Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-03808-215

Evaluation of Suicide Prevention Programs in Veterans Health Administration Facilities

May 18, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General completed a healthcare inspection of suicide prevention programs in Veterans Health Administration (VHA) facilities. The purpose of the review was to evaluate facility compliance with selected VHA guidelines.

In 2013, suicide was the 10th leading cause of death in the United States.[1] The VA Suicide Prevention Program reported that in 2014, an average of 20 veterans died from suicide per day, which accounted for 18 percent of all deaths from suicide within the United States for that year.[2] Since 2006, VHA has implemented several initiatives aimed at suicide prevention, including the development of a patient record flagging system to identify and monitor patients at high risk for suicide (hereinafter "high-risk" patients) and the establishment of suicide prevention programs in each facility. In 2008, VHA issued guidance for evaluating and monitoring high-risk patients, which requires clinicians to create written Suicide Prevention Safety Plans, document the plans in patients' medical records, and give each patient a copy of the plan.

In 2009 and 2010, the Office of Inspector General conducted similar reviews of facility compliance with VHA guidance applicable to suicide prevention programs. In 2009, we identified system weaknesses in documented collaboration between mental health providers and Suicide Prevention Coordinators and in developing comprehensive and timely Suicide Prevention Safety Plans. In 2010, we identified a continued weakness in developing Suicide Prevention Safety Plans for all high-risk patients.

We performed this latest evaluation at 28 VHA facilities during Office of Inspector General Combined Assessment Program reviews conducted across the country from October 1, 2015 through March 31, 2016.

We determined that most facilities had a process for responding to referrals from the Veterans Crisis Line 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 six system weaknesses.

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

- Suicide Prevention Coordinators provide at least five outreach activities per month.
- Clinicians complete Suicide Prevention Safety Plans for all high-risk patients, include in the plans the contact numbers of family or friends for support, and give the patient and/or caregiver a copy of the plan.

[1] National Center for Injury Prevention and Control. "Suicide Facts at a Glance." 2015.
[2] VA Suicide Prevention Program. "Facts about Veterans Suicide." July 2016.

- When clinicians, in consultation with Suicide Prevention Coordinators, identify high-risk inpatients, they place Patient Record Flags in the patients' electronic health records and notify the Suicide Prevention Coordinator of each patient's admission.
- A Suicide Prevention Coordinator or mental health provider evaluates all high-risk inpatients at least four times during the first 30 days after discharge.
- When clinicians identify outpatients as high risk, they review the Patient Record Flags every 90 days and document the review and their justification for continuing or discontinuing the flags.
- Clinicians complete suicide risk management training within 90 days of hire.

Comments

The Acting Under Secretary for Health concurred with the report. (See Appendix B, pages 12–16, for the full text of the comments.) The implementation plans are acceptable, and we will follow up until all actions are completed.

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

Purpose

The VA Office of Inspector General (OIG) completed a healthcare inspection of suicide prevention programs in Veterans Health Administration (VHA) facilities. The purpose of the review was to evaluate facility compliance with selected VHA guidelines.

Background

In 2013, suicide was the 10th leading cause of death in the United States.[3] The VA Suicide Prevention Program reported that in 2014, an average of 20 veterans died from suicide per day, which accounted for 18 percent of all deaths from suicide within the United States for that year.[4]

Since 2006, 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, 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.[5]

In April 2008, VHA issued guidance for evaluating and monitoring patients identified to be at high risk for suicide (hereinafter "high-risk" patients), which requires clinicians to create written Suicide Prevention Safety Plans (SPSP), document the plans in patients' medical records, and give each patient a copy of the plan.[6]

In 2008, VHA requested that OIG evaluate facility compliance with VHA guidance applicable to suicide prevention programs. In 2009, we reviewed 24 facilities and reported that although all 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 SPSPs.[7]

In 2010, we re-evaluated practices specific to SPSPs, and although facilities showed improvement in developing comprehensive, timely SPSPs for high-risk patients, we identified a continued weakness in developing SPSPs for all high-risk patients. We

