CARING FOR VETERANS IN CRISIS: ENSURING A COMPREHENSIVE HEALTH SYSTEM APPROACH

HEARING

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C O N T E N T S

WEDNESDAY, JANUARY 29, 2020

Page

OPENING STATEMENTS

Honorable Mark Takano, Chairman 1
Honorable David P. Roe, Ranking Member 3

WITNESSES

Ms. Renee Oshinski, Deputy Under Secretary for Health for Operations and Management, Veterans Health Administration, U.S. Department of Veterans Affairs 5

Accompanied by:

Dr. David Carroll, Executive Director, Office of Mental Health and Suicide Prevention, Veterans Health Administration, U.S. Department of Veterans Affairs

Mr. Frederick Jackson, Senior Executive Director, Office of Security and Law Enforcement, U.S. Department of Veterans Affairs

Dr. Julie Kroviak, Deputy Assistant Inspector General for Healthcare Inspections, VA Office of Inspector General U.S. Department of Veterans Affairs .. 7

Dr. C. Edward Coffey, Affiliate Professor of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, South Carolina 8

APPENDIX

PREPARED STATEMENTS OF WITNESSES

Ms. Renee Oshinski Prepared Statement 49
Dr. Julie Kroviak Prepared Statement 57
Dr. C. Edward Coffey Prepared Statement 69

STATEMENTS FOR THE RECORD

American Legion 133
American Federation of Government Employees 134

CARING FOR VETERANS IN CRISIS: ENSURING A COMPREHENSIVE HEALTH SYSTEM APPROACH

WEDNESDAY, JANUARY 29, 2020

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
Washington, D.C.

The committee met, pursuant to notice, at 10 a.m., in room 210, House Visitors Center, Hon. Mark Takano (chairman of the committee) presiding.

Present: Representatives Takano, Brownley, Lamb, Levin, Brindisi, Rose, Pappas, Luria, Lee, Cunningham, Cisneros, Peterson, Sablan, Allred, Underwood, Roe, Bilirakis, Radewagen, Bost, Bergman, Banks, Barr, Watkins, Roy, and Steube.

OPENING STATEMENT OF MARK TAKANO, CHAIRMAN

The CHAIRMAN. Good morning. I call this hearing to order. I am not sure whether a quorum is present, but it does not matter—so I am informed that a quorum is present.

Pursuant to Committee Rule 4 and House Rule XI, Clause 2, the chair may postpone for the proceedings today and, without objection, the chair is authorized to declare a recess at any time.

This committee's top priority is addressing the public health crisis of veteran suicide, and this is why the first Full Committee hearing of 2020 will explore Veterans Health Administration's (VHA's) adherence to policies on suicide prevention, care coordination, and medical facility safety and environment of care.

We will also examine training for VA employees to identify veterans at risk of suicide, and VA Police's role in identifying veterans in crisis on VA campuses.

Today's hearing is a crucial step toward a truly comprehensive approach to reducing veteran suicide by focusing on the ways VA can provide a safe, functional, and effective environment for veterans in crisis.

Suicide remains a national crisis. More than 39,000 died by suicide in 2017 in the United States and, of these, 6,139 were veterans of the United States Armed Forces.

As Ranking Member Roe astutely noted in a recent interview, almost as many veterans due by suicide each day in this country than died in combat casualties or accidents in Afghanistan over the course of last year. VA estimates that 20 veterans and servicemembers die by suicide each day. This is simply not acceptable. VA data indicates that of these 20 veterans and

servicemembers, 20 had received care in the past 2 years from a VA—excuse me, six had received care in the past 2 years from a VA health care provider.

Our focus is not only on medical staff directly treating veterans in crisis, we need to examine and improve how VA as a whole is working to create comprehensive approaches to reduce risk and prevent suicides among veterans in its care.

Thousands of employees across VA work hard every day to provide high-quality, life-saving mental health care to veterans and to help them access additional supportive services. VHA is a leader in suicide prevention research and evaluation, and many of VHA's discoveries have informed better screening, assessment, treatment, and management for mental health and suicide prevention for all Americans.

VHA has also established many policies and training requirements for facility-level leaders, mental health providers, suicide prevention coordinators, and other staff.

These efforts are commendable and credit must be given to VA for its work. Yet, since the beginning of 2018, the VA Inspector General has published at least a dozen reports on facility security, environment of care, and investigations into a lack of care coordination at VA facilities.

According to today's testimony, quote, "The Office of Inspector General (OIG) found inadequate coordination of care to be an underlying theme in every one of its recently conducted reviews," end quote. Whether it was within a mental health treatment team, with non-mental health providers during the discharge process, or by care providers with patients or their family, there was an issue with care coordination.

In two tragic instances in the Minneapolis VA Medical Center, emergency department staff failed to report one patient's suicidal ideation to the facility's suicide prevention coordinator. In a different case at this very same facility, the OIG determined that VA's in-patient treatment team failed to coordinate with the patient's out-patient treatment team. Both of these incidents showcase a failure in care coordination that could have prevented these veterans from completing suicide.

The rate of suicide among veterans in VA's care has been steadily increasing over the past decade, despite significant investments by VA toward better suicide care. VA spent $64.7 billion on mental health services in the last decade, including almost $9 billion just last year, but we have not moved the needle to stem the rate of suicide.

We cannot tolerate any number of veteran suicides, let alone 20 a day. VHA's research discoveries and its policies must be put into practice in every VA facility for these policies and treatment protocols to be effective.

I call to mind—I will depart from the script just slightly, but if we think about the accident rate in aviation and commercial airlines, it is pretty good. This is what I think I want this committee and this hearing today to drive at.

The Centers for Disease Control and Prevention and VA have both promoted the use of an evidence-based public health approach. It requires VA to define the problem, identify risk and protective

factors, and develop and test prevention strategies. When those strategies are found to be effective, VA must ensure that they are widely and systematically adopted.

For this public health approach to work, VA must ensure its hospitals and clinics adhere to uniform environment-of-care standards; it must prioritize circumstances for suicide prevention coordinators at VA hospitals and clinics to coordinate care for veterans in crisis. All, I underscore all VA clinicians, along with every other VA employee in every VA facility must have the training to identify veterans in crisis and be empowered to act to save veterans' lives. VA already has dedicated and hard-working staff who believe in the organization's mission. By incentivizing staff to speak up, we can help VA move toward a culture of continuous quality improvement that works to reduce veteran suicide.

As the Office of Inspector General noted at the West Palm Beach VA, the patient safety manager did the right thing and reported concerns to leadership about hazards in the in-patient mental health unit that represented, quote, "an immediate threat to life," end quote, but the employee's concerns were dismissed and eventually a veteran died. No employee should be discouraged from reporting serious concerns about facility safety and, when employees raise concerns, VA leaders need to take them seriously.

In another example, at the Chillicothe VA Medical Center in Ohio, a veteran who was supposed to be at arm's reach from a facility observer at all times escaped view and jumped from a window. The OIG determined VA staff did not adhere to the facility observer policy and the facility leadership failed to monitor staff compliance. The right policy was in place, but the policy was not followed.

My hope is that today's hearing will expose what must be done to ensure uniform adherence to policies, treatment protocols, and care coordination at VA hospitals and clinics, and how Congress can work with VHA to enforce these standards. This is not about holding one single individual accountable; instead, our approach must be to understand why policies are not being followed, whether training is adequate and utilized correctly, and how we can mitigate hazards that represent a threat to patients in crisis at VA. This crisis is not new, but our solutions and our behavior must be.

I now recognizing the ranking member, Dr. Roe, for 5 minutes for any opening remarks that he may have.

Dr. Roe.

OPENING STATEMENT OF DAVID P. ROE, RANKING MEMBER

Mr. ROE. Thank you, Mr. Chairman.

During today's hearing, we will assess how the Department of Veterans Affairs coordinates care for at-risk veterans, examining incidences of suicide in VA medical facility, including two in-patient suicides at the VA medical facilities in West Palm Beach, Florida, as the chairman mentioned, and Minneapolis, Minnesota, that were subject to recent reports by the VA Inspector General.

My prayers are with those of loved ones of the two veterans and with the loved ones of each of the 20 of their brothers and sisters in arms who die by suicide every day in this country. Every time a life is lost to suicide, it is a tragedy. When suicide occurs in a

hospital, a place where the most vulnerable go for help, that loss feels particularly acute. VA is a leader in suicide prevention in many respects, but if the policies and procedures that VA has in place to screen veterans for suicide tendencies and ensure their safety while they are receiving VA care is not consistently applied, the consequences can be deadly.

Led by Secretary Wilkie, the Trump administration has made suicide prevention VA's top clinical priority and call for a broad-based public health approach, in recognition of the fact that suicide is not solely a mental health problem and that preventing it will require addressing the numerous health and economic, relational, and other complex factors that cause an individual to consider ending their life.

Mr. Chairman, as you were speaking, something occurred to me. We are involved and policies and procedures are important in preventing, but we need to move a step back before we get to that and prevent it before we ever get to those, if you can see what I mean. We are actually at the point where we should be preventing a person ever being in the hospital and I think that is one of the things we need to work on. That is the rationale behind President Trump's Executive Order that created the PREVENTS Task Force on March 5th, 2019.

I welcomed Dr. Van Dahlen, the PREVENTS Task Force Executive Director, to my district last month, which we had six roundtables and a veterans town hall while she was in Johnson City, and discussed the various issues that are involved that I just mentioned and what the other task force members are doing to break down barriers that prevent at-risk individuals from getting the help they need and disseminate best practices for suicide prevention across all levels of government and the private sector.

Chairman Takano announced earlier this week that the committee will be adopting President Trump and Secretary Wilkie's model by tackling the veteran suicide crisis from a holistic perspective and aligning our various lanes of effort under a single umbrella goal, preventing veteran suicide. We have no more important mission and I certainly support that effort.

I also want to note, Mr. Chairman, as we sit here today, the Senate Veterans' Affairs Committee is meeting to mark up the companion to the Improve Act, General Bergman and Congresswoman Houlahan's suicide prevention bill that we spent so much time on last fall. Today's hearing will painfully illustrate once again just why the Improve Act is so necessary and why it must include an ability for suicidal veterans to receive some level of clinical care from VA's partners in the community, because a veteran in crisis, every door should be opened to having them get the help that they need.

Finally, as we discuss the failures and missed opportunities in West Palm Beach and Minneapolis, and other locations detailed in the IG's testimony this morning, I don't want to underestimate how difficult this work is. Suicide is endlessly complex and hindsight is always 20/20.

I am grateful to the thousands of VA staff around the country who do their best every day to serve the veterans who are struggling the most. Their work is unquestionably life-saving. I thank

them for doing it and encourage them to stay the course and keep fighting the good fight, just as their patients did in uniform.

With that, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Dr. Roe.

This morning we will move on to—we will hear from Dr. Renee Oshinski, Deputy Under Secretary for Health Operations and Management at VA. Welcome, Dr. Oshinski. She is accompanied by Dr. David Carroll, Executive Director of the Office of Mental Health and Suicide Prevention. Good to see you, Dr. Carroll. Mr. Frederick Jackson, Senior Executive Director of the Office of Security and Law Enforcement. Welcome, Mr. Jackson.

