rates using both internal and external sources.

- *VHA Data Collection of Known Suicide and Suicide Events*. In 2008, VHA MH Services established an internal suicide surveillance and clinical support system. VHA SPCs enter data on suicides and suicide events (non-fatal attempts, serious suicidal ideation, and suicide plans) known to VHA into the Suicide Prevention Applications Network (SPAN) database, which is maintained on the VHA campus in Canandaigua, New York. Coordinators enter multiple data elements related to completed and attempted suicides. These data elements include the patient's medical and MH diagnoses; whether the patient had a history of previous attempts; whether the patient was seen at VA within 7 and 30 days of the suicide event; and the patient's military era.[3] The data limitation was that only suicides and attempted suicides known by VHA SPCs were captured in the data.

- *VHA Analyses of Known Suicide Attempts and Suicide Re-events*. Each year, the VHA Serious Mental Illness Treatment Resource and Evaluation Center and staff funded through the suicide prevention program at the Center of Excellence (COE) completes an annual analysis of non-fatal suicide attempts and re-attempts.

- *Matching to the NDI to Determine Rates among VHA Users*. The Serious Mental Illness Treatment Resource and Evaluation Center staff matched individual VHA services users with individual deaths coded as suicides in the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) NDI databases as a separate effort to calculate suicide rates. Veterans who stopped using VHA services in the prior year were considered possible deaths, and staff compared these veterans' information to the NDI database to determine actual veteran deaths and the subset of suicide deaths.

- Compared to the SPAN data, this methodology expanded the numerator from suicide deaths known to VHA to suicide deaths among all VHA services users.

[3] Military era is the period in which a service member served in the military.

Compared to the state-based reporting agreement initiative, the NDI match captured deaths occurring within the U.S. that were reported by all 50 states.

What percent of veterans who die by suicide have been under the care of VHA?

On August 3, 2016, the VA Office of Suicide Prevention published the report, *Suicide Among Veterans and Other Americans 2001–2014*. This report provided a systematic assessment of characteristics of suicide among veterans—both those veterans who used VHA services and those who did not—and compared veteran suicide data, such as rates, to non-veteran suicide data. Key findings of the suicide mortality data in the report were obtained from the VA/DOD Joint Suicide Data Repository, which included:

- VA epidemiologists and other subject matter experts in the field conducted analyses of suicide data. The data showed that an average of 20 veterans died by suicide each day, 6 of the 20 were recent utilizers of VHA services—in the year of their deaths or the previous year.

- The risk for suicide was 21 percent higher among veterans when compared with U.S. civilian adults after adjusting for differences in age and gender.

Are data on suicides turned over to MH providers in real time?

We found that real time data on suicide, such as statistics on suicide rates by age, race/ethnicity, gender, suicide methods, and number of suicide attempts, were not available to MH providers in all states. Delays in collecting and sharing relevant data occurred in states that utilized paper-based reporting systems.

According to NCHS staff, approximately 75 percent of the vital records jurisdictions have implemented electronic death registration systems (EDRS). In jurisdictions with fully or partially functioning EDRS, funeral directors initiated the process by entering decedent demographic data. A medical certifier,[4] in the case of a natural death, or a coroner[5] or medical examiner, [6] in the case of an unnatural death,[7] then entered cause of death determinations into a computer data system. The completed record was electronically transmitted to the appropriate jurisdiction that, in turn, linked the information to the state's vital records statistics office. In jurisdictions with paper-based death reporting, the coroner, funeral director, medical certifier, and/or medical examiner filled out and transmitted paper forms via mail to the state's vital statistics office. The deployment of an electronic reporting system by all states and the use of such a system by funeral directors and medical certifiers allowed for the creation of more timely aggregate data. Such data was readily available to each state's vital statistics offices and to the NDI in near real time.

[4] A medical certifier can include physicians, nurse practitioners, dentists, and physician assistants.
[5] Coroners are not required to be physicians and typically have varied backgrounds; 80 percent are elected to their position, and they typically operate via a county-based system.
[6] Medical examiners are forensic pathologist physicians, typically appointed, and operate via a statewide system.
[7] An unnatural death can include drug overdose, suicide, or homicide.

What risk factors associated with higher veteran suicides are being explored in depth, and by whom?

We identified several VA and non-VA research projects and initiatives underway that included risk models, analyses of social media, and ongoing research by the COE and the Mental Illness Research, Education and Clinical Center (MIRECC).