[3] National Center for Injury Prevention and Control. "Suicide Facts at a Glance." 2015.
[4] VA Suicide Prevention Program. "Facts about Veterans Suicide." July 2016.
[5] Deputy Under Secretary for Health for Operations and Management. "Suicide Prevention Coordinator Outreach Activities" memorandum. February 22, 2010.
[6] Deputy Under Secretary for Health for Operations and Management. "Patients at High-Risk for Suicide" memorandum. April 24, 2008.
[7] VA OIG, *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009*, Report No. 09-00326-223, September 22, 2009.

recommended that VHA ensure that MH providers develop and document timely SPSPs that meet all applicable criteria.[8]

Suicide rates are a top priority for VA. Evidence-based practices to reach veterans at risk for suicide, such as suicide risk assessments and SPSPs, should be comprehensive, timely, and implemented to be effective.[9]

Scope and Methodology

We performed this evaluation at 28 facilities during Combined Assessment Program reviews conducted from October 1, 2015 through March 31, 2016. The facilities we visited were a stratified random sample of all VHA facilities and represented a mix of facility size, affiliation, geographic location, and Veterans Integrated Service Networks. OIG generated an individual Combined Assessment Program report for each facility. In this report, we summarized the data collected from each facility.

We reviewed facility policies and interviewed managers and employees with suicide prevention program responsibilities. Additionally, we reviewed 1,175 electronic health records (EHR) of patients who were admitted for reported suicidal thoughts and/or behavior, whose EHRs were flagged for being at high risk for suicide, or who completed suicide during the 12 months prior to the onsite visit. If facility compliance with VHA guidelines dropped below 90 percent for a given activity, we considered making recommendations.

Two policies cited in this report were expired:

1. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008. (Expired September 30, 2013, Amended November 16, 2015.)

2. VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010. (Expired December 31, 2015.)

We considered these policies to be in effect as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),[10] the VA Under Secretary for Health mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[11] The Under Secretary for Health also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with

[8] VA OIG, *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.
[9] VA Suicide Prevention Program. "Facts about Veterans Suicide." July 2016.
[10] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016.
[11] VA Under Secretary for Health. "Validity of VHA Policy Document" memorandum. June 29, 2016.

ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[12]

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

We observed many positive suicide prevention practices at the facilities we visited. Most facilities had a process for responding to referrals from the Veterans Crisis Line and a process for following 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.

Issue 1: Outreach Activities

VHA requires that facilities complete five outreach activities each month for community organizations, MH groups, and/or other community advocacy groups. Outreach activities have direct effects on suicide hotline call volume and VHA's ability to get help to veterans in need.[13] Examples of outreach activities performed by facility SPCs included having informational booths at college campuses, community health fairs, and homeless shelters. At 17.9 percent of facilities, SPCs did not provide at least five outreach activities per month. Reasons SPCs gave us for not providing outreach activities included lack of leadership approval or support to attend events or activities.

We recommended that facility SPCs provide at least five outreach activities per month and that facility managers monitor compliance.

Issue 2: Suicide Prevention Safety Plans

VHA requires that clinicians develop SPSPs for high-risk patients.[14] In addition, clinicians may develop SPSPs for any patients about whom they are concerned. 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*

[12] Ibid.
[13] Deputy Under Secretary for Health for Operations and Management. "Suicide Prevention Coordinator Outreach Activities" memorandum. February 22, 2010.
[14] Deputy Under Secretary for Health for Operations and Management. "Patients at High- Risk for Suicide" memorandum. April 24, 2008.

or agencies that veterans can contact in order to help them lower their imminent risk of suicidal behavior.[15]

The components of a safety plan include[16]:

- Recognizing warning signs that precede an impending suicidal crisis
- Identifying and employing internal coping strategies
- Using contacts with people as a means of distraction from suicidal thoughts
- 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

Patients should have input into each step of the SPSP, and the patients and/or caregivers should receive copies. Clinicians need to maintain the SPSPs in the patients' EHRs.[17] We found that 11.4 percent of high-risk inpatients' and high-risk outpatients' EHRs did not contain current SPSPs. Previously we reported that 12 percent of high-risk patients did not have current SPSPs.[18] While the recent results indicate a slight improvement, more work is needed.