We also have Julie Kroviak, Deputy Assistant Inspector General for Healthcare Inspections, who offer insights about gaps and barriers that are plaguing VA's ability to properly coordinate care for at-risk veterans and abate hazards that represent a threat to suicidal patients on VA campuses.

Finally, we are also joined by Dr. C. Edward Coffey, Affiliate Professor of Psychiatry and Behavioral Sciences at Medical University of South Carolina. He is a leading expert on achieving system-wide culture change within a health system in order to reduce suicide deaths.

We will begin with Ms. Oshinski. You are recognized for 5 minutes for your opening statement.

STATEMENT OF RENEE OSHINSKI

Ms. OSHINSKI. Thank you. Good morning, Chairman Takano, Ranking Member Roe, and members of the committee. Thank you for the opportunity to come today to discuss the Department of Veterans Affairs' policies and procedures related to suicide risk and the environment in which we care for those veterans experiencing a mental health crisis.

I am accompanied today by Dr. David Carroll and Mr. Frederick Jackson.

Suicide is a complex issue with no single cause. It is a national public health issue that affects people from all walks of life. The Centers for Disease Control and Prevention (CDC) tells us that deaths by suicide have risen 30 percent across the Nation.

VA has embarked on a journey to become a High Reliability Organization, an HRO, to eliminate risk to veterans who receive care at the VA. This journey is a long-term commitment to our veterans and to our workforce to continuously improve and drive to zero harm across VHA, drawing on lessons learned from other industries, other health systems, and leading VHA facilities.

Learning from Dr. Coffey's work, we translate zero harm to zero suicides. We have begun a multi-prong strategy that places veterans at the center of care from the VA, as well as from State and local governments through our Governor's and Mayor's Challenges.

Our Suicide Risk Identification Strategy is the most extensive standardized suicide risk screening and assessment process in any industry, but we are continuing to research and refine to make our tools even better.

While we are strengthening our community network and proactively engaging veterans before crisis, it is imperative that we equip staff with the training and tools to intervene when veterans

present in a mental health crisis. We have a network of over 400 suicide prevention coordinators. They facilitate the implementation of these strategies within their specific catchment areas.

Unfortunately, there are times when our engagement and care coordination is not enough. In those cases, we conduct robust reviews of each case with the goal of learning ways to improve our care, as we strive to become that High Reliability Organization that our veterans deserve.

An HRO promotes a just culture. We do not blame individuals, we generally have to focus on ways that we improve the systems that support those individuals. One key area has been the review of our physical infrastructure and environmental safety, with the focus on reducing hazards that are normally associated with suicides.

In conjunction with our National Center for Patient Safety, we developed the Mental Health Environment of Care Checklist. This tool is used by interdisciplinary safety inspection teams to assess the environment for hazards and determine actions that need to be taken to protect our veterans. The rate of suicide prior to the implementation of the checklist was 4.2 deaths per 100,000 admissions, it is now at less than 1 per 100,000 admissions.

VHA has recently mandated that all medical centers with an acute mental health unit install over-door alarms. All facilities are expected to be compliant by the summer of 2020; however, most medical centers have already finished the installation. This is an example of high reliability. When deficiencies are found, VHA has the opportunity to scale innovative solutions across the enterprise.

Our Emergency Departments (ED) are another high-risk area. All patients are screened during the visit for suicide and homicide risk. The ED directive is being revised to ensure that all EDs have at least one psychiatric intervention room. We are working toward standardizing our clinical processes in these EDs. Many sites have made permanent police officers stationed in emergency departments, others patrol them as needed.

We work with our police force to heighten awareness to improve surveillance of parking lots and parking structures. We are installing deterrent devices that inhibit self-inflicted harm on exposed roofs of parking garages. With increased rounding, we can reduce opportunities for suicides when VA Police are alerted and can take actions to stop veterans and keep them safe from harm.

Recently, in Cincinnati, a VA police officer working a parking detail observed a female veteran attempting self-harm on the sixth floor of the garage. After attempts to verbally de-escalate the situation, two officers and an employee pulled her to safety.

Collaboration between law enforcement and health care professionals is crucial when responding to veterans at risk. Our police officers have over 30 hours of classroom training specific to de-escalation and conflict management, and continue to focus on suicide awareness and prevention. Over the course of 2019, VA Police have intervened to stop veteran self-harm in many instances, including in Loma Linda, Murphysboro, Detroit, and Syracuse.

All of us are saddened when any person attempts to take their life. We appreciate this committee's continued support and encouragement as we identify challenges, solutions, and opportunities to

apply evidence-based practices that result in the reduction of death by suicide of our Nation's veterans.

Thank you for the opportunity today. This concludes my testimony.

[THE PREPARED STATEMENT OF RENEE OSHINSKI APPEARS IN THE APPENDIX]

The CHAIRMAN. Yes. Next is Dr. Julie Kroviak, you are recognized for 5 minutes for your opening statement.

STATEMENT OF JULIE KROVIAK

Dr. KROVIAK. Thank you. Chairman Takano, Dr. Roe, and members of the committee, thank you for the opportunity to testify today on a topic that not only impacts veterans and their families, but the entire country: Ensuring our Nation's veterans receive timely access to the highest quality of mental health in a setting that is comfortable, safe, and respectful of their privacy and unique experiences.

Prior to joining the OIG in 2014, I had the honor of serving veterans as their primary care physician for over a decade at VA. Treating veterans with complex mental health care needs not only requires sophisticated clinical skills, but also training and compliance with policies and procedures to guide seamless coordination of care.

I witnessed inspirational recoveries and successful reintegration into civilian life, but I, like other health care providers, also experienced grief and loss when a patient died by suicide, despite receiving quality mental health care.

The OIG shares this committee and VA's priority to improve VHA's mental health and suicide prevention capabilities. We recognize the significant work VA's dedicated mental health providers and other professionals are doing; however, there are still considerable challenges.

VHA's effort in suicide prevention, including the Veterans Crisis Line, have been largely directed at crisis intervention, but the opportunity to intervene once a person decides on self-harm is very short, often less than an hour before the actual attempt. For veterans, it is even more fraught with peril, because they are very likely to use firearms.

To significantly reduce suicide and improve veterans' lives, prompt and effective mental health treatment must be paired with a wide variety of additional approaches. For example, VA has promoted firearm safety by urging veterans to secure guns with locks, remove firing pins, and store firearms where they are not easily accessed.

My written statement discusses numerous reports the OIG published in recent years, detailing veterans' challenges in accessing and receiving high-quality mental health care within VHA. Tragic events such as suicides are the most publicized and are typically understood to be the result of unrecognized, untreated, or undertreated mental health disorders. Because of this, much of our work focuses on the complete health care journey of those veterans with a wide variety of mental health diagnoses and treatment needs.

Our reports identified deficiencies in how VHA staff coordinated care for veterans in mental health crisis, as well as the quality of the environment where veterans receive that care.

On the first point, we found breakdowns in communication between members of the mental health treatment team. We also found communication failures between mental health and other clinical providers, community resource contacts, families, and caregivers. Such gaps in communication and care coordination weaken effective management and discharge planning, and ultimately put patients at risk for serious complications and potentially devastating outcomes.

While policies promoting effective communication may have been in place, staffing shortages, inconsistent training, and leadership failures compromised patient management.

We also found risks in the environment where veterans receive their care and made many recommendations to VHA aimed at ensuring a safer therapeutic setting by correcting structural and other hazards that are unique to high-risk patient care. The recommendations also support staff and visitor safety.

We take a proactive approach to evaluating the environment of care and continuously review site-specific allegations related to cleanliness, safety, and facility maintenance. This supports VHA's work to maintain a clean and safe, healing, recovery-oriented environment, and is even more important in areas often associated with high risks of harm to patients such as locked mental health units.

Despite VA's efforts, there are significant challenges ahead. VHA must continue to focus attention on outreach efforts, providing all stakeholders with evidence-based tools that not only help identify high-risk veterans, but also encourage those veterans to engage in the care they need.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or other members of the committee may have.

[THE PREPARED STATEMENT OF JULIE KROVIAK APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you.

Dr. Coffey, you are recognized for 5 minutes for your opening statement.

STATEMENT OF C. EDWARD COFFEY

Dr. COFFEY. Good morning, Chairman Takano, Dr. Roe, and members of the committee. Thank you for inviting me here today to participate in this very important conversation about the public health crisis of suicide in our country.

You requested that I share with you our experiences at a non-VA health system in implementing a comprehensive suicide prevention strategy, and in my written comments submitted earlier I described the work that we began at Henry Ford Health System about 20 years ago known as "perfect depression care."

In my comments this morning, I would like to briefly describe that model, and then dive into a bit of the detail around Zero Suicide and how it might apply as a model for other health systems.

Our adventure began back in 2001 when the Institute of Medicine published its groundbreaking report, "Crossing the Quality Chasm." You will recall that that report called for a sweeping overhaul of America's health care system. It was described as badly broken and not repairable; it had to be overhauled and transformed. The report also provided a model for how we might move forward to create that transformation.

Now, in response to the report, the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement launched a national collaborative called Pursuing Perfection, and the goal of that collaborative was to incentivize and support health care systems to use the Chasm report as a roadmap to rapid transformation and dramatically better care; indeed, ideal care. I emphasize the word "ideal" here because they were not looking for better care, that is not going to do it, and they were not even looking for best care—what does it mean to be the best in a mediocre industry—they were calling for ideal care. That was the challenge from the collaborative.

At Henry Ford, we chose to focus our participation in this collaborative on our depression care system, but we struggled initially to create a vision for what perfect depression care might look like. How would we know if the care was perfect and, more importantly, how would our patients know if our depression care was perfect? We struggled with this issue for many, many weeks. We had focus groups involving our patients, their families, community leaders, our system health care leaders. And, finally one day, one of our staff spoke up and said, "Well, maybe if we were doing perfect depression care, nobody would die from suicide."

Our room was as quiet as you are now, but that moment transformed our department, absolutely transformed our department. We began a conversation wherein we recognized that this goal might sound unrealistic, might sound impossible, might be frustrating, might create problems in some scenarios, but we decided that if zero was not the right number for our goal, what number could be the right number?

We began an initiative to transform our mental health care delivery system and, to make a long story short, we achieved a dramatic and unprecedented reduction in suicide among our patients, a 75 percent reduction, that was sustained for a decade in Detroit. This was occurring at a time when the rate of suicide in the State of Michigan was actually increasing, just as it was in the rest of the country.

This concept of Zero Suicide has been endorsed now by the Joint Commission, the CDC; it is embedded in the 2012 National Strategy, as you probably know; and a number of organizations and governments across the world now are adopting at least iterations of this model to try and get a handle on this issue of suicide.

Just now a word about the model and it is described, or depicted at least, in this graphic that is being shown and you have a copy of it in the written report. There are three components to this model and, starting at the base of the pyramid, that first component is a radical conviction that ideal care is possible.

