DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Summary Report: Evaluation of Mental Health in Veterans Health Administration Facilities, Fiscal Year 2020

CHIP REPORT | REPORT #21-01506-76 | FEBRUARY 17, 2022

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Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CMHO	Chief Mental Health Officer
HRS	High Risk for Suicide
OIG	Office of Inspector General
OMHSP	Office of Mental Health and Suicide Prevention
PRF	Patient Record Flag
SPC	suicide prevention coordinator
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years. The OIG selects and evaluates specific areas of focus each year.

The purpose of this report's evaluation was to determine whether VHA facility leaders, clinicians, and staff complied with selected requirements for suicide prevention coordinator processes, provision of suicide prevention care, and suicide prevention training.

The OIG initiated unannounced inspections at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. These inspections involved interviews with key staff and evaluations of clinical and administrative processes. The OIG also randomly selected and reviewed electronic health records at five additional facilities but did not conduct site visits or issue individual reports to these facilities because of COVID-19 restrictions.[1] The findings in this report are a snapshot of VHA performance at the time of the fiscal year 2020 OIG reviews and may help VHA identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.[2]

Inspection Results

The OIG found general compliance with requirements for designated facility suicide prevention coordinators, tracking of high-risk veterans, and timely completion of suicide prevention safety plans with the required elements. However, the OIG identified weaknesses with

- completion of four follow-up visits within the required time frame,
- appropriate follow-up with veterans who have a High Risk for Suicide-Patient Record Flag and fail to attend mental health appointments,
- suicide prevention training, and
- completion of five monthly outreach activities.

[1] The five facilities were: VA Central Iowa Health Care System in Des Moines; VA Black Hills Health Care System in Fort Meade, South Dakota; Iowa City VA Health Care System in Iowa; Minneapolis VA Health Care System in Minnesota; and VA Nebraska-Western Iowa Health Care System in Omaha.

[2] Fiscal year 2020 began on October 1, 2019, and ended on September 30, 2020.

Conclusion

The OIG conducted detailed inspections at 36 VHA facilities and electronic health record reviews at these and five additional facilities to ensure the leaders implemented suicide prevention processes. The OIG subsequently issued four recommendations for improvement to the Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders. The intent is for VHA leaders to use these recommendations to help guide improvements in operations and clinical care at the facility level. The recommendations address findings that may eventually interfere with the delivery of quality health care.

VA Comments and OIG Response

The Acting Under Secretary for Health concurred fully or in principle with the findings and recommendations (see appendix C, pages 15–17, and the responses within the body of the report for the full text of the executive's comments.) The OIG addressed all of the comments and made one requested change to clarify a sentence (see addendum to appendix C, page 18). The OIG will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
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Purpose and Scope

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years.

While the OIG selects and assesses specific areas of focus on a rotating basis each year, the evaluation of VHA facilities' mental health programs is an ongoing review topic because the Caregivers and Veterans Omnibus Health Services Act of 2010 designates oversight of patient care quality and safety to leaders at the national, network, and facility levels.[1] These leaders are directly accountable for program integration and communication within their level of responsibility.

The purpose of this report's evaluation was to determine whether VHA facility leaders, clinicians, and staff complied with selected requirements for designated facility suicide prevention coordinators (SPCs), tracking and follow-up of high-risk veterans, suicide prevention training, and monthly outreach activities.

To determine compliance with the above required processes for suicide prevention, the OIG inspectors assessed various requirements related to SPCs:

- Assignment of a full-time SPC
- Tracking and follow-up of high-risk veterans
  - Patients' completion of four appointments within the required time frame
  - Safety plan completion within the required time frame
  - Mental health teams' contact with patients for missed appointments
- Provision of suicide prevention training for nonclinical employees at new employee orientation
- Completion of at least five outreach activities per month

All VHA staff must complete suicide risk and intervention training within 90 days of entering their position. Clinical staff (including physicians, psychologists, dentists, registered nurses, physician assistants, pharmacists, social workers, case managers, and Vet Center counselors) must complete Suicide Risk Management Training for Clinicians, and nonclinical staff must

[1] Caregivers and Veterans Omnibus Health Services Act of 2010, Pub. L. 111-163, § 505 (2010).