Regardless of a patient's suicide risk level, when clinicians initiate SPSPs, the SPSPs need to include all required components. Although clinicians generally documented warning signs, internal coping strategies, and contact information for professional agencies, clinicians did not document contact numbers of family or friends for support to resolve crises in 13.3 percent of inpatients' SPSPs and 25.4 percent of outpatients' SPSPs. Reasons clinicians gave us for not documenting contact numbers of family or friends included that the item was not in the template note and that many patients already had their contacts saved in their cell phones. We do not have specific comparative data from the previous report.

When clinicians developed SPSPs, they 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. Reasons clinicians gave us for not documenting that they gave the patient and/or caregiver a copy of the plan included that the item was not in the template note and that they provided the copy but forgot to document providing it in the EHR. In our previous review, we found that patients and/or caregivers did not receive a copy of the plan in 25 percent of the EHRs. While the recent results indicate an improvement, more work is needed.

[15] Stanley B and Brown G K. "Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version." August 20, 2008.
[16] VHA Manual. "Suicide Prevention Coordinator Guide." August 21, 2014. VHA reissued this reference with some new content during the review period; however, the components of the SPSP did not change.
[17] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.
[18] OIG Report *Combined Assessment Program Summary Report – Re-evaluation of Suicide Prevention Safety Plan Practices in VHA Facilities*, Report No. 11-01380-128, March 22, 2011.

We recommended that clinicians complete SPSPs for all high-risk patients, include in the SPSPs the contact numbers of family or friends for support, and give each patient and/or caregiver a copy of the SPSP, and that facility managers monitor compliance.

Issue 3: Patient Record Flags, Notification, and Follow-Up

VHA requires that facilities use Patient Record Flags (PRF) in inpatients' EHRs to identify and track high-risk patients.[19] The PRF serves to communicate to other treating clinicians that the patients are at high risk for suicide. Clinicians did not place PRFs in 13.6 percent of EHRs of high-risk inpatients. Reasons clinicians gave us for not placing PRFs included reluctance to label patients, concerns about liability, and the perception it would increase their workload.

VHA requires that clinicians notify the facility SPC when they admit high-risk patients so the SPC can track the patients.[20] Clinicians did not notify SPCs of high-risk patients' admissions 10.6 percent of the time. Reasons clinicians gave us included concerns about patient restrictions, liability, and reduced risk level during the admission.

VHA requires that SPCs or MH providers evaluate high-risk patients at least four times during the first 30 days after discharge from an inpatient admission to provide continuity of care in the crucial period following discharge.[21] SPCs or MH providers did not evaluate high-risk patients at the required frequency in 15.3 percent of EHRs. Reasons SPCs and MH providers gave us for not contacting patients included workload, the inability to provide timely access to clinics, and the inability to reach patients (for example, incorrect phone number, no phone, or no address).

For high-risk outpatients, VHA requires that clinicians review PRFs regularly—approximately every 90 days—and document justification for continuing or discontinuing the PRF.[22] Clinicians did not document review of the PRF during the previous 120 days for 25.4 percent of EHRs.[23] For those EHRs with a PRF review, clinicians did not document justification for continuing or discontinuing the PRF in 14.5 percent of EHRs. Reasons providers gave us for not documenting review of PRFs and/or justification for continuing or discontinuing PRFs included workload.