Now, this sounds sort of common sense, but, believe it or not, there is not a universal belief, at least in mental health care, that

we can prevent all suicides, that belief does not exist. Maybe we need to look at that and challenge that issue. If we do not have that conviction, we do not have the energy needed to do the relentless work of transformation that is so hard and that requires attention each and every day.

The second element of this model is a roadmap which we call "pursuing perfection in a just culture." The goal here is to set perfection goals, not incremental goals, which we typically have done forever in health care.

For example, if your suicide rate is—I am making up a number—ten and your goal is zero, you commit to cutting that gap in half in some period of time, in our case it was 12 months. Zero is the goal, where are we today? We are going to cut that in half over the next period of time and that gap we will then tackle in the 12 months to cut in half. That is the concept of pursuing perfection.

Now, this is not possible, as Ms. Oshinski mentioned, if you do not have a just culture. If you expect people to go up to the plate and swing for the fence every time, and then turn around when they strike out and punish them, it is not going to happen, it is not going to happen. We have to transform our systems to look at where the defect occurred at the system level, not at the person level.

We went so far, for example, to take the word "who" out of our process maps for error reviews, we have removed the word "who" from the document.

Then, lastly, every member of the team needs to be an expert in systems engineering. That is really health care today. Health care is a team sport where we work together to create systems that reliably produce the best quality care; indeed, perfect care.

I think the model, while initially sounding audacious, has application to a number of health care systems, and I think it is worthy of further consideration and research. Fortunately, research is underway now, sponsored by both National Institutes of Health (NIH) and Substance Abuse and Mental Health Services Administration (SAMHSA), to look at the essential elements of this model and how we might make it even more effective.

Thank you again for the opportunity to be here today, and I am looking forward to our comments.

[THE PREPARED STATEMENT OF C. EDWARD COFFEY APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Doctor.

I will now recognize myself for 5 minutes for questions.

After the release of the VA's OIG report on the veteran suicide at the VA Medical Center in West Palm Beach, I called for a VHA-wide stand-down last September. This was to ensure facilities were adhering to their policies and so the employees were trained to confidently assist veterans in crisis, and raised concerns with facility leadership and have those concerns taken seriously.

In West Palm Beach, we learned that cameras were not functioning, and the patient safety coordinator's concerns about facility safety were not taken seriously by facility leadership.

Ms. Oshinski, are the security cameras functioning in the in-patient unit at West Palm Beach?

Ms. OSHINSKI. Thank you, Chairman. Yes, I confirmed that the cameras are working both in the acute mental health unit, as well as the emergency department.

The CHAIRMAN. How about the door alarms?

Ms. OSHINSKI. Yes.

The CHAIRMAN. Thank you. You said in your oral testimony that door alarms will be installed in all VHA facilities by summer of 2020, but the VA's written testimony says May 2020—excuse me, March. When will door alarms be installed in every VA facility? Can you clear up that discrepancy?

Ms. OSHINSKI. Thank you for the opportunity to clear that up. One of the things that we have done as we are installing this across the enterprise, what we have found is that we no longer are able to get the appropriate equipment. The market could not—does not have the supply that we need in order to retrofit all our facilities.

For example, places that—I saw an issue briefed just the other day that talked about we were supposed to be done, the delivery cannot be made. Instead of being done in March, it has to be done in May.

We are working very hard to get this done and hoping, you know—and, again, I do have to say probably hoping we are done by summer, but it really is dependent on the ability to get the appropriate equipment.

The CHAIRMAN. Again, the door alarms are part of VA's own standards; is that correct?

Ms. OSHINSKI. That is correct. We put this on ourselves, because we believe it fits in exactly with what we are talking about, zero suicide and zero harm. If you go out to the community, you are not going to find as many—when we have to send people out, many of those places will not have over-door alarms, but we want to be the standard.

The CHAIRMAN. This is an example of you know what to do, but we know that knowing it is not the same as being or doing it. It is concerning to me that there seems to be so many facilities without door alarms. How many facilities out of your 150-some-odd facilities need door alarms?

Ms. OSHINSKI. Every facility with an acute mental health unit, I am not sure if Dr. Carroll knows how many of those there are, and we probably have completed, I believe, 80 percent of those now.

If I could share just a story——

The CHAIRMAN. Sure.

Ms. OSHINSKI.—of something that came in on Friday? Is that there was an incident at Loma Linda, where a resident——

The CHAIRMAN. Excuse me, I am——

Ms. OSHINSKI. Okay.

The CHAIRMAN.—I said yes to the story, but I have got limited time and I have got to get to a question to Dr. Kroviak.

Dr. Kroviak, why do facilities continue to struggle with adherence to environment-of-care and care coordination policies?

Dr. KROVIAK. Thank you. As you have described in your opening comments, the policies are in place, but the actual work that needs to get done consistently on the front line is where the problem usually exists and that is what our reports highlight. Most of the rea-

sons stem from staffing shortages, inconsistent training, and, ultimately, leadership failures at the local level to ensure that the policies are consistently played out.

The CHAIRMAN. Staffing shortages, leadership failure, and inconsistent training.

Ms. Oshinski, why are not facilities following policies, your own policies?

Ms. OSHINSKI. I think there is an effort on the part of individuals to follow policies. As we talk about filling vacancies, oftentimes new people will come in, we need to ensure that we train them at that time and that we continue to retrain. I really believe that is a large part of the issue.

The CHAIRMAN. Well, the Government Accountability Office (GAO) placed VHA on its high-risk list in part due to this problem. This has got to be a bigger priority. We must ensure that the six veterans out of the 20 veterans who commit suicide a day, who commit them at VA facilities or who are connected somehow in the VA's care—you know, I agree with Dr. Roe, we need to address the upstream interventions, but we definitely need to make sure that the public is assured that the VA is a safe place for a veteran who needs critical emergent care to go and know that the standards everywhere are at the ideal level.

Dr. Roe, you are recognized for 5 minutes.

Mr. ROE. Thank you, Mr. Chairman.

On the mandatory suicide prevention training, since 1917, the last 3 years, all VA employees, both clinical and non-clinical, are required to undergo mandatory annual training. The newly hired clinicians must complete a web-based course entitled, "Suicide Risk Management Training for Clinicians," I want to take that course. If you all can get that, I want to go through it and see what I think about it after I get through.

Dr. Coffey, I want to go over a couple of questions that I would like to have for you. Do you have evidence that the suicide prevention model that your testimony focuses on has been able to achieve sustained reductions in suicide in the health care systems where it is being used?

Dr. COFFEY. Well, to State the obvious first, its implementation has not been wide at this point in time. There are a small number of organizations, Centerstone in Tennessee is one, that are reporting results similar to what we saw at Henry Ford.

Now, remember, ours is a quality improvement initiative, it is not a controlled experiment. When we talk about evidence, it is a different level of evidence. We are doing lots of things at one time to try and quickly improve the systems of care.

It is very hard to say this particular intervention resulted in the particular outcome. That is the point of the research that is underway currently with NIH and SAMHSA.

Then others, in addition to Centerstone, there are some tribes in the U.S. I think SAMHSA has testified to this committee before about some of the work that is being done there, and they are also reporting preliminary positive results.

Mr. ROE. The members here have heard me say this many times, in the Guard in Tennessee we have a program called Guard Your Buddy, which has been shown to reduce suicide by almost 70 per-

cent, very similar to what you recognize. Given the opportunity that significant suicide increases in our country among our veterans, the supposed effectiveness of the Zero Suicide model that your testimony references, why is the Zero Suicide model not more widely known and adopted? Is it just—and I mentioned to you before we started the committee hearing about Dr. Van Dahlen, who is working with the Administration through the VA, and they should be in contact with you.

Dr. COFFEY. Well, I do not know the answer to your question, obviously. I mean, I guess we could do a study and do a survey and find out what is going on.

From where we sit, a lot of organizations are acknowledging an aspirational goal of zero suicide, and I wonder whether that is really—that sort of goal is really sufficient to generate the traction and the energy that is needed to do this kind of work. If we say, well, we would really like to get to zero, you know, if everything works out okay, that drives one set of behaviors. If we say, nope, we are committed to a nonevent, not on our watch, not today, then you have a very different set of behaviors that take place.

I do think there is power in how the goal is conceptualized and articulated.

Mr. ROE. I agree with you 100 percent on that. I mean, my goal when a patient came to me who was pregnant was to have a healthy baby and a healthy mother, that was my goal every single patient I saw.

I think one of the most distressing statistics I heard during our roundtable in Tennessee was that the second-leading cause of death between the ages of 10 and 34 is suicide. That is an amazing thing. We have seen the rate go up in the population in general and I think our veterans are mirroring. I mean, we all are living in the same environment.

When you peel the onion back, you find out it is relationship difficulties, it is financial difficulties, it could be substance abuse, which could be caused by those first two things I mentioned, and that is why I believe we have to really get back and reconstitute our mental health infrastructure in this country. We dismantled it in the 1970's and never really put a place—if you are working in an emergency room right now, Dr. Coffey, and you know this very well, if you are down there and you see a patient—and I applaud the VA for having a place to start the treatment and a coordinator that you can hand someone off to—if you are in the civilian sector, you are an ER guy in Union City, Tennessee, I picked that out, you basically have nowhere to go, and that is a sad situation in a country as wealthy as we are and as much money as we are spending.

I think I want to give the VA a shout-out and there are some—obviously, we are going over some problems today that the VA had, but all in all I think the VA probably has the opportunity to be one of the best systems in the country, I really believe it, because the resources are there.

My time has expired. I yield back.

The CHAIRMAN. Thank you, Dr. Roe. Thank you for mentioning the dismantling of our infrastructure, mental health infrastructure in the 1970's, I agree with you.

Mr. Lamb, you are recognized for 5 minutes.

Mr. LAMB. Thank you, Mr. Chairman. I will kind of pick up where Dr. Roe left off.

Dr. Coffey, could you spell out maybe, what are the challenges you would see for a large and kind of powerful and distributed organization like VHA in adopting your model or beginning to adopt it, how would you recommend that something like that even gets started if it was something they were serious about pursuing?

Dr. COFFEY. Well, I think they are serious about it and I think they are beginning to adopt, as you heard, various elements of the model.

The challenge for any system really begins at the leadership level, I think—and I am not singling out the VA here, I am just talking in general——

Mr. LAMB. Right.

Dr. COFFEY.—can leaders get behind a quantitative goal of zero defects? I mean, can a culture stand that, can it withstand that kind of examination and public statement that we are not going to have, let me fill in the blank, a medication error in our organization, we are not going to have a patient fall in our hospitals, we are not going to have a pregnant woman have a problem with her delivery. Zero. I think that is the first step.

Mr. LAMB. Well, and I guess on that, when you talk about leadership in an organization as large as VA, there are so many different levels of leadership. Like it would be one thing for the Secretary to say that at a press conference, it is a whole other thing for the person who is really in charge on the ground at an individual health center or even community outpatient center to be bought into that and supervising it, you know, on a day-to-day level. In the military they say "inspect what you expect," right? I mean, like the person would—that is the leader who I am thinking of, the on-the-ground person.

How does that change get made, how do you get that person bought in to what you are talking about?