complete Operation S.A.V.E. training.[2] VHA also requires that all staff receive annual refresher training.[3] In addition, SPCs are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.[4]

Lastly, VHA requires that any patient determined to be at high risk for suicide be added to the facility high-risk list and have a High Risk for Suicide (HRS)-Patient Record Flag (PRF) placed in his or her electronic health record "as soon as possible but no later than 1 business day after such determination by the SPC."[5] According to VHA, "Some studies indicate that up to two-thirds of patients who commit suicide have seen a physician in the month before their death…The primary purpose of the High-Risk for Suicide PRF is to communicate to VA staff that a veteran is at high risk for suicide and the presence of a flag should be considered when making treatment decisions."[6] The HRS-PRF is reviewed at least every 90 days and, depending on changes to the suicide risk status, will remain active or be removed.[7] VHA also requires designated high-risk patients to have a completed suicide safety plan and four face-to-face visits with an acceptable provider within the first 30 days of designation.[8]

The OIG noted that from July 1, 2018, to June 30, 2019 (the time frame for this retrospective review), VHA required that "Any patient determined to be High-Risk for Suicide [by the licensed independent provider] must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination."[9] However, on January 16, 2020, the Deputy Undersecretary for Health for Operations and Management changed the requirement

[2] Operation S.A.V.E. is a VA gatekeeper training program provided by suicide prevention coordinators to veterans and those who serve veterans. The acronym "S.A.V.E" summarizes the steps needed to take in recognizing and responding to a veteran in suicidal crisis: signs of suicidal thinking, ask questions, validate the person's experience, encourage treatment and expedite getting help. The training was designed for nonclinical employees and includes food service workers, registration clerks, volunteers, and police. It should also be viewed by ancillary/support staff or any other category not covered by the clinical training.

[3] VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017.

[4] DUSHOM Memorandum, *Suicide Awareness Training*, April 11, 2017. The training was designed for nonclinical employees and includes food service workers, registration clerks, volunteers, and police. It should also be viewed by ancillary/support staff or any other category not covered by the clinical training.

[5] Deputy Under Secretary for Health for Operations Management (DUSHOM) Memorandum, *Update to High Risk for Suicide Patient Record Flag Changes*, January 16, 2020.

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

[7] *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care, Suicide Prevention Coordinator Guide*, January 5, 2018; DUSHOM Memorandum, *High Risk for Suicide Patient Record Flag Changes*, October 3, 2017.

[8] VA Manual, *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version,* August 20, 2008. A safety plan is a "written list of coping strategies and sources of support that patients can use during or preceding suicidal crises." Face-to-face visits may be performed as telephone visits if requested by the patient. The requirement for four face-to-face visits within 30 days of designation can be found in *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care, Suicide Prevention Coordinator Guide*.

[9] DUSHOM Memorandum, *High Risk for Suicide Patient Record Flag Changes*.

for the HRS-PRF placement to be "as soon as possible but no later than 1 business day after determination by the SPC."[10] VHA further provided additional clarifying information:

- The "SPC exclusively controls the HRS-PRF and must limit their use to patients who meet the criteria of being placed on the facility high-risk suicide list."[11]
- "The time frame of placing the flag begins once the SPC makes the determination that an HRS-PRF is warranted."[12]
- The SPC's determination process "may be beyond 24 hours after a referral, due to case consultation and review."[13]

On March 27, 2020, VHA also updated existing policy requirements to allow the review of an HRS-PRF to "occur no earlier than 10 days before and no later than 10 days after the 90-day due date."[14] As a result, the OIG expressed concern that the requirement changes may have resulted in delayed placement of HRS-PRFs for at-risk patients, as these patients could have flags placed in their charts several days after referral.[15]

Additionally, inspection teams examined the completion of several requirements:

- Review of HRS-PRFs within the required time frame
- Completion of at least four mental health visits within 30 days of HRS-PRF placement
- Appropriate follow-up for no-show high-risk appointments
- Completion of suicide safety plans with the required elements within the required time frame

[10] DUSHOM Memorandum, *Update to High Risk for Suicide Patient Record Flag Changes*.

[11] VHA, response to questions by VA OIG Office of Healthcare Inspections from February 12, 2020, received February 19, 2020.