We recommended that when clinicians, in consultation with SPCs, identify high-risk inpatients, they place PRFs in the EHRs and notify the SPC of the admission. We also recommended that the SPC or MH provider evaluate these patients at least four times during the first 30 days after discharge. Further, we recommended that when clinicians

[19] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010. This Directive expired December 31, 2015, and has not yet been updated.
[20] Deputy Under Secretary for Health for Operations and Management. "Patients at High- Risk for Suicide" memorandum. April 24, 2008.
[21] Ibid.
[22] VHA Manual. "Suicide Prevention Coordinator Guide." June 19, 2015.
[23] After discussion with the VHA program office, we decided to assess for review within 120 days to allow for confusion about the 90-day requirement in the field.

identify high-risk outpatients, they review the PRFs every 90 days and document the review and their justification for continuing or discontinuing the PRFs. We recommended that facility managers monitor compliance with each of these items.

Issue 4: Employee Training

VHA requires that primary care and MH providers receive training on suicide risk assessments and management of high-risk patients. In 2008, VHA mandated that non-clinicians complete "Operation Save" (suicide prevention) training during orientation and that clinicians complete a separate risk management training within 90 days of hire.[24] Facilities generally provided suicide prevention training to new non-clinical employees (84.4 percent);[25] however, 45.7 percent of the time clinicians did not complete suicide risk management training within 90 days of hire. Reasons clinical managers gave us for not training clinicians included lack of allocated time to complete training, lack of leadership support, and not understanding that it was required.

We recommended that clinicians complete suicide risk management training within 90 days of hire and that facility managers monitor compliance.

Conclusions

We determined most facilities had a process for responding to referrals from the Veterans Crisis Line 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 six system weaknesses.

SPCs need to increase their involvement in community outreach activities by participating in at least five activities per month. Clinicians need to complete SPSPs for all high-risk patients and include in plans the contact numbers of family and friends for support or help to resolve the crisis. Clinicians also need to give a copy of the SPSP to each patient and/or caregiver to promote easy access to coping strategies and support sources to use during a crisis.

When clinicians identify high-risk inpatients, they need to place PRFs in patients' EHRs and notify the SPC of the admission so that the SPC can appropriately monitor patients throughout the continuum of care. For high-risk outpatients, clinicians need to review PRFs regularly—approximately every 90 days—and document justification for continuing or discontinuing the PRF.

[24] Deputy Under Secretary for Health for Operations and Management. "Suicide Awareness Training" memorandum. June 25, 2008.
[25] Although the result is below 90 percent, the interpretation of this training requirement changed during the review period. Therefore, we did not make a recommendation.

SPCs or MH providers need to evaluate high-risk patients at least four times during the first 30 days after discharge so that clinicians have the opportunity to intervene with these patients. Finally, clinicians need to complete suicide risk management training within 90 days of hire.

Recommendations

1. We recommended that the Acting Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that Suicide Prevention Coordinators provide at least five outreach activities per month and that facility managers monitor compliance.

2. We recommended that the Acting Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinicians complete Suicide Prevention Safety Plans for all high-risk patients, include in the plans the contact numbers of family or friends for support, and give the patient and/or caregiver a copy of the plan, and that facility managers monitor compliance.

3. We recommended that the Acting Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that when clinicians, in consultation with Suicide Prevention Coordinators, identify inpatients as at high risk for suicide, they place Patient Record Flags in the patients' electronic health records and notify the Suicide Prevention Coordinator of each patient's admission, and that facility managers monitor compliance.

4. We recommended that the Acting Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that a Suicide Prevention Coordinator or mental health provider evaluates inpatients identified as at high risk for suicide at least four times during the first 30 days after discharge, and that facility managers monitor compliance.

5. We recommended that the Acting Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that when clinicians identify outpatients as at high risk for suicide, they review the Patient Record Flags every 90 days and document the review and their justification for continuing or discontinuing the Patient Record Flags, and that facility managers monitor compliance.

6. We recommended that the Acting Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinicians complete suicide risk management training within 90 days of hire and that facility managers monitor compliance.

Project Questions and Data

Table 1. Validated Facility Self-Assessment Responses.