Dr. COFFEY. Well, again, I think it is culture building. I always think back to the movie Apollo 13. That was one of my favorite movies, but if you remember the story there where the moon landing had to be canceled and they had to get the capsule back to Earth and there was no possible way, according to all the scientists, that this was going to happen. In fact, their power was going to be 2 days short. It is impossible, it can not happen. Every individual in NASA at every level participated in bringing that capsule back to Earth safely.

That participation was driven by, you know, some of the famous quotes from the movie, "Houston, what more can we do? Houston, what more can we do?" That is Tom Hanks' character saying that. Of course, on the ground, failure is not an option——

Mr. LAMB. Yes.

Dr. COFFEY.—failure is not an option.

Mr. LAMB. You talked about Department-wide certification in cognitive behavior. What would it take to achieve that in say an individual hospital? I guess in terms of like how much training, time, and resources are we talking about, in your experience, to achieve something like that?

Dr. COFFEY. Right. Well, I will make a point first of all that, as I mentioned in my report, we end up not getting the grant. We got a small training grant as part of our participation, but we were not one of the six finalists who got a million bucks to do this, but we were so geeked about the whole thing that we decided to pursue it anyway.

We had zero budget to do this at Henry Ford, we had no resources. What we had to do, it had to be——

Mr. LAMB. Time is your resource at that point.

Dr. COFFEY. It had to be supported by taking something from somewhere else that was not adding value and investing that resource here where it did add value.

In the case of department-wide competency in Cognitive Behavioral Therapy (CBT), we sent key trainers to the Beck Institute, the birthplace of CBT, and got them formally certified, and then brought them back and they became the trainers on the ground for our team locally. There was an expectation by a certain date that every member who engaged in the provision of psychotherapy at Henry Ford was going to be certified by the institute. That is the way we do it.

Mr. LAMB. Do you have any estimate of what that means in terms of hours, days, weeks?

Dr. COFFEY. It is an intensive process——

Mr. LAMB. Yes.

Dr. COFFEY.—because the supervision is very intensive. There are audio tapes of the session, those are sent to Philadelphia, they are critiqued and coached. Now, the model may be a little bit different today, I do not know, but it was intensive. But most of the staff in Georgia——

Mr. LAMB. Thank you, sir. I hate to cut you off. Just one last question before my time runs out.

Dr. COFFEY. Yes.

Mr. LAMB. Dr. Oshinski, I think we had a hearing last year where Dr. Franklin mentioned that there were 444 suicide prevention coordinators on board, but an additional 246 were on the way in the hiring process. Do you have any idea where we are on those numbers at this point?

Ms. OSHINSKI. I would have to take that for the record, unless Dr. Carroll has——

Mr. LAMB. If you would not mind——

Ms. OSHINSKI. Yes.

Mr. LAMB.—just getting back to us. I think we had 444 active and 246 on the way, if you could just give us an update.

Ms. OSHINSKI. Yes.

Mr. LAMB. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Mr. Bilirakis, you are recognized.

Mr. BILIRAKIS. Thank you very much. I appreciate it, Mr. Chairman. Thanks for holding this hearing.

Ms. Oshinski, recently the VA committed to proactively contacting new transitional servicemembers through the Solid Start Program, and your testimony credits this directly to the President's 2018 Executive Order focused on mental health for transitioning servicemembers and veterans post-separation. What type of suicide

screening is being done through this program and how does VA plan to track its success?

Ms. OSHINSKI. Thanks for the opportunity to comment. I would actually like to ask Dr. Carroll, if he would, he has much more information about the detail of that program to address the question you raised.

Mr. BILIRAKIS. Okay.

Mr. CARROLL. Thank you, sir. We appreciate the question. Solid Start is a transformative initiative that, with your support and that of the Administration, VA has undertaken. It has taken us a while to build this capability, but within the first year after separation from service we are calling each transitioning servicemember at least three times.

To the point of your question, the contacts are checking in with the veteran. They are not clinical contacts, it is not a clinical interaction with a clinical provider screening them for suicide, but it is the caring support, it is making sure that they are connected, that they feel connected, that they know how to connect to either resources in the VA or the community. Then, if they need something or they indicate—you know, if there is a crisis, we will hand off, a warm handoff to the Crisis Line; if they need some other service from VA, there will be a handoff to service—but it is really to remind veterans that they are not alone, that the VA is there for them, as well as local resources.

Mr. BILIRAKIS. Let me ask a question, a clarification, because I know we had language in the MISSION Act. Can a veteran, can a veteran go to a community health center, a walk-in clinic, a what have you, to seek private care for mental health, mental health counseling, what have you, and would the VA reimburse?

I know there is some language that I have had some legislation to strengthen that. Where are we on this, because I think it is so very important. If you can not answer the question now, please get back to me. You know, has this been implemented? How easy is it for a veteran, you know, for convenience purposes too, to go to their local community health center for mental health treatment?

Ms. OSHINSKI. I believe after an initial approval it would be very easy, but I would like to confirm that for you for the record, to make sure that could someone do it without authorization.

Mr. BILIRAKIS. Anyone else? Okay. Well, please get back to me on this, because I think it is very important that the patient, again, the veteran have access to these services.

One more question. I just had cataract surgery, so forgive me, it is tough. Ms. Oshinski, what type of suicide prevention materials or training is provided to servicemembers as part of the VA's portion of the Transition Assistance Program?

Ms. OSHINSKI. Again, I would like to recognize Dr. Carroll as our expert on these programs.

Mr. BILIRAKIS. Please, Doctor.

Mr. CARROLL. Thank you. Over the last couple of years, the Transition Assistance Program has been remodeled or redone in collaboration with Department of Defense (DOD), our DOD partners, and I think there is an entire day that is focused on VA services, on VA care. There is a focus on suicide prevention, how to register for care. In fact, we actually ask them to complete an applica-

tion for VA care that can be activated as soon as they are separated from service. There is information about suicide prevention and how to reach out for resources.

What we are also trying to do is to include information for family members, so family members also have that information as well. Then these calls that you mentioned earlier, sir, will remind them of that opportunity going forward.

If I may just circle back to your last question for a moment. If any veteran ever contacts us, we are going to find help for them today. If they come in and whether they are registered with us or not, if someone calls us or walks into one of our medical centers, we are going to find help for them today if they need it.

Mr. BILIRAKIS. Okay, that same day?

Mr. CARROLL. Yes.

Mr. BILIRAKIS. Okay, that is so very important. Time is of the essence in a lot of cases.

Ms. Oshinski or whoever wants to answer the question, whoever is qualified to answer this question, you mentioned—Ms. Oshinski, you mentioned briefly in your testimony about the Whole Health Program. As a strong advocate for this program and the use of a public health and whole health wraparound approach to suicide prevention, I want to ask, what progress is VA making in implementing findings for evidence-based alternative therapies that are otherwise outside of VA's traditional mental health system?

I know that my local VA hospital is doing an outstanding job with this, the alternative therapies, but I want to see this nationwide. Can you—whoever is qualified to answer the question, I appreciate it.

Ms. OSHINSKI. I can help with that one. Thank you for the question.

Mr. BILIRAKIS. Okay.

Ms. OSHINSKI. Whole Health is currently being expanded across our system. We started out with 18 flagships, each of the network has been asked to identify two more facilities within their network to be able to expand, but also to spread across every single facility in the country.

In the coming year, we will be doing increasing training. I can tell you right now, people feel exactly the way you do. They can see, whether or not the evidence-based is all out there—and I understand we are probably close to being able to issue a report with research on that, I have not seen it yet, but I understand it is in process——

Mr. BILIRAKIS. Yes——

Ms. OSHINSKI.—that really shows——

Mr. BILIRAKIS.—we have got to get——

Ms. OSHINSKI.—that this is something——

Mr. BILIRAKIS.—yes, we are waiting for it.

Ms. OSHINSKI.—that makes a difference.

Mr. BILIRAKIS. Yes.

Ms. OSHINSKI. Everybody wants to do it, they are doing it whether they are identified as a flagship or not.

Mr. BILIRAKIS. All right, very good. Thank you.

I yield back. Thanks for giving me the extra time, Mr. Chairman——

The CHAIRMAN. You are welcome——

Mr. BILIRAKIS.—I appreciate it.

The CHAIRMAN.—Mr. Bilirakis.

Mr. Brindisi, you are recognized.

Mr. BRINDISI. Thank you, Mr. Chairman.

Ms. Oshinski, just in response to Congressman Lamb's question, I also would like to see the numbers on the suicide prevention coordinators, because I know in previous testimony the former National Director talked about a surge in hiring. If you can get that to our office as well, I would love to see those numbers.

Ms. OSHINSKI. Certainly.

Mr. BRINDISI. Then my main concern, I represent a very rural district in upstate New York, and I know you all know the challenges of serving veterans in rural communities because of the lack of cell phone service, the lack of Internet coverage, the transportation and distances to community-based out-patient clinics or hospitals.

Ms. Oshinski or Dr. Kroviak, can you speak to the VA's efficiency in reaching veterans who live in rural communities?

Ms. OSHINSKI. Thank you for the opportunity to address how we reach out to veterans in rural communities. I agree, we have tried to make sure that we have community-based out-patient clinics whenever we can and that we are expanding our telehealth network, but, as you said, we also struggle sometimes with the bandwidth that you may have in more rural communities.

We are working with a variety of private sectors folks as well. One of the things I would like to highlight is we are trying to work with Walmart, because there are Walmarts in very many rural communities across the country, is there a way that we can do that. That is one of the areas that we are looking at.

Dr. Carroll, would you like to add anything in terms of other alternatives?

Mr. CARROLL. One of the things that we have developed recently is a program called Together With Veterans. It was developed by our team out in Colorado and it is an evidence-based program to go into rural communities and to help those communities recognize and connect and support with their veterans in their local communities. We have seen promising results from that and we are spreading that across our system, in addition to what Ms. Oshinski said about the importance of telehealth services.

Mr. BRINDISI. Dr. Kroviak.

Dr. KROVIAK. Yes, if I could add, we are also very much aware of the challenges associated with providing care to rural veterans, in particular specialty care. We have developed several products that are now looking—taking deep dives into specialty care coordination for rural vets, as well as the expansion and safety of telehealth.

Mr. BRINDISI. What else can we do in Congress to help VA reach these veterans, any ideas?

Ms. OSHINSKI. Well, certainly we appreciate the support that we have from this group and through the funding process. I mean, we have worked very hard to try to expand bandwidth sometimes and, as you know, it can be difficult in some of these more rural areas, so I think the awareness.

One of the things I think is just so important is that really younger veterans in particular love telehealth and I think we need to do everything we can to make sure that people understand just how effective telehealth can be.

Dr. Carroll, anything from your standpoint? Okay.

Mr. CARROLL. Thank you.

Mr. BRINDISI. Okay. Then another question I have, Ms. Oshinski, you mentioned in your testimony that suicide prevention coordinators also do outreach to Guard and Reserve units, and they come to mind as one population that could be served by VA mental health services. I have introduced legislation, it is bipartisan, the Care for Reservists Act, that would do just that.

If Congress decided to expand critical mental health services to more populations, what are the challenges you see in making that work?