[12] VHA, response to questions by VA OIG Office of Healthcare Inspections from February 12, 2020.

[13] VHA, response to questions by VA OIG Office of Healthcare Inspections from February 12, 2020.

[14] VHA Notice 2020-13, *Inactivation Process for Category I High Risk for Suicide Patient Record Flags*, March 27, 2020. (This notice was amended to VHA Notice 2020-13(1) on September 8, 2020, rescinded on May 28, 2021, and replaced with VHA Notice 2021-10, *Inactivation Process for Category I High Risk for Suicide Patient Record Flags*. The three documents contain similar language related to the review of HRS-PRFs.)

[15] The current requirement would allow for a patient to be identified as high risk for suicide and referred to the SPC on Monday. The SPC could assess the patient for risk and determine the need for an HRS-PRF that Friday and then place an HRS-PRF on the subsequent Monday (a week after referral).

The findings in this summary report are a snapshot of national-level VHA performance at the time of the fiscal year 2020 OIG reviews.[16] The findings may help VHA identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

[16] Fiscal year 2020 began on October 1, 2019, and ended on September 30, 2020.

Methodology

To determine whether VHA facilities complied with selected suicide prevention program requirements, the OIG initiated unannounced inspections at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. The facilities reviewed represented a mix of size, affiliation, geographic location, and Veterans Integrated Service Networks (VISNs).

The OIG interviewed key staff and reviewed relevant documents and the electronic health records of 1,516 randomly selected outpatients who had an HRS-PRF flag from July 1, 2018, through June 30, 2019. The OIG also randomly selected and reviewed electronic health records at five additional facilities but did not conduct site visits or issue individual reports to these facilities because of COVID-19 restrictions.[17]

Unless otherwise noted, the OIG published individual CHIP reports for each facility. For this report, the OIG analyzed the data from the individual facility reviews to identify system-wide trends. The OIG generally used 90 percent as the expected level of compliance for the areas discussed.

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VHA leaders complete corrective actions. The comments and action plans submitted by the Acting Under Secretary for Health in response to the report recommendations appear within the report. The OIG accepted the action plans that the Acting Under Secretary for Health developed based on the reasons for noncompliance.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[18] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

[17] The five additional facilities were: VA Central Iowa Health Care System in Des Moines; VA Black Hills Health Care System in Fort Meade, South Dakota; Iowa City VA Health Care System in Iowa; Minneapolis VA Health Care System in Minnesota; and VA Nebraska-Western Iowa Health Care System in Omaha.

[18] Pub. L, No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[19] The suicide rate for veterans was 1.5 times greater than nonveteran adults and estimated to represent approximately 13.8 percent of all suicide deaths in the United States during 2018.[20] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[21]

VHA has identified suicide prevention as a top priority and implemented various evidence-based approaches to reduce the veteran suicide rate. In addition to expanded mental health services and community outreach, VHA developed comprehensive screening and assessment processes to identify at-risk patients.[22]

Findings and Recommendations

The OIG found general compliance with some of the selected requirements. However, across VHA facilities reviewed in fiscal year 2020, the OIG identified weaknesses with

- completion of four follow-up visits within the required time frame,
- appropriate follow-up with veterans who have an HRS-PRF flag and fail to attend mental health appointments,
- suicide prevention training, and
- completion of five monthly outreach activities.

With VHA's original requirement that was in place when these patients received care—that "Any patient determined to be High Risk for Suicide must have a[n] HRS-PRF Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination"—the OIG estimated that 35 percent of HRS-PRFs were not placed within 24 hours of referral to the SPC.[23] Based on the current updated requirement that the SPC be responsible for determining placement of the HRS-PRF (without a defined time frame for doing so), the OIG further calculated that the average time from referral to HRS-PRF placement for the patients reviewed was three days (observed range was 0–57 days).

[19] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed September 27, 2021, https://www.cdc.gov/violenceprevention/suicide/fastfact.html.
[20] Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report,* November 2020.
[21] Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*.
[22] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021.
[23] DUSHOM Memorandum, *High Risk for Suicide Patient Record Flag Changes*. The OIG estimated that 95 percent of the time, the true compliance rate is between 62.0 and 66.8 percent, which is statistically significantly below the 90 percent benchmark.