Project Questions	Yes	Percent Yes	No	Percent No	Total
Does the facility have a process for responding to referrals from the Veterans Crisis Line?	27	96.4%	1	3.6%	28
Does the facility have a process to follow up on high-risk patients who have missed appointments?	28	100.0%	0	0.0%	28
Has the facility identified any patients who attempted or died by suicide within the past 12 months?	28	100.0%	0	0.0%	28
If yes, did the facility create issue briefs in accordance with the 10N Guide to VHA Issue Briefs?	25	89.3%	3	10.7%	28
Did any of these patients die by suicide within 30 days of a clinical encounter with a VA health care provider?	22	78.6%	6	21.4%	28
If yes, did the facility complete a mortality review or behavioral autopsy for each death?	21	95.5%	1	4.5%	22
Has the facility identified any patients who died by suicide as an inpatient or within 7 days of discharge?	4	14.3%	24	85.7%	28
If yes, did the facility initiate a root cause analysis?	4	100.0%	0	0.0%	4
Has the facility provided at least five outreach activities per month for community organizations, MH groups, and other community advocacy groups?	23	82.1%	5	17.9%	28

Source: VA OIG Review Guide

Table 2. EHR Review Results for All Patients.

Project Questions	Yes	Percent Yes	No	Percent No	NA	Total
All Inpatients						
Did the patient have an SPSP developed prior to the admission?	183	22.8%	620	77.2%		803
Did clinicians develop an SPSP during the admission? (NA if patient refused, left against medical advice, or died before an SPSP could be completed.)	343	59.8%	231	40.2%	46	620
Did clinicians give the patient and/or caregiver a copy of the SPSP?	422	79.8%	107	20.2%		529
Did the SPSP include identification of warning signs that precede a crisis (also termed stressors and triggers)?	525	99.6%	2	0.4%		527
Did the SPSP include identification of internal coping strategies?	526	99.8%	1	0.2%		527
Did the SPSP include identification of contact numbers of family or friends for support or help to resolve crisis?	457	86.7%	70	13.3%		527
Did the SPSP include identification of professional agencies that can support or help to resolve crisis?	526	99.8%	1	0.2%		527
Did the SPSP include assessment of available lethal means and how to keep the environment safe?	476	90.3%	51	9.7%		527
All Outpatients						
Did the patient have an SPSP developed? (NA if patient refused.)	228	67.7%	109	32.3%	33	370
Did clinicians give the patient and/or caregiver a copy of the SPSP?	204	89.5%	24	10.5%		228
Did the SPSP include identification of warning signs that precede a crisis (also termed stressors and triggers)?	225	98.7%	3	1.3%		228
Did the SPSP include identification of internal coping strategies?	225	98.7%	3	1.3%		228
Did the SPSP include identification of contact numbers of family or friends for support or help to resolve crisis?	170	74.6%	58	25.4%		228
Did the SPSP include identification of professional agencies that can support or help to resolve crisis?	225	98.7%	3	1.3%		228
Did the SPSP include assessment of available lethal means and how to keep the environment safe?	205	89.9%	23	10.1%		228

Source: VA OIG Review Guide

NA=Not applicable

Table 3. EHR Review Results for High-Risk Patients.

Project Questions (Patients Identified as High Risk)	Yes	Percent Yes	No	Percent No	NA	Total
High-Risk Inpatients						
Did a MH clinician assess the patient as high risk for suicide at the time of admission?	198	100.0%	0	0.0%		198
If yes, was a PRF placed?	171	86.4%	27	13.6%		198
Did clinical staff notify the SPC of the admission?	177	89.4%	21	10.6%		198
Did the patient have an SPSP developed prior to the admission?	63	31.8%	135	68.2%		198
If no, did clinicians develop an SPSP during the admission? (NA if patient refused, left against medical advice or died before an SPSP could be completed.)	119	92.2%	10	7.8%	6	135
Did the SPC or MH provider evaluate the patient at least four times during the first 30 days after discharge? (NA if readmitted during the 30 days after discharge.)	122	84.7%	22	15.3%	54	198
High-Risk Outpatients						
Did a MH clinician assess the patient as high risk for suicide at the time the PRF was placed?	191	100.0%	0	0.0%		191
Did the patient have an SPSP developed? (NA if patient refused.)	162	86.2%	26	13.8%	3	191
Was there a note indicating that the PRF was reviewed? (NA if insufficient time has passed.)	138	74.6%	47	25.4%	6	191
If yes, was there a clinical justification for continuing or discontinuing the PRF?	118	85.5%	20	14.5%		138