Ms. OSHINSKI. Thank you for the opportunity to address that. I do not think it is a secret to talk about the fact that sometimes the issues of trying to recruit, particularly in areas where it may be more—where we may have smaller populations, we can struggle with recruitment. I think that would be something that we would face. However, obviously, if the Congress wanted us to expand those services, we would do whatever we could to make sure that that occurred.

Mr. BRINDISI. Do you think that you have staff capacity at VA's facilities to serve more veterans?

Ms. OSHINSKI. Well, I think we are serving as many veterans as we can, we are looking at ways that we can expand that.

Dr. Carroll.

Mr. CARROLL. As we continue to expand our mental health staffing, and we have increased our net mental health staffing over the last 2 years, the demand also increases. I think, you know, we are hiring to meet the demand, but as demand increases, we need to continue to hire.

Support for our training programs is an important component, because that is a major way that we recruit providers into our system.

Mr. BRINDISI. Okay.

Dr. KROVIAK. Thank you for recognizing my angst in wanting to participate.

Mr. BRINDISI. Thank you, Doctor.

Dr. KROVIAK. I would also really stress the importance of a staffing model. It is near impossible to staff up to the demand when you have not really measured exactly what you need and where you need to spend your dollars in that staffing.

Mr. BRINDISI. Thank you all.

The CHAIRMAN. All right.

Mr. BRINDISI. I yield back.

The CHAIRMAN. Thank you, Mr. Brindisi. Mr. Bost, you are recognized.

Mr. BOST. Thank you, Mr. Chairman. Ms. Oshinski, let me ask this. We know that, first off, that zero number that we are trying for is very difficult, because so many are not even coming in contact with VA. The fact that we have them actually committing suicide at the VA is a huge problem. What is being done, I know you

explained a little bit of it, but when Dr. Coffey was giving his testimony, he said that it is the mind set of all thinking and understanding that that zero number is possible. What is it that we are doing to train our frontline staff, and make sure that they have that same attitude?

Ms. OSHINSKI. Thanks for the opportunity to address this. I think there are several levels of this. First, I think the kind of training that we do, the same training, making sure that people understand the very most important thing about recognizing suicide is the fact that, or preventing it, is recognizing when someone is having an issue. It is that direct kind of interaction that each and every one of our employees, whether they be in a facilities management employee or someone who is doing grounds maintenance, those folks sometimes are the ones who first run into people outside the emergency department or on their way in and will actually bring things to others' attention.

I think we are beginning to get there, but we need to continue to do that kind of interaction. I will tell you that when a veteran commits suicide on a VA campus, or harms himself on a VA campus, as a network director, I used to go in and visit the teams, the suicide prevention coordinators and then some of the teams. The emotions that came out in those meetings, this is the most difficult thing for any provider, to lose someone. When you know that VA is there to do something good for people, and instead, they harm themselves.

It is something that every employee at the VA is on the alert for.

Mr. BOST. Dr. Kroviak, in your testimony, you actually talked about a particular case where someone that was a high risk, the red flag was removed. What are we doing to make sure the procedure does not go down that path again?

Dr. KROVIAK. That was a critical recommendation in the report you are referencing. In fact, it was the first recommendation. We follow up on the recommendations with data from VA to show that the changes have been put in place. We have not yet closed it. The data that we have been provided has not supported sustaining that. Until we see enough data to suggest that it has been implemented, corrected over a course of time, would we then close that recommendation to say it has been satisfied.

Mr. BOST. Okay. As I said off the start, the worst thing we could have is these suicides actually occurring at our facilities.

Dr. KROVIAK. Yes.

Mr. BOST. Manpower, and being informed, and communication is vitally important. I know that is part of what you are working on, but you brought up an issue that also the people of maintenance, it is vitally important.

I know when reading our report, one of the suicides was the fact that a hallway camera was out. In my particular case with one of my VAs, which actually does a great job, and that is the St. Louis VA and Johns Hopkins, we had a person that actually walked into the waiting room at 4 o'clock in the morning, actually contacted his nephew, and said what he was going to do, because he was angry about the service he received from the VA. Laid down on the bench, committed suicide, and it was an hour before he was found.

The implementation and the putting in of those proper cameras and making sure that our staff understands and also then understanding that our staff needs to be informed for that zero policy. These are things that this committee is wanting to push so hard to try to reduce this unbelievable level of suicide rates. The zero policy for our facilities has got to be met.

I think you are trying anything, and everything that this committee can do, let us know. We will continue to have oversight of this. Thank you for being here today, and with that, I yield back.

The CHAIRMAN. Thank you, Mr. Bost. I associate myself with your sentiment toward the end. I agree that we have to drive a zero policy at the facility.

Ms. Luria, you are recognized for 5 minutes.

Ms. LURIA. Well, thank you. Thank you all for being here today to talk about this very important issue of veteran suicide. I associate myself with my colleagues' comments that we all focus and want to provide as much help, assistance to the VA to accomplish their mission as possible in this area.

One of the things that came to my attention in the testimony that you provided ahead of today's hearing is that 99 out of 140 VHA facility directors reported that they had at least one severe shortage area in mental healthcare providers. I wanted to know how that affected our community.

I reached out to the director and the staff at the Hampton VA in Virginia, and I found out that the vacancy rate at the Hampton VA for mental health care providers is 35.5 percent. Whereas, the VHA rate in mental health across the country is 10 percent, roughly. In certain areas, there are zero providers, so 100 percent vacancy in that specific field or type of provider.

That made me think, are staffing shortages the reason that you are not meeting benchmarks that you feel that you are not necessarily able to provide the care, and the time to the number of people who might need the care? Just basically, what impact is this having on our ability to go after this problem?

Ms. OSHINSKI. Thank you for that question. Definitely, the issue of trying to recruit the appropriate staff to staff all of our mental health units across the country continues to be a challenge. As Dr. Carroll mentioned, we have made some tremendous progress in the last few years. However, there are pockets, and you are mentioning one of those, where we still have difficulty trying to bring the staff onto the level that we need to support the demand, because you have a very high growing area, where we have a lot of veterans who are seeking care.

It is something that we are working on. Dr. Carroll, you may have some additional information about that specific site.

Ms. LURIA. Well, and also, as you continue to address this in your response, what can we do about the hiring? I understand the shortage of mental health care professionals, whether I am in a jail, a school, the VA, anywhere in our community there is a shortage. But why is the VA not one of their locations of choice for employment?

We have both the Hampton VA and we have two military intreatment facility hospitals as well, one of which is Portsmouth Naval Hospital. We are constantly losing providers between DOD,

VA. It takes months to bring someone on board, even if they are identified. Just at the administrative level with the hiring process, can we not do something to make that more efficient? To make it a more attractive place to work? To be able to provide health care to these veterans?

Ms. OSHINSKI. Just before I turn it to you, Dr. Carroll, a couple things just to say. We have an initiative to hire right, hire fast. We are really trying to do that, and we would target a particular area like Hampton, because of the vacancy rate.

We are also trying to use all the flexibilities that we have in terms of, what are the kinds of incentives that we can offer people.

Ms. LURIA. For the hire fast, so I have been to the VA four times in the last year, and I hear that it takes them months. They have to re-credential someone. I mean, someone might already be working for a VA facility in another State. They might be working for DOD. They are already working as a health care provider in a Federal health care system. Why do we have to go back to ground zero and verify every single credential when there should already be standard record saying that this person meets the standard to be employed by us?

It is adding months in getting people into a treatment room where they can treat veterans who need the care. Can we do anything to streamline the process and just get rid of what seem like true redundancies?

Ms. OSHINSKI. We are taking a close look at the credentialing process and what are the things that we can do to improve that. You are exactly right. It is challenging and we do replicate that information. I think the issue is you never want anything to slip through the cracks. We need to tighten up our process and make sure, just like everything else, we have zero defects when we do this as well as anything else.

Dr. Carroll, anything else?

Mr. CARROLL. I would just highlight, we have a mental health sustainability initiative going on currently, where we are looking at not just bringing on new providers, as we want to do and we have had success with that, but we are also looking at retaining our providers. We have a national program to conduct stay interviews, because want to minimize our losses and generally speaking, we do fairly well in that regard.

We are also looking at things like open and continuous recruitment for these critical vacancies that you mention.

Ms. LURIA. Well, I will just bring something up about retention, and I have found that providers like to work at the VA. They like to provide that care. The environment for employees at the VA right now is very tense and very stressed, especially due to the fact that a lot of them feel like they have no recourse as far as some of the executive orders that have been passed; the fact that employees are being disciplined without the ability to repeal those specific actions; the fact that unions basically that represent them, and represent their rights, are being kicked out of VA facilities; that time is not allowed for the people who represent them.

I hear this over and over again from long time VA employees who want to continue to work there, but they really feel like their rights are being infringed on. How do you address that with your

workforce to make them feel like they can have fair representation and fair recourse in employment decisions?

The CHAIRMAN. You may answer the question. Go ahead.

Ms. OSHINSKI. Well, I think one of the things that is very important to all of us is that people have the opportunity to be able to respond to, or raise any concerns that they have. That is why we established the Office of Accountability, so that there are places for people to go. There are hotlines, anything, if they are worried about things that happened.

I have to say that my preference is——

Ms. LURIA. When you say, "People," is this for employees?

Ms. OSHINSKI. For staff, I am sorry. Yes, for staff. I apologize for using that terminology. For any of our employees to go. I mean, I am hopeful that our leadership is listening and that one of the ways that we can learn to better ourselves is by listening to our employees and reacting to what they tell us to make the environment a better place.

That is the expectation that I would have of anyone who works in our environment.

Mr. CARROLL. Within mental health, we conduct an annual mental health staff survey every year, and that is part of our metric in terms of how we look at the experience of care. It is not just from the veteran's perspective. That, of course, is the most important thing. We need to find out from our providers, and we do, whether or not they can schedule appointments as frequently as they feel that they should, whether they feel supported by leadership.

We ask that annually and we use that in our oversight process.

Ms. LURIA. I appreciate the feedback on that. I will just tell you from what I hear, from employees at the VA, in our region, is they do not necessarily feel that they have that outlet. We have new leadership. I am very encouraged by our new director and I know that he is working very hard to improve that morale, but just as one VA around the country, I just wanted to make you aware that there is a significant amount of concern amongst the VA employees.

The CHAIRMAN. Ms. Luria. Ms. Luria, we have to move on. Thank you. I associate myself with your frustration with the hiring process and climate, but we need to move on.

Ms. Radewagen, you are recognized. By the way, thank you for that lovely shirt you sent me. Thank you.

Ms. RADEWAGEN. Thank you, Mr. Chairman and Dr. Roe. Thank you to the panel for appearing today. My question is for Dr. Coffey. The suicide prevention approach that you highlight in your testimony centers on achieving ideal health care delivery and zero incidents of suicide, rates of perfection that I am sure many would say are impossible, particularly in a health care system as large and complex as VA. In what ways does your approach to preventing suicide differ from the suicide prevention approach occurring in VA right now? Why do you think your approach is not only possible but preferable for our Nation's veterans?