Further, the OIG noted deficiencies with reviewing HRS-PRFs within the required time frame. VHA required that all patients with an HRS-PRF be reevaluated at least every 90 days.[24] The OIG estimated that 54 percent of patients with an HRS-PRF were not reevaluated at least every 90 days.[25] However, based on the updated requirement that the HRS-PRFs be reviewed up to 10 days prior to or after the due date for reevaluation, the OIG found that clinical staff did not review 13 percent of patient flags within the expected time frame (observed range was 1–222 days).[26] The OIG made no recommendations but remains concerned about this update.

VHA requires a patient to have four outpatient follow-up visits with a qualified provider within 30 days of the HRS-PRF placement. The follow-up visits must be face-to-face unless the patient requests a telephonic visit, and there must be documentation identifying the patient's preference for a telephone call.[27] The OIG estimated that providers did not conduct four mental health follow-up visits for 20 percent of the patients reviewed.[28] This may have prevented staff from providing optimal treatment to patients with suicidal ideation. Reasons for noncompliance included lack of oversight, staffing issues, and managers' stated beliefs that facility efforts met the requirements.[29]

Recommendation 1

1. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, makes certain that facility providers conduct four follow-up visits, either face-to-face or telephonic with documented patient preference, within the required time frame.

[24] VHA Directive 2008-036.

[25] The OIG estimated that 95 percent of the time, the true compliance rate is between 32.2 and 58.3 percent, which is statistically significantly below the 90 percent benchmark.

[26] VHA Notice 2020-13, *Inactivation Process for Category I High Risk for Suicide Patient Record Flags*, March 27, 2020. (This notice was amended to VHA Notice 2020-13(1) on September 8, 2020, rescinded on May 28, 2021, and replaced with VHA Notice 2021-10, *Inactivation Process for Category I High Risk for Suicide Patient Record Flags*. The later document changed the requirement from reevaluating HRS-PRFs at least every 90 days to HRS-PRFs to be reviewed up to 10 days prior to or after the reevaluation due date.)

[27] *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care, Suicide Prevention Coordinator Guide*.

[28] The OIG estimated that 95 percent of the time, the true compliance rate is between 76.4 and 82.7 percent, which is statistically significantly below the 90 percent benchmark.

[29] Managers specifically reported believing that telephonic encounters without documenting the patients' preferences for telephone calls met the expectation.

VHA concurred in principle.

Target date for completion: August 2022

VHA response: The VHA Office of Mental Health and Suicide Prevention (OMHSP) recognizes the importance of standards of care for Veterans most at risk for suicide. Currently, VHA employs quality improvement metrics to assist with the examination of compliance with policy that sets minimum standards for enhanced care.

VHA OMHSP will re-educate the field on the current policy by reviewing requirements and data tools to monitor progress at the local level on a national call. OMHSP will also include a review of compliance with providing Veterans most at risk for suicide with four follow-up appointments as part of the newly implemented Veterans Integrated Service Network (VISN) suicide prevention site visit process.

OMHSP will explore the impact of additional variables on related clinical processes to identify opportunities in redefining how this metric captures the standard of care for patients most at risk for suicide within 30 days of when the High-Risk for Suicide Patient Record Flag (HRS-PRF) is activated.

For patients with HRS-PRFs who miss or fail to attend mental health or substance abuse appointments, VHA requires that a mental health provider contact, or attempt to contact, the patient. Further, when attempted contact is unsuccessful, "the suicide prevention coordinator will collaborate with the treatment provider(s) to determine the next appropriate step utilizing clinical judgment and the pre-developed Safety Plan."[30] The OIG estimated that 18 percent of electronic health records reviewed did not contain evidence that the provider collaborated with the SPC after unsuccessful follow-up contact attempts with high-risk veterans who failed to keep their mental health appointments.[31] Failure to follow up with a patient who is at high risk for suicide could result in missed opportunities to assess the patient and provide needed interventions. Reasons for noncompliance included lack of follow-through and oversight.

Recommendation 2

2. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures providers collaborate with suicide prevention coordinators when follow-up contact is unsuccessful for high-risk patients.

[30] DUSHOM Memorandum, *Guidance on Patients Failure to Attend Appointments (No Shows)*, August 6, 2013.

