
# Department of Veterans Affairs
# Office of Inspector General

# Healthcare Inspection

# Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009

**Report No. 09-00326-223** **September 22, 2009**

**VA Office of Inspector General**
**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations**

**Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time, Monday through Friday, excluding Federal holidays**

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# Executive Summary

## Introduction

The VA Office of Inspector General, Office of Healthcare Inspections (OHI) completed an evaluation of Veterans Health Administration (VHA) facilities implementation of suicide prevention programs in compliance with VHA requirements. VHA mental health (MH) officials estimate that there are approximately 1,600–1,800 suicides per year among veterans receiving care within VHA and as many as 6,400 per year among all veterans. OHI conducted this review at 24 VA medical facilities during Combined Assessment Program reviews performed across the country from January 1–June 30, 2009.

## Results and Recommendations

Although all 24 facilities implemented suicide prevention programs that generally met the VHA requirements, program effectiveness could be strengthened through improvements in documented collaboration between MH providers and suicide prevention coordinators (SPCs) and in the development of comprehensive and timely safety plans. An additional area that needed attention was ensuring that very large CBOCs had full-time SPCs.

We recommended that the Acting Under Secretary for Health, in conjunction with Veterans Service Network and facility managers, ensure:

- Documentation of collaboration between SPCs and MH providers.
- MH providers develop comprehensive and timely safety plans.
- Full-time SPCs are appointed at very large CBOCs.

**DEPARTMENT OF VETERANS AFFAIRS**
**Office of Inspector General**
**Washington, DC 20420**

**TO:** Acting Under Secretary for Health (10)

**SUBJECT:** Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities, January–June, 2009.

## Purpose

The purpose of this review was to evaluate the extent Veterans Health Administration (VHA) facilities implemented suicide prevention programs in compliance with VHA requirements.[1]

## Background

VHA mental health (MH) officials estimate that there are approximately 1,600–1,800 suicides per year among veterans receiving care within VHA and as many as 6,400 per year among all veterans. VHA and the Centers for Disease Control and Prevention state that a major predictor for increased risk of suicide is a history of a prior suicide attempt. In November 2004, VHA finalized the MH Strategic Plan (MHSP) that was designed to provide a plan for comprehensive MH services for all veterans who receive MH care from VHA. The MHSP covered fiscal years 2005–2009, and one major goal of the plan was to reduce suicides among veterans. Since 2006, VHA implemented several initiatives aimed at suicide prevention, including establishing the National Suicide Prevention Center of Excellence; appointing a National Suicide Prevention Coordinator (SPC); establishing a suicide prevention hotline staffed 24 hours per day, 7 days per week; developing a distinct patient record flagging system; and establishing suicide prevention programs in each facility and very large community based outpatient clinics (CBOCs).[2] In April 2008, VHA requested that the Office of Inspector General (OIG) Office of Healthcare Inspections evaluate compliance with implementation of suicide prevention programs during Combined Assessment Program (CAP) reviews. According

[1] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
[2] Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled.

to Handbook 1160.01 (the HB), facility suicide prevention programs must have at least one full-time SPC at each facility and very large CBOC; and SPCs must:

- Establish and maintain a list of patients assessed to be at high-risk for suicide.
- Maintain a medical record alert mechanism known as patient record flags (PRFs).
- Track veterans assessed to be at high-risk for suicide.
- Respond to referrals from the national suicide prevention hotline and other staff.
- Provide training to VA staff that have contact with veterans, including all health care providers.
- Provide training to appropriate community organizations.
- Report monthly to MH leaders and the National SPC on veterans who attempted or completed suicides.
- Ensure that there is a process to follow up on high-risk patients who have missed MH appointments.
- Ensure high-risk patients receive education and support about approaches to mitigate suicide risks (safety plans).

Additionally, SPCs and MH providers should collaborate regarding decisions about placement and removal of PRFs, intensified patient treatment needs, and the development of comprehensive safety plans with patients and/or their families.