Dr. COFFEY. Well, I can not answer the question about what is happening in the VA right now, because I do not know. I am not privy to the detail of those operations. As I said earlier, I firmly

believe that everyone that works in the VA is committed to eliminating suicide. I have no question about that.

Stepping back, in general in health care, we have the same story. Hardworking people, smart people, dedicated to doing the right thing. What is getting in the way is terrible, broken systems. That is the general issue. That was the issue that was called out 20 years ago in the Kazim (phonetic) report. I am sad to say that I don't think we are a whole lot further along today in fixing some of those fundamental systems issues.

I think that is the starting point. We have to step back, look at these systems, and begin to think about, okay, what adds value and what does not. If I may just tag on a question that came earlier, which was a wonderful question, and it was what could this committee do to help the VA. I thought that was fabulous. I get goosebumps thinking about it.

My boss at Henry Ford asked me the same thing when we started our work and when we did not get the grant. I had to beg for some time. I went back and thought about it. Then I went back to her and said, "Help us with the bureaucracy. Let me bring to you a list of issues that we do not think are adding value. We could be wrong, and we may not understand it completely based on your perspective. Let us bring you a list. If you agree, can we take some of these off the plate? Can we stop doing things that, in our view, at the front line, do not add value to the care of the patient?"

That was a blessing from heaven. She stood by that, allowed us to make those changes. Perhaps there is some opportunity there for the VA.

I have worked in the VA and I know the challenges that bureaucracy in such a system. It is all well-intentioned. It is there to try to make things better, but maybe it is a time to look at some of that and say, okay, this has outlived its usefulness. Let us let the sun set and move on to processes that add more value.

Ms. RADEWAGEN. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you, Ms. Radewagen. Ms. Brownley, you are recognized.

Ms. BROWNLEY. Thank you, Mr. Chairman. I wanted to ask, with the way VHA is set up and organized, the medical centers have a lot of autonomy. When we are talking about this grave issue of suicide and solving that, and you are talking about a lot of different programs, different directives, expectations, and the like. We know from OIG reports that we have different medical facilities who may be out of compliance and not fulfilling all of those requests and requirements.

In an organization as big as VHA is, who has the accountability? How do you ensure that each one of those medical facilities are in compliance and who are doing what you are asking them to do? They even have large controls over their budgets. How are you ensuring that they are investing in their facilities to meet some of these goals that we are trying to attain and reach by actually really reducing the suicide rate?

Ms. OSHINSKI. Thank you for that question. One of the ways that we do that, obviously, you are right. Each individual medical center operates on its own. We have the network directors. The Veterans Integrated Service Networks (VISN) directors are really responsible

for ensuring that we reduce the variation and that we, then, make sure that facilities across that entire network are complying with what they need to do in each of these areas.

We have a lot of conference calls. We have a lot of information that is shared. We have a mental health lead, for example, in each network, who will visit each of the medical centers and make sure that the things that are happening there are consistent with what the policy is across VHA.

We also have things at the national level. Dr. Carroll's office in mental health also looks at the consistency of what we are doing across the country.

Ms. BROWNLEY. The next question I have is in direct opposition to Dr. Coffey's philosophy in terms of a new approach to all of this. What are the consequences for a medical center that is not putting their resources where we want them to put them in relationship to suicide prevention?

Ms. OSHINSKI. One of the things that I really believe is that everybody that—the idea of Zero Suicides and that preventing suicide is the VA's No. 1 priority, I believe, is shared by every executive across our country.

I think the issues are less with not doing it, but how is it they prioritize some of those things. That is what the job of the network and the mental health office is that we need to make sure they prioritize that.

The consequences, the way I would look at it is accountability is all about making sure that you have the best outcomes for your patients. That if that does not happen, that is something that we will be discussing in our evaluation process.

Ms. BROWNLEY. Well, with suicide, we have not moved the dial. We are not getting good outcomes. It is—and, I mean, I think that is why we are having this hearing and why there is such a focus on this. It just seems to me that the system, the way it is built right now, is not working the way we would like it to. It may be a general patient care, general mental health care and the like, but with regard to suicide, we are still dealing with the issues.

I do not have that much more time, and I wanted to ask another question. I do not think that we can really solve this problem without understanding where the problems lie. I think we have, over the last couple of years, we have really started to break down of the 20, 21 suicides per day, who are those people and what are the demographics?

I know in the staff report we are saying of that number, it is about 16.8 are veterans and 6.3 of those have used the VHA facilities. Do we know, of that population, how many are—who are women? Who are native veterans? I just visited the Dakotas the last couple of days, and suicide in tribal lands is disproportional to the rest of the country.

Do we know who they are, because I believe that we probably—well, with native veterans, we are not getting the programs that the VA has that are good programs to the tribal lands, one. I do believe that there are different ways to address suicide, depending on who the population is. I have run out of time, so if——

The CHAIRMAN. Witness will answer the question.

Mr. CARROLL. Thank you, ma'am. I will try and do this briefly. The Together With Veterans program that I mentioned a moment ago will address tribal veterans, and I think that is one of the focus of that program.

In terms of women veterans, we have the programs that you know and that you are supporting us on. One of the things that we saw in our data report between 2016 and 2017, there was no increase among suicide deaths for women who were engaged in VA care. Unfortunately, there was no decrease. I think that was a point that caught our attention. I think we feel that we may be taking steps in the right direction for women veterans in our care. We need to see that number, of course, decrease.

In terms of the question that you asked about other veterans. We know, for example, that of those 11 who die by suicide everyday, who have not been in recent VA care, at least two of them have been previously, and we are putting together a program to help them reengage in VA care. We are also looking at what we can do more broadly in the population through our mayors and Governor's challenge.

I am happy to talk more about it with you.

Ms. BROWNLEY. Thank you. I yield back. Thanks for the extra time, Mr. Chairman.

The CHAIRMAN. You are welcome, Ms. Brownley. Mr. Bergman, you are recognized. General Bergman.

Mr. BERGMAN. Thank you, Mr. Chairman. I will just get to the point right away. There is nothing more radical than a Marine in the fight. Okay? I thank you, Dr. Coffey, for giving radical a positive definition, because sometimes when we hear terms that it will pop up either a negative or a positive, normally when you think of the term radical, it tends to have a negative connotation on the front end. I applaud you, because if there is one phrase that we have is that we never leave a Marine behind, whether it be on the battlefield, or here back in the States in their personal environment, because we are looking out for him and making every effort to look out for him at all times.

This is a question to the panel. The Improve Well-being For Veterans Act is legislation that I introduced to help the VA reach out into the community and provide life saving services to veterans who do not always make it to the VA or are just not within the VA system.

As originally written, a merit of this legislation was that we would not only touch the veterans we were not previously reaching, but we would learn from them, and use metrics and information gathered, sharing to help the VA and other communities understand the many complex factors that lead to suicidal ideations. In your view, what is the value of reaching veterans in our communities who do not use the VA often or at all, or maybe were in it and are out of it, as you just referenced, Doctor? Would you agree that the learning that we get from these veterans' interactions would assist the VA to improve the environment of care, and therefore the results, on its own campuses and VA facilities? Anybody want to make a comment on that?

Mr. CARROLL. Thank you, sir, for the question and for the opportunity to talk about that. We believe that we do need to know

about veterans in the community. Our commitment in VA healthcare, and certainly in mental health and suicide prevention in particular, is to serve all of American veterans. That is out mission. That is our commitment. It is absolute.

We need to understand there may be veterans who choose not to receive care or services from VA, and we respect that. We want to make sure that they are well-connected in their community. And we have seen models for——

Mr. BERGMAN. It is okay to have other entities that maybe are not employees of the VA to actually make those connections?

Mr. CARROLL. We partner with external organizations all the time. Yes.

Mr. BERGMAN. Anybody else?

Dr. KROVIAK. I would just add from the oversight perspective, we are typically focused on the sick veterans that are engaged in care, and measuring and monitoring the quality of care they receive. We do support outreach efforts, and are targeting products that will hopefully be able to support VA in their expansion of vet centers, which I think, and we as an organization think, will be critical in serving those veterans who have not, for whatever reason, chosen not to engage in facility care.

Mr. BERGMAN. Basically, the overall goal is to engage those veterans, who are not engaging with the VA. In some cases, you are going to be able to bring them in, because that is going to be the right answer for them. In other cases, they are going to be outliers, if you will, through tele-health or whatever it happens to be. The goal is 100 percent outreach. Whatever we do to get that is the VA—it is the right answer, because the VA is the valuable partner. You are the big dog here. You are the St. Bernard, if you will, in this that is, in the end, going to have the overall responsibility.

Dr. Carroll and Dr. Coffey. Dr. Coffey, you talked about the Henry Ford effort. Dr. Carroll, you talked about the Colorado effort. What I do not know is the timeframe of those efforts. Has there been any, if you will, after action, collaborative exchange of data and/or results or lessons learned between those two efforts?

Dr. COFFEY. Not that I have been involved in.

Mr. CARROLL. Not those two efforts specifically. I think, too, we respect and appreciate so much Dr. Coffey's work. In our suicide prevention strategy that was published last year, we have tried to incorporate. There are several principles in Dr. Coffey's work to incorporate those.

Together With Veterans program is relatively new. We have not been able to crosswalk it yet.

Mr. BERGMAN. Okay. Well, again, I see my time is almost up. The point is when we look at military operations, we talk about intelligence sharing. That comes across all spectrums. Think of you two as entities, all of you as different entities, whatever that might mean, to share than intelligence, to share that data collected. Because sometimes the best example of something being done, we just do not see it.

I will just conclude by an—Dr. Coffey, you said stop doing things that do not add value. Okay. Jim Collins, good to great, 101. Stop doing the things that no longer add value to your business model.

I enjoin VA, like any other entity, do everything you can to stop doing the things that do not add value. Identifying—break a few China bowls, if you will, in the process, because there are rice bowls that people love to protect. It is about the veteran and it is about the outcome. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, General. Mr. Cisneros, you are recognized.

Mr. CISNEROS. Thank you, Mr. Chairman, and thank you all for being here today.

Ms. Oshinski, on May 29th of last year, I led a bipartisan letter with my House Veterans' Affairs Committee (HVAC) colleagues, Rev. Banks and Rev. Bergman, requesting the VA elaborate on DOD and VA's responsibilities for carrying out a warm handover of service members from DOD to VA care.

As you are well aware, the time period after separation from service is critical period for service members, especially as it relates to the risk for wellness. This is exactly why I founded the Military Transition Assistance Pathway Caucus, with Rep. Bergman, to build a bipartisan coalition of members engages with the Veteran Service Officers (VSOs), veterans, service members, and stakeholders to solve and improve.

Although I appreciate the VA's response to our letter highlighting the president's executive order on veteran suicide, however, it did not elaborate in detail what is being done for a warm handover.

I ask you today, what exactly is the VA doing specifically to this critical period between when a service member leaves active duty and transfers to the VA to make sure that those that are suffering from maybe suicidal tendencies while they were on active duty, get the VA care that they need and it is done quickly?

Ms. OSHINSKI. Thank you. One of the things that we have done, and we mentioned a little earlier, but I think it is certainly worth continuing to talk about is the new solid start initiative, where we are contacting every service member as they leave the service, that they are contacted three times during the year that they return to civilian life.