[31] The OIG estimated that 95 percent of the time, the true compliance rate is between 75.1 and 88.1 percent, which is statistically significantly below the 90 percent benchmark.

VHA concurred in principle.

Target date for completion: April 2022

VHA response: VHA recognizes the importance of collaboration and consultation with facility suicide prevention coordinators (SPC) and has incorporated language in VHA Directive 1160.07, *Suicide Prevention Program*, dated May 24, 2021, that emphasizes this importance.

The complexity of the Veteran's clinical presentation and circumstances regarding the no-show inform the Veteran's treatment team's consultation with the suicide prevention coordinator. Because the clinical presentation varies, depending on the clinical presentation and circumstances, consultation for unsuccessful follow-up contact may vary. VHA has established policy for no-show follow-up procedures in VHA Directive 1232, *Consult Processes and Procedures*.

Due to these recent policy updates, VHA will require each health care system to update local standard operating procedures (SOP) to ensure HRS-PRF management incorporates local procedures for collaboration with the SPC when follow-up after missed appointments has been unsuccessful. VHA will verify the completion of this action by obtaining an attestation from the VISN Chief Mental Health Officers (CMHO) from each VISN.

VHA requires that all employees complete suicide risk and intervention training within 90 days of hire and annual suicide prevention refresher training.[32] The OIG reviewed the training records of 720 employees and found that 13 percent did not complete the initial suicide risk and intervention training within 90 days of hire. Further, the OIG found that 23 percent did not complete annual suicide prevention refresher training. Failure to complete the initial and annual refresher training could prevent employees from providing optimal interventions for patients who are at risk for suicide. Reported reasons for noncompliance included lack of oversight and attention to detail.

Recommendation 3

3. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that employees complete initial suicide risk and intervention training within 90 days of hire and annual suicide prevention refresher training.

[32] VHA Directive 1071.

VHA concurred.

Target date for completion: April 2022

VHA response: OMHSP will ensure required training on suicide risk management is completed within 90 days of hire and annually as a refresher, per VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, dated December 22, 2017. Compliance is monitored by facility directors through the Talent Management System (TMS), and the compliance information is available to SPCs, facility managers, and VISN CMHOs.

VISN CMHOs will review three consecutive months of reports demonstrating compliance with mandatory training requirements for all new employees within 90 days of being hired and annually as a refresher. To close this recommendation, VISNs will be required to demonstrate they have submitted action plans for any health care system that has less than 95% compliance with training, as outlined in VHA Directive 1071.

While the policy states that "all" eligible employees are required to complete this training, a 95% target is established due to valid reasons which may cause a facility to fall below 100% (for example, employees who are on extended sick leave during their 90 days, technical challenges, etc.) A review of action plans will consider a given VISN's opt-in or out of the moratorium on Non-COVID-19 Training requirements specific to suicide prevention.

VHA requires facility SPCs to deliver five outreach activities each month.[33] The OIG found that for 9 of 36 facilities (25 percent), SPCs did not complete the five required outreach activities per month from October 1 through December 31, 2019. Failure to provide outreach could limit veterans' awareness of VA mental health programs and services. Reasons for noncompliance included lack of attention to detail, staffing issues, and managers' stated beliefs that facility efforts met the requirements.[34]

Recommendation 4

4. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that all facility suicide prevention coordinators complete at least five outreach activities per facility each month.

[33] *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care Suicide Prevention Coordinator Guide*.

[34] Managers reported believing that the following actions met requirements: two suicide prevention case managers covered the staffing gap after the former SPC was promoted, the vocational development specialist conducted activities as part of veteran outreach, and training was conducted during new employee orientation. Managers also indicated that they believed the requirement was an average of five outreach activities per month.

VHA concurred.

Target date for completion: April 2022

VHA response: SPCs will continue to enter all outreach events into the currently existing Suicide Prevention Application Network. This data will be monitored at the VISN level for overall compliance. Any facilities not in compliance will submit an action plan to the VISN CMHO for monitoring.

