DEPARTMENT OF VETERANS AFFAIRS
Under Secretary for Health
Washington DC 20420

APR 10 2017

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 No. DI-15-4906

Dear Ms. Lerner:

I am responding to your February 15, 2017, request for a supplemental report on eight specific questions related to corrective actions at the Albuquerque VA Medical Center (the Medical Center), Albuquerque, New Mexico, following VA's report of November 4, 2016. A whistleblower at the Medical Center had made three allegations of shortcomings of a Suicide Prevention Coordinator. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

The November report did not substantiate either of the first two allegations, found one instance only of the third allegation, and made eight recommendations to the Medical Center and two to the Veterans Health Administration (VHA). Both the Medical Center and the VHA Program Office submitted action plans in response to their respective recommendations and have now completed many of these actions as detailed in the enclosed supplemental report.

Please let me know if I can be of further assistance.

Sincerely,

Poonam L. Alaigh, M.D.
Acting

Enclosure

Department of Veterans Affairs Supplemental Report
To the
Office of Special Counsel
OSC File Numbers DI-15-4906

New Mexico VA Health Care System
Albuquerque, New Mexico

March 24, 2017

TRIM 2017-D-838

At the direction of the Secretary of the Department of Veterans Affairs (VA), the Under Secretary for Health asked the Office of the Medical Inspector (OMI) to investigate complaints lodged with the Office of Special Counsel (OSC) concerning the New Mexico VA Health Care System, (the Medical Center) in Albuquerque, New Mexico. An anonymous whistleblower alleged that an employee may have engaged in actions that constitute violations of law, rule or regulation; gross mismanagement; an abuse of authority; and a substantial and specific danger to public health and safety. The VA team conducted a site visit to the Medical Center on April 26–28, 2016, and submitted its report on November 4, 2016.

On February 15, 2017, OSC emailed a request to the Department for a supplemental report to address eight specific questions related to VA's November report. OSC's questions, sequenced A – H, and VA's responses follow:

Question A

On page 11, the report states that "the relevant VHA Directives, SPC Guides, and local policy do not identify a time-frame requirement from Veteran assessment as high risk of suicide (HRS) to (Patient Record Flag) PRF placement in the EMR. Can you cite a specific reason why such a policy does not exist? The possibility of a patient being identified as being a high risk of suicide but not having a PRF placed in their file until months later appears to represent a significant risk to that patient's treatment.

VA's Response

The Veterans Health Administration (VHA) has determined that a standard timeframe for placing a HRS PRF should be required. Revisions to the HRS Patient Record Flag Directive, currently a collaboration effort with Office of Suicide Prevention (OSP), Coordination of Care, and the National Center for Patient Safety, will include a standard timeframe for placing a high-risk flag once a Veteran is identified as HRS. In the meantime, while the Directive is in the revision and approval process, relevant guidance from the VHA Handbook is available: VHA Handbook 1160.06 1, "As part of the discharge planning process, all patients admitted to an inpatient unit for evaluation of

suicide risk must be re-evaluated and flagged for high risk for suicide if necessary and not already done." VHA expects to complete this action by July 2017.

Question B

On page 11, the report states that [redacted] made a principle-based decision to focus on the acute need of Veterans, instead of conducting the 90-day re-evaluations for Veterans with HRS PRFs. What evidence is there to suggest that this occurred beyond [redacted] statements?

VA's Response

[redacted] productivity and workload during this period of time is sound evidence that [redacted] focused on acute needs of Veterans and is supported by medical record documentation, clinic encounters, calendar appointments, as well as testimony provided during the initial site visit. [redacted] responded judiciously to referrals for Veterans with acute suicidal ideations and attempts, as well as to referrals from the Veterans Crisis Line; [redacted] led several suicide prevention group therapy sessions; conducted numerous individual therapy sessions; offered monthly staff member and outreach training; followed up on Veterans recently discharged from inpatient units; and responded to frequent consultative requests for Suicide Prevention (SP) services.

Question C

What developments, if any, have there been in "institut[ing] a standardized process that utilizes the Suicide Behavior Report (SBR) to document each incident of suicidal behavior, provide training on this process to all clinicians, monitor for compliance, and address noncompliance" as was recommended on page 14?

VA's Response

As of March 10, 2017, the Medical Center has developed and approved a new Standard Operating Training Procedure for New Employee Orientation that reviews Suicide Prevention and Psychiatric Emergencies. The training includes a review of required documentation, including the SBR. The Medical Center also has a newly revised Standard Operating Procedure (SOP) regarding the mandatory completion of a SBR for all reports of suicidal behaviors. The SOP reviews the policy that mandates all clinical staff complete the SBR, and also provides direction for nonclinical staff to follow to ensure the SBR is complete for each report of suicidal behavior. The Medical Center has proposed a Talent Management System (TMS) training course covering Suicide Behavior Reporting, which will be mandatory for all clinical staff. The proposed curriculum is currently under review by the Medical Center's Education Service. Attendance rosters for both training sessions will be maintained in TMS. SP staff will monitor compliance by conducting chart reviews on patient referrals to ensure the SBR is appropriately utilized for reported instances of suicidal behaviors.

Question D

What developments, if any, have there been in revising the policies, procedures, and guidelines to reconcile differences, address conflicting information, and increase clarity about suicide prevention efforts, as was recommended on page 14?