Each of those, it is really meant to be, as you said, a warm handoff. Let us find out what is going on in your life. If there are issues, let us connect you. Again, to make sure that they understand that VA, and that is all of VA, is there to support them.

They would also be able to refer them to community resources. Dr. Carroll, would you like to add anything to that?

Mr. CARROLL. I would highlight two other things. One, for certainly the most critically ill people, that we often will do a warm handoff between DOD and VA to our trauma centers, our Traumatic Brain Injury (TBI) centers. In addition, there is a program called, "In Transition," that will hand off individuals who are receiving mental health care within DOD, directly either to VA or set up a community care appointment for them, to make sure that those individuals do not fall through the cracks.

Mr. CISNEROS. Right. Where there is also situations where service members do not want to self-report that they are having any problems, because it might take them out of status, whether it be flying or anything else, while on active duty. What is the VA doing

to help identify those individuals, to give them a comfortable place so they can self-report when they come to the VA after they leave active duty?

Mr. CARROLL. I would highlight our vet center program is a particular resource for those individuals. It has a completely separate record system. And at vet centers, many of the counselors are veterans themselves. They really have an expertise in dealing with combat veterans. Many individuals, like the situation you described, find that a welcoming and good place to go. We work closely with our vet center partners in the health care.

Mr. CISNEROS. I would ask, as Members of Congress, and members of this committee, how can we help you out to make sure that you have the ability to go out and contact these veterans, because most veterans are not going to the VA once they are—I should say, once they leave active duty, are not going to the VA initially. How do we create that and make it more welcoming for them so that they can do this? How can we help in that process?

Mr. CARROLL. Sure. We appreciate your support. We appreciate opportunities like this hearing and other opportunities to talk about that. We talked earlier about support for our education, training, and research programs. That helps us.

I think to the point of ensuring—using all of the platforms that you have to inform veterans that VA is there for them. We are committed to do that. If they contact us, we are going to find help either in our system or in their community. We need to change together the conversation in America, that there is always hope. There is always a way forward for someone. That no one is ever alone.

To Dr. Coffey's point, zero is the right answer and we are committed to that. We need to infuse that, not only within our health care system, but within the population of veterans that we serve.

Mr. CISNEROS. All right. Well, thank you for your answers today and use us as a resource in how we can help, because this is an issue that we all need to solve and we need to work on so that we can get this through and make sure that these veterans are taken care of. With that, I yield back.

The CHAIRMAN. Thank you, Mr. Cisneros. Mr. Banks, you are recognized.

Mr. BANKS. Thank you, Mr. Chairman. Thanks to each of you for being here today to talk about a very important subject.

It is safe to say that the Suicide Prevention Coordinators (SPC) are the face of the VA's efforts to combat veteran suicide. Yet, this committee has found that many SPCs report being overworked and unable to keep up with any of their responsibilities. Late last year, President Trump signed into law a piece of legislation that this committee supported that required the GAO to review the training, workload, and staffing at the VA to ensure that our SPCs have the tools and resources they need to assist veterans in crisis. I look forward to reviewing those findings in the coming year.

Dr. Kroviak, in your testimony regarding the incident at the Minneapolis VA, you stated that the "suicide prevention coordinator did not collaborate with the inpatient interdisciplinary treatment team during the admission." Is it possible that the SPC at

Minneapolis was too overworked to have a thorough collaboration with the treatment team?

Dr. KROVIAK. It is certainly possible that that is the case and not just unique to that facility. I would also add that suicide prevention coordinators are important team members in serving as the face of suicide prevention, but we can not disregard the other providers and support staff that are also critical in combating suicide.

Mr. BANKS. Okay. That is fair and I appreciate that feedback, but are there any enforcement mechanisms that exist to ensure that staff are informing the SPCs?

Dr. KROVIAK. There are policies in place that guide these coordinators, but I would have to defer to VA in terms of holding up those policies and recognizing accountability in those situations.

Mr. BANKS. I know we do not want to minimize the efforts of the SPC.

Dr. KROVIAK. Not at all. We cite many short—or in the reports that we found shortcomings, we are very careful to assign accountability to those, as well as those that supervise and run the facility. It is certainly not belittling their role, but recognizing it as part of an important team.

Mr. BANKS. I would prefer you to defer to Dr. Carroll. I mean, do SPCs have any responsibilities to double check and make sure that nothing is overlooked? I mean, what are some of the rules that are governed about how the SPCs operate within the team structure?

Mr. CARROLL. Yes. The SPCs are an important part of our health care situation. As Dr. Kroviak said, we do not place the entire responsibility for suicide prevention on these 450 individuals. It has to be a team effort. They are the leader around suicide prevention, and so they have the responsibility to communicate with the team, and the team has the responsibility to communicate with them. It is a team based—that is one of the strengths of our organization is our team based structure, both within primary care and mental health.

Mr. BANKS. I get it. I do not want to walk away thinking that either of you are minimizing the SPC. What responsibilities do they do have? What responsibilities exist within the team structure to keep them informed to ensure that they are doing their job?

Mr. CARROLL. One of the key responsibilities that the SPC has, and they have many, but I will highlight this one, because I think it is relevant, is to ensure that any veteran who has a high risk flag for suicide on their electronic health record, to make sure that that flag gets reviewed every 90 days.

I think that is a critical responsibility. That helps us keep track of individuals who are at highest risk perhaps among our population. That is a function that they have. They need to make sure that that staff training takes place. They do have this outreach responsibility that we talked about as well, to interact across the system.

Mr. BANKS. I want to stay on the same subject. I see heads nodding, so I wonder if there are others on the panel that want to weigh in about how the SPCs can—what responsibilities the team has to informing the SPCs? Anybody else?

Dr. KROVIAK. My nod was not specific to that. I would also want to recognize, the SPCs play a role in management at a later time in the management of the patients. Recognizing the care that is required up until the point where they would intervene.

Mr. BANKS. Thank you. I have got 30 seconds left. At the end of——

Ms. OSHINSKI. I just would like to also, and Dr. Carroll talked about the outreach. They do have internal things that they are doing, but we have been talking about rural health care. The SPCs, and I am going to speak particularly to General Bergman's area, I have been up there visiting those folks. They are out there across the upper peninsula. I think we can not minimize the fact, they are part of our public health outreach. That is part of their job.

I think that is going to become more important as we move to this multi-pronged approach to try and look at how do we get our word out to those 14 who are not seen in the VA, it is through those SPCs.

Mr. BANKS. Thank you. My time has expired.

The CHAIRMAN. Thanks. Mr. Levin, you are recognized.

Mr. LEVIN. Thank you, Mr. Chairman. I appreciate you holding this hearing on this critically important issue to all of us.

I have the honor of serving as the chair of the Subcommittee on Economic Opportunity, so I want to focus my questions on that intersection.

Assistant Secretary Oshinski, in your written testimony, you emphasize the importance of social determinants of health, which, as you note, include economic factors, such as employment and housing. The CDC includes strengthening economic support as one of its seven core strategies for suicide prevention.

As far as I can tell, none of the goals or objectives in VA's national strategy for preventing veteran suicide address economic opportunity specifically. I am concerned that perhaps you are being too siloed within VHA, so I wanted to ask how you can work better together; specifically, how can you connect veterans at VHA with the VBA-provided benefits, such as the G.I. Bill, vocational training, home loans, and housing vouchers.

In general, can you address how is VHA going to better collaborate with VBA on suicide prevention.

Ms. OSHINSKI. Thank you for that opportunity.

I think, again, that Solid Start is the first place that we are looking at because VBA is really a key driver in making this happen and they are going to be ensuring that we connect people right away when they begin to leave the service and enter civilian life. I think that is certainly one item.

We do understand that the economic factors in a veteran's life can be a big determinant of what happens in their mental health status, so we obviously cannot ignore that. I think we are looking at, you know, making sure that veterans have housing. We do get involved in helping them with job placements.

Dr. Carroll, would you like to elaborate on some of those?

Mr. CARROLL. If I could mention two things, sir, I think within our mental health programs are Compensated Work Therapy program and Supported Employment. We want to help veterans, par-

ticularly those with mental health challenges, find and sustain, you know, competitive employment in the community.

VA is working with, through our Office of Strategic Partnership, through our office, working with the Chamber of Commerce, also looking at what we can do to support employers to hire veterans and to recognize and support veterans within their workforce. We are looking beyond just working within our own organization—certainly, our partnership with VBA is important—but what we can do with the larger community.

Mr. LEVIN. Thank you. If there is anything that we can do on the policy level to help you better collaborate, we would obviously like to entertain that.

Dr. Kroviak and Dr. Coffey, VHA has set forth several policies to identify and mitigate suicide risks, but multiple OIG reports have found that those policies are not being consistently followed. What can VHA leadership do differently to promote policy compliance manage facility staff?

Dr. KROVIAK. Much of our recommendations are focused on filling leadership vacancies and other staff vacancies to promote consistent training and consistent caring out of those policies.

We have also talked about culture to where we have identified in several high-profile reports where staff members will complain, will speak up, will say, This is not right, This has been consistently not practiced. The culture was such that after they complained 5 or 6 times, they stopped because there was no action in place.

Really, supporting, effective leadership responding to leadership vacancies and staff vacancies, and, again, I point to a staffing model: understanding what you need so you can design it to work.

Mr. LEVIN. One of the local feedback from local veterans is VA, as whole, is doing a good job, but local VA facilities are not being held, perhaps, to the metrics or accountability that is necessary. Looking at ways to address that, I think, is helpful.

Finally, I want to turn to VA police officers, who I think are generally doing a great job playing a key role in de-escalating difficult situations on VA campuses.

Mr. Jackson, how many of the 400 hours of training that VA police officers receive are specifically focused on suicide prevention?

Mr. JACKSON. Yes, sir. Thirty and a half hours are definitely focused on suicide prevention and then 24 hours on doing scenario-based, because we want to evaluate that you are doing the right things in terms of recognizing, de-escalating, and identifying.

As Ms. Oshinski mentioned earlier about the saves that the police have done, that is just a few; it has been quite a few.

Mr. LEVIN. Mr. Chairman, my last question.

We have heard a bit about security cameras and the issues there, where in one instance, cameras had not been operational for 3 years. Who is responsible for maintaining security cameras on VA premises and what are we doing to fix these issues in the future?

Ms. OSHINSKI. Thank you for the opportunity to mention that. The facilities director is responsible for making sure that the equipment on the site works.

I think that it is one of the items that the Office of Security and Law Enforcement reviews during their reviews, whether those be yearly, bi-yearly, or every third year. They will oversee to make

sure that we are doing that, but it should be a facility director responsibility.

Mr. LEVIN. Is that something we could do a better job of, though?

Ms. OSHINSKI. Yes, we certainly can, and I think we are working on trying to do that. We have started an initiative to look and make sure that our cameras are operational and that they are able to be viewed.

Mr. LEVIN. I look forward to following up with you.

I thank the chairman and I thank the colleagues on both sides of the aisle. I look forward to working together to continue to address this crisis in our country.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Levin.

Mr. Watkins, you are recognized.