To demonstrate closure of this recommendation, VISN CMHOs will confirm review of three consecutive months of outreach activities and obtain a corrective action plan for facilities that demonstrate less than 95% compliance.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines four OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient safety issues or adverse events. The intent is for VHA leaders to use these recommendations to guide improvements in operations and clinical care. The recommendations address findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Mental Health: Suicide Prevention	• Designated facility SPC • Tracking and follow-up of high-risk veterans • Provision of suicide prevention care • Completion of suicide prevention training requirements • Completion of at least five outreach activities per month	• Providers conduct four follow-up visits, either face-to-face or telephonic with documented patient preference, within the required time frame. • Providers collaborate with SPCs when follow-up contact is unsuccessful for high-risk patients. • Employees complete initial suicide risk and intervention training within 90 days of hire and annual suicide prevention refresher training. • Facility SPCs complete at least five outreach activities each month.	• None

Appendix B: Parent Facilities Inspected

Table B.1. Parent Facilities Inspected
(October 1, 2019, through September 30, 2020)

Names	City
VA Ann Arbor Medical Center	Ann Arbor, MI
Charlie Norwood VA Medical Center	Augusta, GA
Battle Creek VA Medical Center	Battle Creek, MI
Birmingham VA Medical Center	Birmingham, AL
Boise VA Medical Center	Boise, ID
Ralph H. Johnson VA Medical Center	Charleston, SC
Jesse Brown VA Medical Center	Chicago, IL
Chillicothe VA Medical Center	Chillicothe, OH
Cincinnati VA Medical Center	Cincinnati, OH
Harry S. Truman Memorial Veterans' Hospital	Columbia, MO
Columbia VA Health Care System	Columbia, SC
VA Illiana Health Care System	Danville, IL
Dayton VA Medical Center	Dayton, OH
Atlanta VA Health Care System	Decatur, GA
John D. Dingell VA Medical Center	Detroit, MI
Carl Vinson VA Medical Center	Dublin, GA
Edward Hines, Jr. VA Hospital	Hines, IL
Oscar G. Johnson VA Medical Center	Iron Mountain, MI
Kansas City VA Medical Center	Kansas City, MO
William S. Middleton Memorial Veterans Hospital	Madison, WI
Marion VA Medical Center	Marion, IL
VA Northern Indiana Health Care System	Marion, IN
Milwaukee VA Medical Center	Milwaukee, WI
Central Alabama Veterans Health Care System	Montgomery, AL
Captain James A. Lovell Federal Health Care Center	North Chicago, IL
John J. Pershing VA Medical Center	Poplar Bluff, MO
VA Portland Health Care System	Portland, OR
Roseburg VA Health Care System	Roseburg, OR
Aleda E. Lutz VA Medical Center	Saginaw, MI
VA Puget Sound Health Care System	Seattle, WA

Names	City
Mann-Grandstaff VA Medical Center	Spokane, WA
VA St. Louis Health Care System	St. Louis, MO
Tomah VA Medical Center	Tomah, WI
VA Eastern Kansas Health Care System	Topeka, KS
Tuscaloosa VA Medical Center	Tuscaloosa, AL
Robert J. Dole VA Medical Center	Wichita, KS

Source: VA OIG.

Appendix C: Office of the Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: November 12, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, Comprehensive Healthcare Inspection Summary Report Evaluation of Mental Health in Veterans Health Administration Facilities, Fiscal Year 2020 (2021-01506-HI-1150) (VIEWS # 6173700)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report Comprehensive Healthcare Inspection Summary Report: Evaluation of Mental Health in Veterans Health Administration Facilities, Fiscal Year 2020. The Veterans Health Administration (VHA) concurs in principle with recommendations 1 and 2 and concurs with recommendations 3 and 4. VHA provides an action plan in the attachment.
2. VHA asks OIG to consider the following technical comments to improve the accuracy of the report:

   Comment 1

   Draft location: Page v, Paragraph 4, Bullet 2

   Current language: "appropriate follow-up with veterans who have a High Risk for Suicide flag and fail to attend mental health appointments"

   Comment and justification: For purposes of clarity/to avoid confusion, VHA asks OIG to consider adding the words "patient record" to the report language to support reader clarity. VHA proposes the edit to read, "appropriate follow-up with veterans who have a High Risk for Suicide Patient Record Flag (HRS-PRF, respectively) and fail to attend mental health appointments"

   Comment 2

   Draft location: Page 10, Footnote 13

   Current language: Operation S.A.V.E. is a VA gatekeeper training program provided by suicide prevention coordinators to veterans and those who serve veterans. The acronym "S.A.V.E" summarizes the steps needed to take in

recognizing and responding to a veteran in suicidal crisis. The training was designed for nonclinical employees and includes food service workers, registration clerks, volunteers, and police. It should also be viewed by ancillary/support staff or any other category not covered by the clinical training.