## Scope and Methodology

We performed the evaluation during 24 CAP reviews from January 1–June 30, 2009. The facilities represented a mix of facility sizes, affiliations, geographic locations, and Veterans Integrated Service Networks (VISNs). The evaluations focused on validation of each facility's self-assessment of compliance with the Deputy Under Secretary for Health for Operations and Management (DUSHOM) memoranda regarding SPCs and VHA requirements governing the implementation of suicide prevention programs. We reviewed VISN and local policies and 239 patient medical records. One hundred seventy-five (73 percent) of the patients received care at parent facilities and 64 (27 percent) received care at associated CBOCs. Inspectors reviewed the patients' medical records to determine whether there was documented evidence of PRFs, collaboration between SPCs and the patients' MH providers, and safety plans. Inspectors selected the patients from high-risk for suicide lists that each facility provided prior to the CAP review date. Inspectors also conducted interviews with the SPC and other clinical staff at each facility.

The inspection was conducted in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

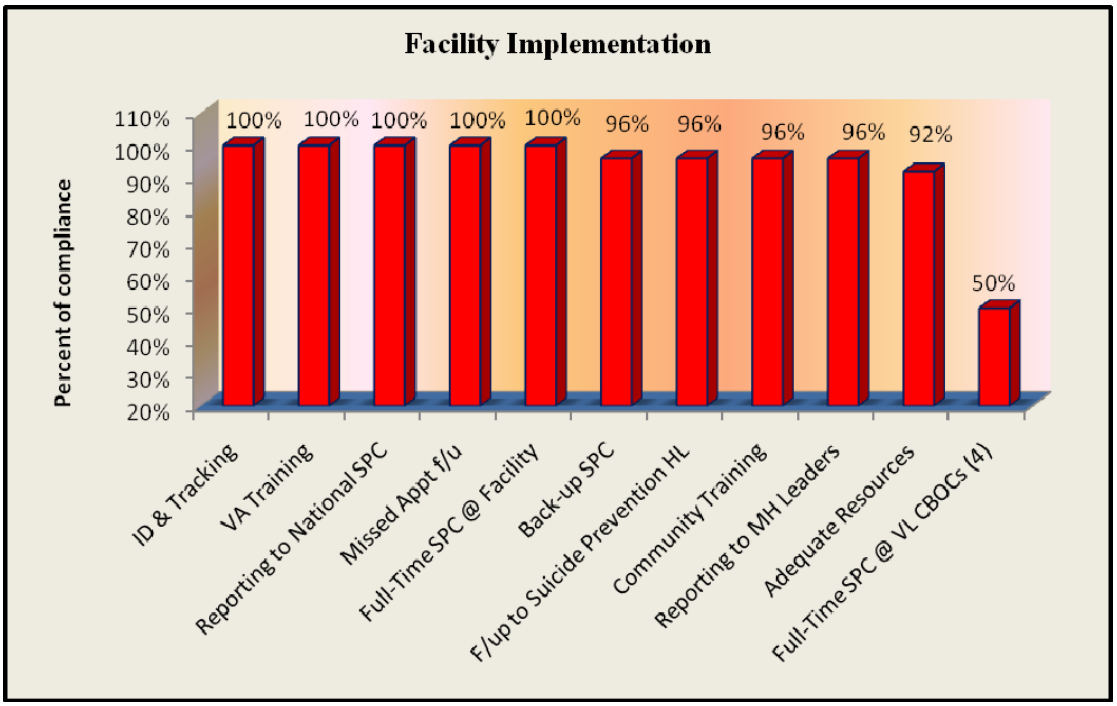
## Results

1. Suicide Prevention Program Implementation.

In February 2007, the DUSHOM sent a memorandum to all VISN directors informing them that VHA would provide funding for one SPC at each facility; and SPCs would facilitate the implementation of suicide prevention strategies at the local level through education, monitoring, and coordination of activities. The DUSHOM memorandum further emphasized that SPC positions would be full-time staff positions, and coordinators should not be given collateral duties. An April 2008 DUSHOM memorandum defined SPC responsibilities and gave guidelines regarding the care that should be provided to patients assessed as high-risk for suicide. Additionally, facilities had to have specific processes in place to follow up high-risk patients who missed MH appointments. VHA mandated the guidelines set forth in the memoranda with the publication of the HB, which also required that facilities appoint full-time SPCs at very large CBOCs. During the CAP reviews, inspectors determined whether facilities appointed SPCs and whether each SPC fulfilled all required responsibilities. Inspectors also determined whether facility managers provided adequate resources to the SPCs to manage their responsibilities and appointed staff to maintain effective programs in the absence of designated SPCs.

