Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Summary Report

Re-Evaluation of Suicide Prevention Safety Plan Practices in Veterans Health Administration Facilities

Report No. 11-01380-128

March 22, 2011

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections completed a re-evaluation of Veterans Health Administration (VHA) facilities' suicide prevention safety plan (SPSP) practices. The purpose was to evaluate the extent VHA mental health (MH) providers consistently developed SPSPs for patients assessed to be at high risk for suicide.

Inspectors evaluated SPSP practices at 45 facilities during Combined Assessment Program reviews conducted from January 1 through September 30, 2010.

VHA facilities recognized the importance of developing comprehensive, timely SPSPs for high-risk patients. Additionally, VHA issued appropriate timeframes for initiating SPSPs. However, despite VHA's efforts to comply with suicide prevention program requirements, problems with SPSP development continue to occur. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that MH providers develop and document timely SPSPs that meet all applicable criteria.

The Under Secretary for Health concurred with the finding and recommendation. The implementation plan is acceptable, and we will follow up until all actions are complete.

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

TO: Under Secretary for Health (10)

SUBJECT: Combined Assessment Program Summary Report – Re-Evaluation of Suicide Prevention Safety Plan Practices in Veterans Health Administration Facilities

Purpose

The VA Office of Inspector General, Office of Healthcare Inspections (OHI) evaluated Veterans Health Administration (VHA) facilities' practices related to suicide prevention safety plans (SPSPs). The purpose was to evaluate the extent VHA mental health (MH) providers consistently developed SPSPs for patients assessed to be at high risk for suicide.

Background

VHA 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 implemented the MH Strategic Plan. One of the major goals of the plan was to reduce suicides among veterans. Since 2006, VHA has 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, developing a distinct patient record flagging system, and establishing suicide prevention programs in each facility.

In April 2008, the Principal Deputy Under Secretary for Health and the Deputy Under Secretary for Health for Operations and Management (DUSHOM) issued a memorandum further outlining actions required for patients identified to be at high risk for suicide. Among the requirements were that there be a written safety plan, that the plan and the

process for developing it be included in the medical record, and that the patient be given a copy of the plan.[1]

In April 2008, VHA requested that OHI evaluate compliance with implementation of suicide prevention programs during Combined Assessment Program (CAP) reviews. We reviewed 24 facilities during the period January–June 2009. We reported that although all 24 facilities had implemented suicide prevention programs that generally met VHA requirements, program effectiveness could be strengthened by improving documented collaboration between MH providers and SPCs and by developing comprehensive and timely safety plans.[2] The review showed that 178 (74 percent) of 239 medical records had documented evidence of safety plans. In August 2009, VHA asked OHI to review SPSP practices during another cycle of CAP reviews.

At the time of this review, VHA directives did not address an acceptable timeframe for initiating an SPSP once a patient was designated as high risk for suicide. In July 2010, VHA issued guidance that SPSPs should be completed prior to discharge from an inpatient facility or at the next scheduled appointment for those patients seen at community facilities or followed as outpatients.

Scope and Methodology

We performed this evaluation at 45 facilities during CAP reviews conducted from January 1 through September 30, 2010. The facilities reviewed represented a mix of size, affiliation, geographic location, and Veterans Integrated Service Networks (VISNs). We interviewed selected program managers and reviewed documents, including the medical records of patients placed on high risk for suicide lists.

We generated an individual CAP report for each facility. For this report, we analyzed the data from the individual facility CAP reviews to identify system-wide trends. We used an expectation of 95 percent as our threshold for making recommendations.

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

Inspection Results

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

[1] DUSHOM, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.

[2] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009*; Report No. 09-00326-223 September 22, 2009.

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."[3] The basic components of a safety plan include:

- Recognizing warning signs that are proximal to an impending suicidal crisis.
- Identifying and employing internal coping strategies without needing to contact another person.
- Utilizing contacts with people as a means of distraction from suicidal thoughts and urges.
- Contacting family members or friends who may help to resolve the crisis.
- Contacting MH professionals or agencies.
- Reducing the potential for use of lethal means.

The patient should have input into each step of the plan and should be given a copy of the agreed upon plan. The plan should be maintained in the patient's medical record.

Inpatients and outpatients placed on the high risk for suicide list must have a current SPSP. We reviewed the medical records of 469 inpatients and outpatients placed on the high risk for suicide list. We found that 412 (88 percent) of 469 medical records had documented SPSPs. These results indicate improvement compared with 74 percent in our previous report.

Of the 412 SPSPs, we found that 389 (94 percent) fully addressed the components listed above. For the remaining records, SPSPs did not contain all the essential elements, such as contact numbers for family and professionals. In almost all the medical records reviewed, we found that the patient and/or family members participated in development of the SPSP. However, we only found documented evidence in 310 (75 percent) of the 412 medical records with SPSPs that the patient and/or family members received a copy of the plan as required.

Conclusions

VHA facilities recognized the importance of developing comprehensive, timely SPSPs for high-risk patients. We acknowledge VHA's issuance of clear timeliness expectations as a positive action. The SPSPs created were generally comprehensive. However, completion of SPSPs for all patients on the high-risk list needs improvement.

Recommendation

We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that MH providers develop and document timely SPSPs that meet all applicable criteria.

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

Comments

The Under Secretary for Health concurred with the finding and recommendation. (See Appendix A, pages 5–6 for the full text of the comments.) The implementation plan is acceptable, and we will follow up until all actions are complete.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: March 4, 2011

From: Under Secretary for Health (10)

Subject: **OIG Combined Assessment Program Summary Draft Report – Re-Evaluation of Suicide Prevention Safety Plan Practices in Veterans Health Administration Facilities (Project No. 2011-01380-HI-0066) (VAIQ 7080527)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and concur with the report's recommendation. Attached is the Veterans Health Administration's corrective action plan for the report's recommendation.

2. Thank you for the opportunity to review the draft report. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10B5) at (202) 461-7014.

(original signed by:)
Robert A. Petzel, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Re-Evaluation of Suicide Prevention Safety Plan Practices in Veterans Health Administration Facilities (Project No. 2011-01380-HI-0066, VAIQ 7080527)

Date of Draft Report: February 2, 2011

Recommendations/ Actions	Status	Completion Date

Recommendation

We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that MH providers develop and document timely SPSPs that meet all applicable criteria.

VHA Comments

Concur

The Office of Mental Health Services (OMHS) will identify facilities that have a safety plan completion below 95 percent. Once the facilities have been identified, OMHS will forward the list of these facilities to the Office of the DUSHOM. The DUSHOM will issue a memorandum to those facility directors requesting each facility to submit an action plan outlining steps to ensure that mental health providers develop and document timely SPSPs that meet established criteria. Once the action plans have been received, the DUSHOM will work with OMHS to ensure that action plans meet established criteria. After OMHS has approved the action plans, the DUSHOM will return the action plans to the facility directors and require the facility directors to certify to the DUSHOM that the actions have been implemented.

In Process August 30, 2011

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	Christa Sisterhen Director, Bay Pines Office of Healthcare Inspections
Acknowledgments	Daisy Arugay Gail Bozzelli Vickie Coates Darlene Conde-Nadeau Linda DeLong Dorothy Duncan Kathy Gudgell Stephanie Hensel Frank Keslof Glen Pickens Kimberly Pugh Jennifer Reed Wilma Reyes Clarissa Reynolds Kathleen Shimoda Barry Simon Laura Tovar

Appendix C

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