VA's Response

VHA revised its policies, procedures and guidelines to reconcile differences, address conflicting information, and increase clarity about suicide efforts. The concerns addressed are:

1. Should VHA label all Veterans reporting a suicidal thought or calling the National Suicide Hotline as HRS?

   Currently high risk flags (HRF) are clinical assessments performed by licensed practitioners in consultation with the suicide prevention team (SPT). VA/Department of Defense clinical practice guidelines are the recommended standard to establish level of risk that goes beyond suicidal thoughts or calling a suicide hotline. Not all those who call the Veterans Crisis Line (VCL) are in crisis or suicidal, and not all those who have suicidal thoughts have intentions for suicide. VA endorses following best clinical assessment guidelines in establishing HRS, to not mislabel Veterans and to focus care on the Veterans clinically identified as HRS.

2. Should VHA require an HRS PRF on all Veterans labeled as high risk?

   VHA has determined that Veterans identified as high risk for suicide should have a HRS PRF. The HRS PRF Directive is currently under revision. These revisions will provide additional clarity on placement of an HRF and will require any Veteran clinically determined to be at high risk to have an HRS PRF in place. During the Directive's revision and approval process, relevant guidance from the VHA Handbook is available: VHA Handbook 1160.06 1 states, "Patients who present for admission for suicidal ideation must be assessed for suicide risk and placement of a Patient Record Flag indicating that the patient is a high risk for suicide must be considered. Records of patients who present for admission for suicide attempt are to be flagged.....whether the patient is admitted or not." VA expects to complete the revisions to the Directive in July 2017.

3. Should VHA mandate a specific timeframe for placing an HRS PRF on the chart of a patient labeled high risk?

   VHA determined that a standard timeframe for placing an HRS PRF should be required. Revisions to the HRS Patient Record Flag Directive, currently a collaborative effort with the OSP, Coordination of Care, and the National Center for Patient Safety, will include a standard timeframe for placing an HRF once a

Veteran is identified as HRS. In the meantime, while the Directive is in the revision and approval process, relevant guidance from the VHA Handbook is available: VHA Handbook 1160.06 1 states, "As part of the discharge planning process, all patients admitted to an inpatient unit for evaluation of suicide risk must be re-evaluated and flagged for high risk for suicide if necessary and not already done."

VHA Directive 2008-036 advises, "All staff need to recognize that any Veteran may be at risk for suicide, regardless of the flag status on the Veteran's chart....In the event of concerns for suicide risk, referrals are to be made to the suicide SPC...Front line staff need to be aware that if they are concerned about patient safety....local safety procedures need to be followed."

4. Should VHA mandate a specific timeframe to transfer ownership of a HRS PRF when a patient moves?

   The OSP deployed instruction to all suicide prevention coordinators (SPC) at all sites on November 14, 2016, that flag ownership should be transferred at the time the Veteran has identified a new physical address and before the first appointment at the new site of care.

Question E

What developments, if any, have there been in assessing the current workload of the Suicide Prevention Team and making appropriate staffing adjustments to fulfill its mission, as was recommended on page 14?

VA's Response

The Medical Center completed a review of the SP team workload and provided a report on March 11, 2017. All SPC's responsibilities are now cross-covered by both SP Case Managers. The SPC Team Priority and Assignment of Duties SOP clearly outlines all SP team members' duties and responsibilities. Both SP Case Managers have verified access to place or remove HRS PRF, to complete Suicide Prevention Application Network reports, to respond to VCL referrals and cross-cover SPC duties as necessary. For the first time is several years, the SP team has its full complement of staff and has had no vacancies since August 22, 2016. The team is successfully meeting the demands and requirements of the SP program, and a plan is now in place for cross-coverage of SPC duties that ensures continuation of the SP program in the event of a planned or unplanned absence of the SPC.

Question F

On pages 16-18, the report describes the account of Veteran 3. On page 17, the report notes that VA staff attempted to have Veteran 3 placed in a Residential Rehabilitation Treatment Program (RRTP), but the patient refused. Later, the report says that

[redacted] *"did not initiate a HRS Category 1 PRF for Veteran 3 on the date of his discharge because the Veteran had planned to participate in an RRTP. Once it became clear that Veteran 3 was not going to participate in an RRTP, why was a PRF not placed on his records?*

VA's Response

As stated in the report on page 18, the Veteran's treatment plan changed on June 10, when he declined admission into the Residential Rehabilitation Treatment Program. The SP Case Manager [redacted] received notification of this treatment plan change on June 12. VA found no evidence that the SP Case Manager informed the SPC of this change in treatment plan. The SP Case Manager should have communicated this significant change to [redacted] who could have placed a PRF on the Veteran's record.

Question G

Why is there no time limit mandated in VHA Directives, local policy, or bylaws, for clinicians to acknowledge receipt of a note?

VA's Response

Authors sign their notes, and assign additional staff to certify acknowledgement of its contents. The acknowledgement of notes is an "additional signer" option; acknowledgment does not indicate responsibility for, or concurrence with, content.[1] Therefore, no time limit is warranted for acknowledging receipt.

Question H

How does the Medical Center intend to "reinforce the importance of transferring ownership of HRS Category 1 PRFs when transferring a Veteran's care to another facility" as recommended on page 21?

VA's Response

The OSP deployed instructions to all SPCs at all sites on November 14, 2016, that flag ownership should be transferred at the time a Veteran has identified a new physical address and before the first appointment at the new site of care.

[1] VHA Directive 1907.01: *Health Information Management and Health Records*, March 19, 2015.