The inspection showed that facilities implemented suicide prevention programs that generally complied with VHA requirements. One hundred percent of the parent facilities appointed full-time SPCs, identified and tracked patients assessed to be high-risk for suicide, conducted suicide prevention training for facility staff, reported monthly to the National SPC regarding attempted or completed suicides, and followed up on high-risk patients who missed MH appointments. Twenty-three of 24 (96 percent) parent facilities designated appropriate staff to manage programs in the absence of SPCs, followed up on patients referred from the National Suicide Hotline, conducted suicide prevention training in the community, and reported regularly to MH leaders. Twenty-two of 24 (92 percent) SPCs reported that managers provided adequate resources for them to fulfill their responsibilities. Four facilities reported having very large CBOCs; however, only two had full-time SPCs at the time of the CAP reviews.

The graph on the following page depicts compliance with overall facility implementation of suicide prevention initiatives.




2. Medical Record Documentation

Patient Record Flags. According to VHA directive governing PRFs,[3] the primary purpose of placing a flag in the medical record is to communicate to VA staff that a patient is at risk for suicide; and the presence of a flag needs to be considered when making treatment decisions, such as frequency of MH appointments, involvement of significant others in care planning, and limiting access to means of inflicting self-harm. According to the directive, the need for flag placement is a clinical judgment made after an evaluation of risk factors, such as a history of a previous suicide attempt, a recent discharge from an inpatient MH unit, and serious suicidal ideation with a plan and a method for implementing the plan. The review determined that 227 of 239 (95 percent) of the medical records contained PRFs.

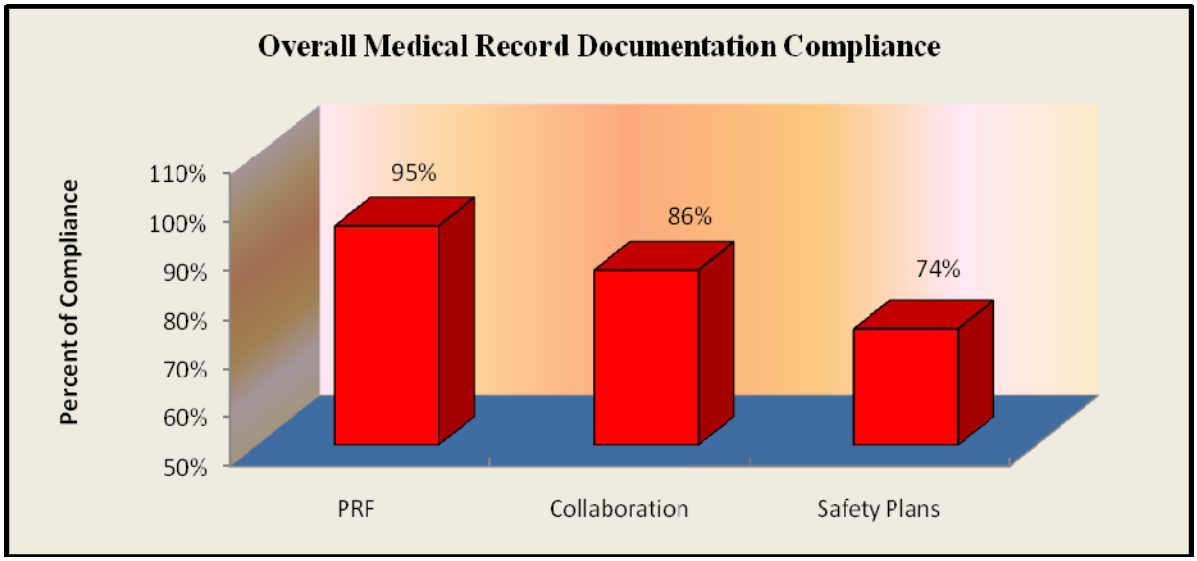
Collaboration. Patients' principal providers are ultimately responsible for patient care decisions. However, the HB requires that MH providers collaborate with SPCs to support the identification of patients who are high-risk to ensure that the patients are provided with increased monitoring and enhanced care; and that high-risk patients receive education and support about approaches to reduce risks of suicide. For example, decisions regarding PRF placement and removal and safety plan development and re-evaluation should be coordinated with all providers involved in the patient's care (including primary care providers) to reduce risk and to ensure optimal patient outcomes. Our review showed that there was evidence of collaboration in 206 of 239 (86 percent) of the medical records.