Source: VA OIG Review Guide

NA=Not applicable

Table 4. Employee Training Record Review Results.

Project Questions	Yes	Percent Yes	No	Percent No	NA	Total
Did this employee have suicide prevention training (Operation S.A.V.E. or Question, Persuade, Refer) within the past 12 months?	352	84.4%	65	15.6%		417
Is the employee a clinician (physician, psychologist, registered nurse, social worker, physician's assistant)?	275	65.9%	142	34.1%		417
Did this clinician complete Suicide Risk Management Training through the Talent Management System within 90 days of hire? (NA if the employee no longer works there at the time of the review.)	145	54.3%	122	45.7%	8	275

Source: VA OIG Review Guide

NA=Not applicable

Acting Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: March 14, 2017

From: Acting Under Secretary for Health (10)

Subject: **Office of Inspector General (OIG) Draft Report, Combined Assessment Program (CAP) Summary Report – Evaluation of Suicide Prevention Programs in Veterans Health Administration Facilities (Project No. 2016-03808-HI-0682) (VAIQ 7773137)**

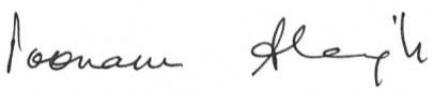
To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the draft report, Evaluation of Suicide Prevention Programs in Veterans Health Administration Facilities. The Veterans Health Administration (VHA) is strongly committed to developing long-term solutions that mitigate risks to the timeliness, cost-effectiveness, quality and safety of the Department of Veterans Affairs (VA) health care system. VHA is using the input from VA's Office of Inspector General, and other advisory groups to identify root causes and to develop critical actions. As VHA implements corrective measures, we will ensure our actions are meeting the intent of the recommendations. VHA is dedicated to sustained improvement in the high risk areas.

2. The recommendations in this report apply to GAO high risk areas 2 and 4. VHA's actions will serve to address inadequate oversight and accountability, and inadequate training for VA staff.

3. I have reviewed the draft report, and provide the attached action plan to address the report's recommendations.

4. If you have any questions, please email Karen M. Rasmussen, M.D., Director, Management Review Service at VHA10E1DMRSAction@va.gov.



Poonam Alaigh, M.D.
Acting

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, Evaluation of Suicide Prevention Programs in Veterans Health Administration Facilities

Date of Draft Report: February 7, 2017

Recommendations/ Actions	Status	Completion Date

OIG Recommendations

Recommendation 1. We recommended that the Acting Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that Suicide Prevention Coordinators provide at least five outreach activities per month and that facility managers monitor compliance.

VHA Comments: Concur

VHA Response:
Suicide Prevention Coordinators (SPCs) will enter all outreach events into the currently existing Suicide Prevention Application Network (SPAN). This data will be monitored at a VISN [Veterans Integrated Service Network] level for overall compliance. Any sites not in compliance will submit an action plan to the VISN Suicide Prevention Coordinator for monitoring.

At completion of this action, the Office of Suicide Prevention will provide three months of activity compliance and a corrective action plan for facilities that demonstrate less than 100 percent compliance.

Status:	Target Completion Date:
In Process	July 2017

Recommendation 2. We recommended that the Acting Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinicians complete Suicide Prevention Safety Plans for all high-risk patients, include in the plans the contact numbers of family or friends for support, and give the patient and/or caregiver a copy of the plan, and that facility managers monitor compliance.

