# Congress of the United States
Washington, DC 20515

May 18, 2021

Honorable Denis McDonough
Secretary of Veterans Affairs
Department of Veterans Affairs
810 Vermont Ave NW
Washington, DC 20420

Dear Secretary McDonough,

As the Department of Veterans Affairs continues to strengthen its efforts in caring for our nation's veterans, we want to thank you for your ongoing leadership in the midst of the COVID-19 pandemic. It is the responsibility of VA to care for our nation's veterans and we are grateful for your continued commitment to that charge. In support of that commitment, we want to draw your attention to the VA Office of the Inspector General's (OIG) recent report, ***Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix VA Health Care System, Arizona*** (Report # 20-02667-93). This report documents a case in which inadequate mental health treatment and monitoring planning, and significant management and policy lapses, potentially contributed to a veteran's death by suicide in Phoenix in 2019. We write to bring the findings of this report to your attention and to offer our support as the VA strengthens mental health care for all veterans and works to ensure that lapses like those documented in this report do not occur at facilities within the VA system.

The OIG found that the Phoenix VA Health Care System provided an inadequate mental health treatment and monitoring plan, a delayed staff response to a family member's phone call, delayed community care consult management, and demonstrated deficient administrative procedures in relation to the veteran patient. This patient had previously received intermittent care between summer 2017 and summer 2018, during which time the patient had reported suicidal ideation and three suicide attempts in 2018. The patient was immediately treated until determined to be stable and low risk. Months later, when the patient returned to the VA requesting to reestablish mental health care, the social worker relied on a suicide risk assessment completed eight months prior, despite potential decompensation and a family member's report of concern over the patient's increased stressors and use of threatening gestures. The patient's initial community care psychology consult was delayed and then incorrectly scheduled, both of which further delayed critical treatment. Additionally, the OIG found that staff did not complete the required outreach efforts in response to the patient's missed primary care appointment the day before the patient's death by suicide.

At the conclusion of its report, VA OIG makes seven recommendations for policy changes to the Phoenix VA Facility Director to close the gaps in performance that contributed to this horrific outcome.[1] Specifically, the recommendations address shortfalls related to "[patient] care, suicide risk assessment, [electronic health record] documentation, timely community care authorization,

[1] See Appendix 1 for the list of recommendations.

missed appointment procedures, community care scheduling accuracy, and timely completion of behavioral health autopsies."[2] We are reassured by the prompt response to this report by Dr. Alyshia Smith—the new Medical Center Director of the Phoenix VA Health Care System—evidenced by a detailed action plan to implement the OIG's seven recommendations and her confirmation that work on many of these recommendations has already begun. Furthermore, we are encouraged that the Phoenix VA has been transparent with Congressional offices, holding a conference call in conjunction with the publication of the report and in welcoming feedback and collaboration on potential improvements.

The Phoenix VA Health Care System is actively taking steps to prevent future errors of this magnitude, and we are committed to conducting oversight to ensure that work is completed. However, we would also like to take this opportunity to begin a dialogue with you to identify and address the potential for similar gaps in care to occur and possibly endanger veterans across the VA Health Care System.

As part of this dialogue, we request that you join us for a staff-level call to discuss the following questions:

1. What is VA's current policy on the use of the standardized suicide risk screening tool for mental health intake evaluations? Does VA plan to consider more stringent, or more standardized guidance?[3]
2. What is the feasibility of conducting an audit to ensure that all VHA facilities are in compliance with recommendations #2-7? What other mechanisms exist to encourage compliance?
3. OIG's report made apparent the impact of staffing shortages on administrative failures in this case. Does VA track which facilities may have staff shortages, and therefore may be at higher risk for similar violations? How does VA respond to these staffing shortages?
4. What VA-wide steps has VA taken to prevent incidents like this from occurring in the future, including additions or changes to staff training?
5. What specific role does the VA play in providing technical assistance and oversight to ensure the implementation of OIG Report recommendations? Does the Office of Mental Health and Suicide Prevention have a role to play here?
6. What steps has VA taken, or will VA be taking, to ensure mental health care and suicide prevention in the transition to and use of Community Care Network (CCN).
7. What additional resources, assistance, or fixes from Congress does VA need to better address the root causes of the problems outlined in the report?

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[2] Department of Veterans Affairs Office of the Inspector General, Report #20-02667-93, March 23, 2021, p. iii, https://www.va.gov/oig/pubs/VAOIG-20-02667-93.pdf.

[3] In the report's inspection results, VA OIG points out, as "of December 31, 2018, VHA mandated the use of a standardized suicide risk screening tool for all mental health intake evaluations at least annually following the initial evaluation. [17] VHA instructs that suicide risk screening should be completed "based on clinical judgment, when there are stressors, warning signs for suicide, or worsening clinical conditions." [18] Facility policy requires completion of a suicide risk assessment, and using the designated note template whenever a patient for whom suicide risk is clinically relevant "undergoes significant clinical decompensation or is judged to be under increased stress."[19]" Department of Veterans Affairs Office of the Inspector General, Report #20-02667-93, p. 9.

As you continue to care for veterans' physical and mental health, we respectfully request you take proactive steps to prevent a situation like this from reoccurring in any VA facility. We hope this VA OIG report serves as a call to action for not only the Phoenix VA, but the Department as a whole.

We must ensure that no veteran who reaches out for life-saving mental health assistance falls through the cracks. We look forward to working with you to ensure that the Department and local VHAs are well-prepared to provide our nation's veterans with the mental health care they need. Please reach out to Alex Sabater with Sen. Kelly's office (alex_sabater@kelly.senate.gov) and Mariel Jorgensen with Rep. Gallego's office (mariel.jorgensen@mail.house.gov) to schedule this call.

Sincerely,

Mark Kelly
United States Senator

Ruben Gallego
United States Representative

**Appendix 1:**
**VA OIG Recommendations 1–7**

1. The Phoenix VA Health Care System Director conducts a full review of the patient's care to determine if administrative action is warranted, consulting with Human Resources and General Counsel offices as appropriate.
2. The Phoenix VA Health Care System Director ensures that staff complete suicide risk assessments consistent with Veterans Health Administration and Phoenix VA Health Care System policies.
3. The Phoenix VA Health Care System Director ensures timely and accurate completion of electronic health record documentation.
4. The Phoenix VA Health Care System Director evaluates the community care psychology consult authorization timeliness and takes action as warranted.
5. The Phoenix VA Health Care System Director conducts a review of Primary Care Clinic missed appointment procedures and ensures patient follow-up and staff training, as appropriate.
6. The Phoenix VA Health Care System Director evaluates scheduling accuracy of mental health community care psychology consults and takes action as appropriate.
7. The Phoenix VA Health Care System Director ensures timely completion of behavioral health autopsies, consistent with Veterans Health Administration policy, and monitors for ongoing compliance.