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

Safety Plans. Comprehensive safety planning is a clinical intervention that can serve as a valuable adjunct to suicide risk assessment. "A safety plan is a prioritized written list of coping strategies and support sources that patients can use during or preceding suicidal crises. The intent of safety planning is to provide a pre-determined list of potential coping strategies as well as a list of individuals or agencies that veterans can contact in order to help them lower their imminent risk of suicidal behavior."[4] The essential elements of a comprehensive plan are (1) identification of the warning signs that precede a suicidal crisis, (2) identification and use of internal coping strategies, (3) identification of when it is time to socialize with family members or others who may offer support or distraction from the crisis, (4) identification of when it is time to contact family members or others who may offer help to resolve the crisis, and (5) identification of when it is necessary to contact professional agencies. The patient should have input into each step of the plan and be given a copy of the agreed upon plan, and the plan should be maintained in the patient's medical record.

The review showed that 178 of 239 (74 percent) of the medical records had documented evidence of safety plans that fully met the criteria. The deficiencies identified by inspectors for the remaining records were that safety plans did not contain all the essential elements, were not completed timely, or were not completed at all.

The following graph depicts overall compliance with the elements of medical record documentation.




[4] Stanley, Barbara and Brown, Gregory K., *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version*, August 20, 2008.

While we included CBOC patients in the overall data analysis, we also reviewed that patient data separately to determine if there were significant differences in compliance between CBOC and overall compliance. We found that CBOC documentation data mirrored the overall data.

## Conclusions

VHA facilities implemented suicide prevention programs that generally met VHA requirements; however, inspectors made recommendations in 12 of 24 (50 percent) of the facilities reviewed. Of those, 10 (83 percent) received recommendations because of a lack of one or more aspects of medical record documentation. Overall program effectiveness could be strengthened through improvements in documented collaboration between MH providers and SPCs and in the development of comprehensive and timely safety plans. An additional area that needs further attention is ensuring that very large CBOCs have full-time SPCs.

## Recommendations

**Recommendation 1.** We recommended that the Acting Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure collaboration between SPCs and MH providers.

**Recommendation 2.** We recommended that the Acting Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that MH providers develop comprehensive and timely safety plans.

**Recommendation 3**. We recommended that the Acting Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that full-time SPCs are appointed at very large CBOCs.

## OIG Comments

The Acting Under Secretary for Health agreed with the findings and recommendations and provided acceptable improvement plans. (See Appendix A, pages 7–10 for the full text of the Acting Under Secretary's comments.) We will follow up on the planned actions until they are complete.

*(original signed by:)*

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

**Appendix A**

# Acting Under Secretary for Health Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** September 11, 2009

**From:** Acting Under Secretary for Health (10)

**Subject:** **Healthcare Inspection – Evaluation of Suicide Prevention Programs in Veterans Health Administration Facilities, January–June, 2009**

**To:** Assistant Inspector General for Healthcare Inspections

1. I have reviewed and I concur with the draft report and recommendations. VHA has produced a comprehensive strategy to reduce suicides and suicidal behaviors. I am pleased your report shows VHA facilities have complied with VHA requirements in this endeavor.