VA leaders implemented a predictive analytics risk model to enhance clinical care. The model identifies which patients are potentially at highest risk of suicide and assists clinicians in implementing preventive interventions. At the time of our review, VA developed a model focused on providing individualized clinical and preventive care for patients who were in the highest 0.1 percent at risk for suicide. Another model in development focused on patients in the highest 5 percent at risk using a broader, population-based public health-oriented intervention.

We found non-VA researchers conducted pilot studies analyzing social media posts, aimed at identifying changes in patients' MH status and/or suicidal ideation to determine suicide risk factors. These researchers identified research barriers that included access to death and death-rate data, limited availability of grant funding, and privacy concerns. Other barriers included leaders' and clinicians' concerns regarding litigation, social media, and time and productivity allocations.

We found that National Center for Veterans Studies (NCVS)[8] researchers analyzed social media postings of military service members who died by suicide and of a demographically matched control group. The research revealed that those who died by suicide were more likely to avoid interpersonal situations and/or lacked interest in participating in activities with others and had more frequent conversations about sleep problems. Researchers also found that immediately prior to a service member's death by suicide, the service member expressed difficulties related to interpersonal relationships and generalized stress. They were also less likely to communicate feelings of anger, which may suggest the military service members had "resigned" themselves to their situation. Researchers found that service members who died by suicide were less likely to express anger in their posts, but more likely to post about negative employment, access to or ownership of firearms, emotional distress, self-help, and implied suicide. An identified barrier with the research was the availability of grant funding and a "Catch-22" situation of needing pilot data to obtain grant funding for expanded research.

What ways can be identified to gather more reliable suicide data?

The collection of data related to suicide is useful in identifying and determining who is at the highest risk of attempting or completing suicide. Types of data collected included, but are not limited to, suicide rates by age, race/ethnicity, and gender; suicide methods; and number of suicide attempts. Once clinicians are able to determine who is at the highest risk for suicide, clinicians can then better target intervention and prevention plans.

[8] NCVS is affiliated with the College of Social and Behavioral Science at the University of Utah and is not affiliated with the VA.

We found that ways to gather reliable suicide data include:

Full Implementation and Use of Standardized Terminology such as the Self-Directed Violence Classification System and its Clinical Tool by VHA Clinicians[9]
Several definitions for suicide and non-fatal self-harm have been developed over the years. In 2003, CDC staff started work on what they called the self-directed violence surveillance that included uniform definitions and recommended data elements.[10]

In 2008, the then VA Secretary, Dr. James B. Peake, formed the "Blue Ribbon Work Group on Suicide Prevention in the Veterans Population" in order to improve VHA suicide prevention programs, research, and education. Unclear and unstandardized use of terms related to suicidal behaviors prompted the work group to recommend the adoption of a standard nomenclature for "suicide definition," "suicide," and "suicide attempts."

In 2009, MIRECC staff and other researchers in the field,[11] which included CDC researchers, collaborated to finalize terms incorporated into the Self-Directed Violence Classification System (SDVCS). MIRECC staff developed a table to aid clinicians in understanding the SDVCS. The table is broken down into types, subtypes, definitions with examples, modifiers, and terms. The back of the table includes key definitions. MIRECC staff also developed the SDVCS clinical tool to help clinicians, researchers, and others classify clinical cases.[12]

In 2010, in response to a recommendation13 by the Blue Ribbon Work Group, VHA announced the adoption of the SDVCS and the SDVCS clinical tool, which were adopted later by DOD. Implementation efforts have included promoting the use of the SDVCS clinical tool and distributing educational materials.

[9] The Self-Directed Violence Classification System (SDVCS) clinical tool is used by clinicians to help themselves, researchers, and others classify clinical cases. The tool is broken down into three decision trees: suicide thoughts only, behaviors without injury, and behaviors with injury.
[10] BB Matarrazo, TA Clemons, MM Silverman, LA Brenner. The self-directed violence classification system and the Columbia classification system algorithm for suicide assessment: a crosswalk, *Suicide Life Threatening Behavior.* June 2013; 43(3):235–249.
[11] CDC and the Senior Advisor to the Suicide Prevention Resource Center (and other research team members representing the VISN 19 MIRECC; the University of Colorado, Denver, School of Medicine; Wellstar Health System, Georgia; the University of Georgia; and the Department of Biostatistics and Informatics, Colorado School of Public Health).
[12] Bridgett B. Matarrazzo, *Psy.D*. The Self–Directed Violence Classification System (SDVCS), what it is and why it matters (PowerPoint presentation), VHA VISN 19 Mental Illness Research, Education and Clinical Center and the University of Colorado, School of Medicine Department of Psychiatry, developed in collaboration with CDC.
[13] The recommendation was to adopt a standard nomenclature/definition for suicide and suicide attempt that was consistent with other federal organizations, such as the CDC and the scientific community.