Comment and justification: To modify and update, VHA notes Operation S.A.V.E. has been retitled VA S.A.V.E. and released to the field for training. This update will be noted formally in policy upon pending re-certification of VHA Directive 1071, Mandatory Suicide Risk and Interventions Training for VHA Employees, December 22, 2017. VHA asks OIG to consider adding this clarification to the footnote.

Operation S.A.V.E. is a VA gatekeeper training program provided by suicide prevention coordinators to Veterans and those who serve Veterans. The acronym "S.A.V.E" summarizes the steps needed to take in recognizing and responding to a Veteran in suicidal crisis. The training was designed for nonclinical employees and includes food service workers, registration clerks, volunteers, and police. It should also be viewed by ancillary/support staff or any other category not covered by the clinical training. Note that Operation S.A.V.E. has been retitled to VA S.A.V.E. and is pending formal retitling in the re-certification of VHA Directive 1071. This occurred with the publication of VHA Memorandum 2021-10-12, Agency-Wide Required Suicide Prevention Training, dated 10/15/20.

3. VHA asks OIG to consider the following general comments in response to the subject draft report:

Comment 1

The COVID-19 pandemic has impacted health care operations nationally, including Suicide Prevention Coordinators community outreach efforts. VHA Office of Mental Health and Suicide Prevention would like to note alternative modalities have been utilized where appropriate during the pandemic to conduct community outreach.

Comment 2

Page 13, Paragraph 4, Sentences 4-8:

VHA recognizes OIG's concerns regarding timely placement of high risk for suicide-patient record flags from the time of referral. VHA's Suicide Prevention NOW 2021 Plank 4, Strategy 2, Develop a High Risk Flag Consult/Referral for SPCs to Assist Decision Making and Implementation of High Risk Flags (Consult) will include a national, standardized consult. This

standardized consult will allow facilities, Veterans Integrated Service Networks (VISN), and the Office of Mental Health and Suicide Prevention to monitor timeliness for High-Risk for Suicide Patient Record Flag placement. Development of this consult is on target for an enterprise- wide release in November 2021 and is expected to mitigate OIG's timely flag placement concerns.

Comment 3

Page 16, Recommendation 3

VHA notes this report did not include OIGs consideration of the potential negative impact of COVID-19 on facilities ability to engage in face-to-face training requirements and focus on the needs of the highest priority throughout the pandemic. VHA implemented the Non-Covid-19 Moratorium. Each site had the option to Opt-In or Opt-Out of the moratorium. Additionally, each site, at their discretion, may authorize the continuance of training for mission critical purposes. The purpose of the moratorium was to provide relief for all staff so as to focus on the pandemic. That relief is the highest priority at this time. Thus, VHA would like OIG to include this information and their consideration of this action within the report.

4. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Steven L. Lieberman, M.D.

Addendum to the Memorandum: OIG Response

The OIG appreciates the feedback from VHA and provides the following responses to the Acting Under Secretary for Health's requests for change. The OIG reviewed and considered the requests as noted below.

1. The OIG edited the report to clarify the subject of "Patient Record" Flags.
2. The OIG did not make changes because the VA S.A.V.E. course is pending formal retitling in the re-certification of VHA Directive 1071.
3. Comment 1: The OIG reviewed the required SPC outreach activities from October 1 through December 31, 2019, which was prior to the COVID-19 pandemic. The OIG cannot provide comment on activities conducted after this time frame.

   Comment 2: The OIG appreciates the Acting Under Secretary for Health's response to concerns about timely placement of patient record flags.

   Comment 3: The OIG recognizes that the COVID-19 pandemic has affected facility operations and face-to-face trainings. However, the OIG also considered the mental health effect of the pandemic on the veteran population as well as the importance of having well-trained staff to address suicide prevention needs.

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