2. Many dedicated suicide prevention coordinators (SPCs) and mental health (MH) providers, help to provide Veterans with ready access to mental health services preventing suicide attempts and completions. I agree that reinforcing collaboration between SPCs and MH providers would increase the effectiveness of the Suicide Prevention Program. This fall, a new patient flag template will be used to document patients' records about communications and collaborations between SPCs and MH providers. Furthermore, to ensure MH providers develop comprehensive and timely safety plans, SPCs will report completion rates for safety plans in their monthly reports to the National Suicide Prevention Coordinator.

3. VHA guidelines for implementing suicide prevention strategies required facilities to appoint full-time SPCs at very large community-based outpatient clinics (CBOCs), those serving over 15,000 unique patients. Patient Care Services Office of Mental Health will review hiring at these facilities to ensure SPC positions are filled. Services provided at CBOCs for 10,000 – 15,000 unique Veterans will be reviewed to determine service adequacy provided by suicide prevention teams located at parent VA Medical Centers. Recommendations to enhance services and staffing will be made to facility leadership and the Deputy Under Secretary for Health for Operations and Management.

4. Thank you for the opportunity to review the report and provide comments. I would be pleased to discuss any concerns or comments you may have about this response. If you have any questions, please have a member of your staff contact Margaret Seleski, Director, Management Review Service (10B5) at (202) 461-7245.

*(original signed by:)*

**Gerald M. Cross, MD, FAAFP**

**Attachment**

## Acting Under Secretary for Health Comments to Office of Inspector General's Report

The following comments are submitted in response to the recommendations in the Office of Inspector General's report:

**OIG Recommendations**

**Recommendation 1.** We recommended that the Acting Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure collaboration between SPCs and MH providers.

**Concur**.

The new patient flag template, which is scheduled to be released this fall, will be used to document patients' records about communications and collaborations between suicide prevention coordinators (SPCs) and mental health providers (MH). After release of the template, it will serve as patients' monitoring and tracking mechanism for compliance with requirements for communication and collaboration.

In process December 1, 2009

**Recommendation 2**. We recommended that the Acting Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that MH providers develop comprehensive and timely safety plans.

**Concur**.

Suicide prevention coordinators will start reporting on completion rates for safety plans in their monthly reports to the National Suicide Prevention Coordinator. This item will be added to the existing quarterly score card reports for review by senior leadership. Facilities will be monitored using the score card, and facility leadership will be required to take actions to ensure that requirements for safety planning are met.

In process October 1, 2009

**Recommendation 3**. We recommended that the Acting Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that full-time SPCs are appointed at very large CBOCs.

**Concur**.

Facilities were funded to place SPCs at very large CBOCs, those serving over 15,000 unique Veterans. It is estimated that 20,000 unique Veterans per SPC is an appropriate panel size. Patient Care Service's Office of Mental Health will review hiring at these facilities to ensure SPC positions are filled.

Services provided at CBOCs serving 10,000 – 15,000 unique Veterans will also be reviewed to determine service adequacy provided by suicide prevention teams located at the parent VA Medical Centers. Recommendations to enhance services and staffing will be made to facility leadership and the Deputy Under Secretary for Health for Operations and Management.

In process December 1, 2009

**Appendix B**

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| OIG Contact | Katherine Owens<br>Chair, OHI Mental Health Product Line<br>603.222.5871 |
| Acknowledgments | **OHI Mental Health Product Line Members:**<br>Jennifer Kubiak<br>Tishanna McCutchen<br>Christa Sisterhen<br>Roberta Thompson<br>**OHI Inspectors:**<br>Daisy Arugay-Rittenberg<br>Lisa Barnes<br>Gail Bozzelli<br>Jennifer Christensen<br>Dorothy Duncan<br>Cathleen King<br>Glen Pickens<br>Kimberly Pugh<br>Susan Zarter<br>**Data Management Support**<br>Jeffrey Joppie |

**Appendix C**

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