DEPARTMENT OF VETERANS AFFAIRS
Under Secretary for Health
Washington DC 20420

June 8, 2016

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File Nos. DI-15-1267 & DI-15-2012

Dear Ms. Lerner:

I am responding to your request for supplemental information related to our August 12, 2015, report and February 9, 2016, supplemental report on the Phoenix Veterans Affairs Healthcare System in Phoenix, Arizona (hereafter, the Medical Center). Your request poses 5 additional questions covering both: 1) various aspects of the Medical Center's actions taken in response to recommendations included in the original August 2015 report; and 2) the results of the Department's additional investigation into the accessing of a whistleblower's electronic health record by certain staff of the Medical Center.

The enclosed supplemental report replies to the 5 questions and makes no additional recommendations to the Medical Center.

If you have any other questions, I would be pleased to address them. Thank you for the opportunity to respond.

Sincerely,

David J. Shulkin, M.D.

Enclosure

Department of Veterans Affairs (VA)
Supplemental Report
Phoenix VA Medical Center
OSC File Nos. DI-15-1267 and DI-15-2012
TRIM 2016-D-1252

The Under Secretary for Health (USH) requested that the Office of the Medical Inspector (OMI) assemble and lead a VA team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the Mental Health (MH) and Social Work (SW) Services of the Phoenix VA Healthcare System, (hereafter, PVAHCS) located in Phoenix, Arizona. Jared Kinnaman, a rehabilitation counselor, and Brandon Coleman, a substance abuse addiction counselor, both of whom consented to the release of their names, alleged that employees are engaging in conduct that may constitute violations of laws, rules or regulations, and gross mismanagement, which may lead to a substantial and specific danger to public health. The VA team conducted a site visit to PVAHCS on March 16–19, 2015, and issued its report on August 12, 2015. VA provided OSC a supplemental report in response to follow-up questions on February 9, 2016.

On May 5, 2016, OSC posed additional questions (here in italics and listed as A through E). This supplemental report addresses those questions.

A. *In Part C of the Supplemental Report, OMI notes, "Review of the documentation completed by psychiatrists from April through September 2015 was completed in December 2015." What are the results of this review and what, if any, changes are being made in response to the findings?*

The PVAHCS developed a process to assess professional competence for completing suicide risk assessments (SRAs); this process is now included in the clinician's Ongoing Professional Practice Evaluation (OPPE) conducted every 6 months. The Acting Chief of Psychiatry conducted chart reviews and reviewed all OPPE's from April through September 2015, and found that 85 out of 90 SRAs were completed by 18 different psychiatrists. The five SRAs not completed were the responsibility of five different providers. Although these five providers did not complete the SRA templated note for their individual patients, they did perform in each case a complete mental status evaluation and suicide assessment which they documented in the Veterans' progress note. Therefore, VA providers did assess the suicide risk of each of the 90 patients.

B. *In Part D, it is noted that Quality Management Department employees conduct random observations to ensure staff compliance with 1:1 patient monitoring requirements. How often are these observations occurring? Have there been any failures to comply and if so, what was done in response?*

The observations occur on a monthly basis at a minimum. From April 2015 through December 2015, Quality Management (QM) staff members performed random, unannounced direct observations on 51 patients assigned to 1:1 observations due to suicidal or homicidal ideations using a Joint Commission tracer method. For each direct

observation, the QM staff member found a patient safety observer (PSO) was in the presence of all Veterans on 1:1 observation. Based on these findings of 100 percent compliance, QM concluded that the 1:1 observation process was in place, and transitioned this program monitoring responsibility to the Emergency Department (ED) Nurse Manager. Between January and May 2016, the Nurse Manager conducted chart reviews to assess whether documentation was present in the nurses' notes indicating that a PSO had always been assigned to, and present with, Veterans requiring 1:1 observation. The Nurse Manager found evidence of 100 percent compliance, based on chart reviews. As a part of ongoing monitoring beginning on June 1, 2016, the QM staff will resume conducting random direct observations in the ED to assess compliance with the 1:1 observation requirement.

C. *Regarding Part E, has staff training been completed? If not, on what date will it be completed?*

Staff training has been completed.

D. *In Part J, regarding the additional training on patients with suicidal ideation that will be given annually, please provide additional information about this training and its materials. Further, will the training be mandatory?*

The Medical Center provided additional training about Veterans with suicidal ideation to all ED nursing staff. The training included a review of the revised Medical Center Policy entitled *Mental Health Crisis Evaluations,* and The Suicide Prevention Center of Excellence's Operation S.A.V.E (Signs of suicidal thinking, Ask questions, Validate the Veteran's experience and Encourage treatment and Expedite getting help). Operation S.A.V.E provides training about the signs of suicidal thinking, methods to determine whether a Veteran is suicidal, and options to offer the Veteran if he/she is suicidal; these options include treatment with a qualified provider, information about the National Suicide Hotline, and other steps to ensure the suicidal Veteran's safety and well-being. This training also included role-playing activities that required staff to dialogue with "potentially suicidal Veterans," determine whether they were suicidal, and provide appropriate guidance to help prevent suicide. This training is a mandatory part of New Employee Orientation.

E. *In Part T, it is stated that "the VHA Office of Informatics and Analytics has submitted a new service request for modifying the sensitive patient record warning methodology." What has been the response to this request and what changes have been made to the sensitive patient record warning methodology as a result?*

VHA Office of Informatics and Analytics (VHA OIA) submitted a new service request (NSR) to modify the existing warning displayed to users when accessing a record flagged sensitive, to add an additional warning based on set criteria for suspicious accesses, and to create a new report listing all suspicious accesses for more efficient auditing and identification of unauthorized accesses. VHA OIA developed

and approved the Business Requirements Document for the NSR. The NSR was submitted to the Clinical Capabilities Management Board in February 2016 for fiscal years 2018–2022 IT Multi-Year Program prioritization. VHA OIA is awaiting notification about prioritization and funding of this request. VA's Office of Information and Technology does not complete development work on an NSR until it is prioritized and funded.