VHA Comments: Concur

VHA Response:
VHA believes that each high risk Veteran deserves the highest level of care to ensure safety. Each Veteran that is identified as high risk has a high risk flag placed in their record within Computerized Patient Record System (CPRS) and monitored until the

Veteran is deemed no longer at acute risk and the flag is removed. Each facility will report to the VISN Suicide Prevention Lead on a monthly basis to include compliance for a completed Safety Plan with documentation of contact numbers of family or friends for support, and that the patient and/or caregiver were provided a copy of the plan.

At completion of this action, the Office of Suicide Prevention will provide three months of compliance and corrective action plans for facilities that demonstrate less than 100 percent compliance.

Status:	Target Completion Date:
In Process	July 2017

Recommendation 3. We recommended that the Acting Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that when clinicians, in consultation with Suicide Prevention Coordinators, identify inpatients as at high risk for suicide, they place Patient Record Flags in the patients' electronic health records and notify the Suicide Prevention Coordinator of each patient's admission, and that facility managers monitor compliance.

VHA Comments: Concur

VHA Response:
In the event a Veteran with a High Risk for Suicide Flag is admitted to an inpatient unit treating staff on that unit will notify the facility's Suicide Prevention Coordinator of the admission for their awareness and any needed action. Each facility will report to the VISN Suicide Prevention Lead on a monthly basis to include compliance for notification of Suicide Prevention Coordinators of inpatient admission of those Veterans with a High Risk for Suicide Patient Record Flag.

At completion of this action, the Office of Suicide Prevention will provide three months of compliance data and corrective action plans for facilities that demonstrate less than 100 percent compliance.

Status:	Target Completion Date:
In Process	July 2017

Recommendation 4. We recommended that the Acting Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that a Suicide Prevention Coordinator or mental health provider evaluates inpatients identified as at high risk for suicide at least four times during the first 30 days after discharge, and that facility managers monitor compliance.

VHA Comments: Concur

VHA Response:
Each Veteran that is identified as high risk will be monitored at least 4 times within the first 30 days post discharge and this will be documented in the Veterans medical record. Each facility will report monthly to the VISN Suicide Prevention Lead compliance of

documentation of mandated post discharge encounters for Veterans identified as high risk for suicide.

At completion of this action, the Office of Suicide Prevention will provide three months of compliance and corrective action plans for facilities that demonstrate less than 100 percent compliance.

Status:	Target Completion Date:
In Process	July 2017

Recommendation 5. We recommended that the Acting Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that when clinicians identify outpatients as at high risk for suicide, they review the Patient Record Flags every 90 days and document the review and their justification for continuing or discontinuing the Patient Record Flags, and that facility managers monitor compliance.

VHA Comments: Concur

VHA Response:
Each facility will report to the VISN Suicide Prevention Lead on a monthly basis compliance with documented review of all Patient Record Flags that have reached 90 day status.

At completion of this action, the Office of Suicide Prevention will provide three months of compliance and corrective action plans for facilities that demonstrate less than 100 percent compliance.

Status:	Target Completion Date:
In Process	July 2017

Recommendation 6. We recommended that the Acting Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinicians complete suicide risk management training within 90 days of hire and that facility managers monitor compliance.

VHA Comments: Concur

VHA Response:
The Office of Suicide Prevention will develop a memo that will be released to the field through the Office of the Deputy Under Secretary for Operations and Management that provides guidance for the required training on suicide risk management that is expected to occur within 90 days of hire. Compliance will be monitored via Talent Management System and available to both Suicide Prevention Coordinators and facility managers as well as Office of Strategic Planning.

At completion of this action, the Office of Suicide Prevention will provide three months of compliance with mandatory training requirements for all new clinical employees within 90 days of being hired and for any facility that demonstrates less than 100 percent compliance, an action plan will be submitted.

Status:	Target Completion Date:
In Process	September 2017

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