Medicolegal Death Investigation Reporting Training for Those Responsible for Completing the Medical Portion of the Death Certificate

A medicolegal death investigation is an investigation of a suspicious, violent, unexplained, or unexpected death. A medicolegal death investigator is responsible for the evidence and investigation related to the deceased person's remains and should have both a medical and legal educational background. In some states, centralized state medical examiner's offices perform death investigations, while other states utilize county/district-based medical examiner offices or a county-based mixture of medical examiner and coroner offices or county/district-based coroner offices. Completion of death reviews vary by jurisdiction. Investigators are responsible for determining and certifying the cause of death on the death certificate and reporting it to vital statistics.

Medicolegal death reporting is important because it is the responsibility of the death investigator to determine a cause of death and provide the information to the state's vital statistics department. Researchers and VHA staff use the information obtained from state vital statistics to determine suicide risk factors, and suicide methods or trends, which clinicians use to implement suicide interventions and prevention approaches.

According to NCHS staff, some challenges and training opportunities related to the difficulty in reporting suicides may include:

- Stigma – in small communities, medical certifiers may feel they are doing the family a favor if they do not choose suicide as manner of death. This could be for cultural or religious reasons, or because they believe, sometimes correctly, that the family will not receive death benefits if the death is ruled a suicide.

- Intent cannot always be determined – especially in deaths that involved high-risk behaviors such as single-car automobile crashes and drug overdose deaths.

- Some medical certifiers may have overly rigid or even incorrect standards by which they judge a death to be a suicide. For example, a medical certifier may require the leaving of a suicide note, when research has found that at most a third of suicide cases, confirmed in other ways, left notes.

According to National Association for Public Health Statistics and Information Systems staff, accurate reporting of the cause and manner of death is essential. Therefore, training of those who are responsible for completing the medical portion of the death certificate is critical to ensure reliable public health data.

DOD Sharing DOD Suicide Event Report Data with VHA

The DOD Suicide Event Report (DODSER) is the system of record for health surveillance of military service members related to suicide deaths, suicide attempts, and suicidal ideation. The November 2014 DOD OIG report, *Department of Defense Suicide Event Report (DODSER) Data Quality Assessment*, stated:

DODSER data is not shared with VA for integration into VA's suicide surveillance database; the System of Record Notification limits DODSER data sharing and has prevented DOD from establishing a routine transfer of relevant information to VA; and VA is, therefore, not able to use DODSER data to better understand how military experience such as deployment history or in-service suicide attempts, impacts post-service suicide behavior.

The DOD OIG report also noted that section 1635 of Public Law 110–181 "…mandates accelerated exchange of healthcare information sharing between DOD and VA; and DOD Directive 6490.02E, Comprehensive Health Surveillance, requires the transfer of health surveillance data to VA, at a minimum when military service members separate or retire from the service."

The DOD OIG report recommended that the Defense Health Agency update the appropriate System of Record Notification to:

- Allow for sharing of DODSER data with VHA staff, and

- Coordinate with VHA staff to ensure appropriate establishment of privacy policies to manage privacy issues while sharing DODSER data.

VHA staff attempted to obtain access to the DODSER data because it may provide useful information to VHA clinicians. Staff at the DOD National Center for Telehealth and Technology maintain the data; the Defense Suicide Prevention Office has a copy. At the time of our review, VHA and DOD Suicide Prevention program staff were developing a sharing agreement.

COMBINED ASSESSMENT PROGRAM SUMMARY REPORT – EVALUATION OF SUICIDE PREVENTION PROGRAMS IN VHA

In May 2017, we reported the results of our reviews at 28 VHA facilitiesthrough our Combined Assessment Program inspectionsconducted from October 1, 2015, through March 31, 2016, regarding suicide prevention programs.[14] We observed many positive practices, including that most facilities had a process for responding to referrals from the VCL and a process to follow up on high-risk patients who missed appointments. Additionally, when patients died from suicide, facilities generally created issue briefs and when indicated, completed mortality reviews or behavioral autopsies and initiated root cause analyses. However, we identified several system weaknesses.

- VHA requires that facilities complete five outreach activities each month for community organizations, MH groups, and/or other community advocacy groups; 18 percent of the facilities did not comply with this requirement.

[14] https://www.va.gov/oig/pubs/VAOIG-16-03808-215.pdf. May 18, 2017

- VHA requires that clinicians develop SPSPs for patients identified as at high risk for suicide; we found that 11 percent of high risk patients' EHR did not contain a suicide prevention safety plan. We found that clinicians did not document that they gave the patient and/or caregiver a copy of the plan 20.2 percent of the time for inpatients and 10.5 percent of the time for outpatients.

- VHA requires that facilities use Patient Record Flags (PRF) in inpatients' EHRs to identify and track patients at high risk for suicide. We identified several areas where improvement was required and recommended that when clinicians identify inpatients as at high risk for suicide, they place PRFs in the EHRs and notify the SPC of the admission. In addition, we recommended that when clinicians identify inpatients as at high risk for suicide, the SPC or MH provider evaluate the patient at least four times during the first 30 days after discharge. Further, when clinicians identify outpatients as at high risk for suicide, we recommended that they review the PRFs every 90 days and document the review and document justification for continuing or discontinuing the PRFs.

- VHA requires that primary care and MH providers receive training on suicide risk assessments and management of patients at high risk for suicide. Facilities generally provided suicide prevention training to new non-clinical employees (84.4 percent); however, 45.7 percent of the time clinicians did not complete suicide risk management training within 90 days of hire.

VHA agreed with our recommendations in this report. They provided action plans to address the recommendations and we are waiting for documentation of those actions to review and then we will determine if we can close the recommendations.

THE VETERANS CRISIS LINE

In the past 2 years, we have published two reports[15] inspecting the VCL in response to complaints about its operations. Both reports found organizational deficiencies and foundational problems in the VCL. All recommendations from the first report have now been addressed. The second VCL report, *Healthcare Inspection—Evaluation of The Veterans Health Administration Veterans Crisis Line*[16] identified a number of issues and that VHA is working on addressing the recommendations from that report.

Findings to Objective 1: VCL Failure to Respond Adequately to a Veteran Caller

We found that VCL staff did not respond adequately to a veteran's urgent needs during multiple calls to the VCL and its backup call centers. In addition to the failure to provide crisis intervention during the calls, VCL supervisory staff did not identify the deficiencies in their internal review of the matter.

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[15] *Healthcare Inspection – Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York,* https://www.va.gov/oig/pubs/VAOIG-14-03540-123.pdf, February 11, 2016.
[16] *Healthcare Inspection - Evaluation of the Veterans Health Administration Veterans Crisis Line,* https://www.va.gov/oig/pubs/VAOIG-16-03985-181.pdf, March 20, 2017.

Findings to Objective 2: VCL Governance Structure, Operations, and Quality Assurance Functions Have a Number of Deficiencies

Our inspection of the VCL governance structure, operations, and quality assurance functions identified a number of deficiencies. We found deficiencies in the VCL's processes for managing incoming telephone calls. We also found deficiencies in governance and oversight of VCL operations. The VCL staff did not have the capacity to answer all calls received, requiring VHA contract with four backup call centers not otherwise affiliated with VA to handle the overflow. We found that VHA contracting staff and Member Services and VCL leaders lacked an understanding of the contract terms and did not verify quality control aspects of contractor performance, resulting in deficient oversight. VCL Quality Management (QM) focuses on making and measuring improvements to a program with the prevention of problems being the primary objective. We found continued deficiencies in the VCL QM program.

VCL policies were not consistent with existing VHA policies for veteran safety or risk management and did not incorporate techniques for evaluating available data to improve quality, safety, or value, to veterans.

Findings to Objective 4: A Number of Issues Raised by a Complainant and Referred by the Office of Special Counsel Were Substantiated

The OSC referred a complaint to VA on August 25, 2016 alleging inadequate training of VCL SSAs that resulted in deficiencies in coordinating immediate emergency services needed to prevent harm. We partially substantiated the OSC complainant's allegations.

IMPROVE COMMUNICATION BETWEEN PROVIDERS AND VETERANS' FAMILY

The OIG has reported on the death of many veterans with diverse mental health issues. Often, there is a significant communication gap between providers and the veteran's extended family. Communication regarding a veteran's mental health issues and related topics between providers and the veteran's extended family are restricted by a series of laws. The OIG believes that more effort should be devoted towards improving this communication. Efforts to pilot the use of advance directives and other mechanisms should be explored to determine if changes in information flow can improve the chances that a veteran will not choose suicide.

CONCLUSION

Strategies that envision extending VHA's efforts to prevent suicide to those veterans who do not receive care through VHA, that move beyond the prediction of who is at risk to an actionable timeframe when a veteran maybe at highest risk to attempt suicide, and efforts to advance communication through advance directives and related strategies may lessen the risk that a veteran will suicide.

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