Mr. WATKINS. All right. Thank you, Mr. Chairman.

Thanks to the panel for being here.

This question will be for anybody who would like to respond. The 22 per day is a raw number. Can someone comment on what percent that is—I understand there is somewhere in the neighborhood of 21 million veterans—and how that percent compares to the general population.

Mr. CARROLL. Yes. Thank you, sir. I am happy to talk about that.

Actually, the daily number that is typically reported is 20 a day and that includes about one active-duty servicemember, 2 or so Guard and Reserve, and then 17 individuals who are veterans; of those, 6 have been engaged in VA healthcare in the year or two prior to their death and 2 of the 11 have been engaged in healthcare at some point, and the other 9, not engaged with VA. That is how it breaks down.

What we see in terms of the rate in the population, it is about 31 per 100,000. What we have seen between 2005 and 2017 is there was a significant increase in the American population rate of suicide. There were somewhere in the neighborhood of 86 deaths per 100,000 among American adults in 2005 and it went up to 124 in 2017.

During that period of time there was an increase among veterans, the rate, but I do not recall what it was in 2005. As I said in 2017, it is 31.

What happened, though, is that the population of veterans went down. The veterans are about 1.5 times more likely to die by suicide than individuals in the population.

Mr. WATKINS. All right. Forgive me.

Just looking at 2017——

Mr. CARROLL. Yep.

Mr. WATKINS.—124 per 100,000 at the national level?

Mr. CARROLL. Yes, Americans.

Mr. WATKINS. Americans, correct.

But veterans, 31 per 100,000?

Mr. CARROLL. Correct.

Mr. WATKINS. Why is it one and a half more times likely to kill yourself if you are a veteran? The numbers do not add up.

Mr. CARROLL. It has to do with the size of the population.

Mr. WATKINS. We are taking the size by taking the denominator of 100,000.

Mr. CARROLL. Yes——

Mr. WATKINS. You are——

Mr. CARROLL.—the experts to review the statistics with you, sir, but——

Mr. WATKINS. Yes, because it looks to me like it is three times more likely if you are a citizen, as opposed to a veteran.

Mr. CARROLL. That is—Okay.

Mr. WATKINS. Okay. Thirty-one veterans out of 100,000——

Mr. CARROLL. Yes. In——

Mr. WATKINS.—but 124 citizens out of 100,000.

Mr. CARROLL. Uh-huh.

Mr. WATKINS. There is a denominator, so there is a percent there.

Mr. CARROLL. Right. Right.

The reality is in 2017, 6,139 veterans died by suicide and that is the number that we need to get to zero, per Dr. Coffey and we would agree with that.

Mr. WATKINS. I just—I understand.

Mr. CARROLL. We would be happy to sit down and walk through our whole day report if that would be helpful.

Mr. WATKINS. Sure. I just want to make sure I know what I am talking about when I go and look at percentages——

Mr. CARROLL. Yes.

Mr. WATKINS.—because what you just cited me is it is roughly three times more likely to kill yourself if you are a citizen. That is literally what you just cited.

I mean, maybe somebody can pull me aside after this, but 31 out of 100,000——

Mr. CARROLL. We will have to go back, and I may have misspoke, sir——

Mr. WATKINS. Okay.

Mr. CARROLL.—so, let me—I will own that. I will go back and look at that, but let me——

Mr. WATKINS. All right.

Mr. CARROLL. You are right, that does not make sense.

Mr. WATKINS. The reason is, as a veteran and as somebody who has buried friends, I mean I have people approaching me and saying, Hey, walk me through this 22 per day, and so I am turning to you and asking you to walk me through it. These percentages—because I am hearing pushback and what you just said is consistent with the pushback.

You do not need to scramble to find the answer for me right now. It is just, I want to——

Mr. CARROLL. I apologize to you and the committee if I misspoke——

Mr. WATKINS. That is Okay.

Mr. CARROLL.—on that, sir. We are happy to get that right——

Mr. WATKINS. Well, politicians never misspeak, so——

Mr. CARROLL. Well——

Mr. WATKINS.—do not worry about it. We will get to the bottom of the numbers. I just eventually want to know what I am talking about.

Mr. CARROLL. Yes. We want to make sure you have that information and we appreciate your support.

Mr. WATKINS. Of course.

Yes. Ms. Oshinski, the death of a patient in a VA facility is a never event, which means exactly what you think—it should never happen—but when it does, what sort of internal review of the systems and procedures take place?

Ms. OSHINSKI. Thank you. We have a root-cause analysis that takes place, which looks at exactly what happened and what are the ways—what are the reasons behind that and what are the things that need to be done to correct it. That is kind of from the investigation side. If we think there is something more that needs to be done, an administrative board of investigation may be chartered; it depends on what we find as we are looking at the situation as we collect the facts.

However, I think one of the other important things we can talk about is the work that we do when this happens with the staff or with veterans who may have interacted with those individuals. One of the things you find is that veterans participate in these groups and when we have one veteran who may lose his life, it affects greatly those individuals who interact with that veteran. We work on, also, on inventions with the staff, as well as veterans who worked together with that individual.

Mr. WATKINS. Thanks.

I am out of time. I yield.

The CHAIRMAN. Thank you, Mr. Watkins.

Ms. Underwood, you are recognized.

Ms. UNDERWOOD. Thank you, Mr. Chairman.

As a public health nurse, I know just how important it is to advance solutions to the veteran suicide crisis that are data-driven and that are evidence-based. Identifying strengths and weaknesses in VA care allows us to focus on those areas that require the most immediate attention.

One of those areas is mental health and suicide prevention workforce. I understand that vacancy rates among mental health clinical staff are critical challenges facing many of our communities, including some at VA facilities, so, at the outset, I will say that I know that just in a community-based setting, this is a problem, okay.

What actions, Ms. Oshinski, is VA taking to retain staff and fill vacancies in the mental health and suicide-prevention space?

Ms. OSHINSKI. Thank you for that question.

One of the things that we try to do, again, is make sure that people are very well oriented so that they understand exactly what—how they are going to interact in that situation——

Ms. UNDERWOOD. Oh, yes, ma'am.

I am sorry. We have limited time, so just, honestly, what are you doing to fill the vacancies, if you can?

Ms. OSHINSKI. What are we doing to fill vacancies? We have open and continuous hiring so that we never close a vacancy. We continually put that out there so that anytime anybody wants to apply for a job, they have that opportunity—it does not mean that a vacancy has to exist—so that we would constantly have people able to step in, that they would already be qualified and we could hire them—overhire them—and that is something that we do on a routine basis when we can do it.

Unfortunately, as you know, often, there is a gap and we do not have those, but open and continuous is certainly one of the things that we have done to improve hiring.

Ms. UNDERWOOD. Okay. Thank you.

Another area is lethal means training.

Ms. OSHINSKI. Uh-huh.

Ms. UNDERWOOD. Research backs up the life-saving benefits of creating additional space and barriers between a veteran who may be experiencing suicidal thoughts or ideations and the lethal means for them to complete any suicidal action.

It is my understanding that VA has implemented lethal means training for all VA mental health-care clinicians who interact directly with the veterans.

Dr. Carroll, is that correct, and can you confirm exactly which categories of VA staff are currently receiving the lethal means safety training.

Mr. CARROLL. I will have to get back to you about which categories of employees across the board, but, yes, all mental health providers would be required to receive that training.

Ms. UNDERWOOD. Okay. In that response, can you please outline, like, clinical and if there is any non-clinical staff that are receiving that training——

Mr. CARROLL. Yes, ma'am.

Ms. UNDERWOOD.—and whether it is voluntarily offered or a requirement——

Mr. CARROLL. Yes.

Ms. UNDERWOOD.—and sort of some of the details around that training would be very helpful.

Can you also tell us more about the training that the VA has developed, like, how often does staff have to receive it—things like that.

Mr. CARROLL. Yes, the lethal means training is not currently an annual requirement, but I think the frequency of training, we will get back in our response to you.

Ms. UNDERWOOD. Okay.

Mr. CARROLL. We have also developed a lethal means training that is available widely in the community in partnership with the American Foundation for Suicide Prevention——

Ms. UNDERWOOD. Uh-huh.

Mr. CARROLL.—as well as the National Shooting Sports Foundation.

Ms. UNDERWOOD. Then, to develop that training, was that something internal to VA or did you work with outside experts?

Mr. CARROLL. We worked with outside experts.

Ms. UNDERWOOD. Was it just the Sports Foundation or others?

Mr. CARROLL. The American Foundation for Suicide Prevention.

Ms. UNDERWOOD. Okay. Then what is your understanding of the lethal means safety training that contractors receive and would you say that it is equivalent to what the staff receives?

Mr. CARROLL. I would like to take that for the record——

Ms. UNDERWOOD. Okay.

Mr. CARROLL.—so we can make sure we get you the correct information.

Ms. UNDERWOOD. Thank you.

In some instances, some of the veterans in crisis no longer require inpatient care supervision by the medical staff at the VHA centers. This requires a handoff to another responsible party—it might be the veteran's family or other members of that veteran's support care network—so, Dr. Carroll, what resources are available to families and the support networks for the veterans that are at risk for suicide and are they able to coordinate with the veteran's clinicians? Are they able to access trainings or any other educational resources provided by the VA?

Mr. CARROLL. Certainly, family members are part of the team that cares for veterans and we respect veterans' wishes in terms of having family members engaged in their care——

Ms. UNDERWOOD. Uh-huh.

Mr. CARROLL.—but to the extent that they are a support of that, we welcome them to our—into the care process. We also have resources available to family members, just like they are to veterans, such as the Veterans Crisis Line. We also have a program called Coaching Into Care, which is a specific resource for families to call, in particular, if their veteran may be hesitant or reluctant. It will help——

Ms. UNDERWOOD. Right.

Mr. CARROLL.—the family kind of understand what some of the resources are and how they can maybe help that person toward getting into care.

Ms. UNDERWOOD. Well, I appreciate that, but that is on the front end. I am talking about after someone has already received care——

Mr. CARROLL. Oh, Okay.

Ms. UNDERWOOD.—at the VA, they have completed an inpatient stay and they need to be discharged. There needs be some kind of handoff——

Mr. CARROLL. Yes.

Ms. UNDERWOOD.—to, likely, a community provider.

What we are seeking to understand is the type of coordination that is offered in that handoff and information that is being shared to both, family and other clinicians in the community or support networks, of which there are plenty——

Mr. CARROLL. Right.

Ms. UNDERWOOD.—in many communities around our country.

Can you speak a little bit about that—I know I am out of time—so, maybe you can take that for the record if the chairman would allow him to answer?

The CHAIRMAN. Okay.

Ms. UNDERWOOD. Okay. If you would answer?

Mr. CARROLL. Yes, so families—there should be a warm handoff when someone leaves an inpatient unit to make sure that they have an appointment, you know, for follow up and they understand, and in many cases, the provider, if it is within our facility, may come on to the unit and may see that patient already or have an existing relationship, and the family members should be involved. If they are going to the community, the community provider needs to acknowledge that they have an appointment, and then we would need to follow up to make sure that that handoff actually occurred.

Ms. UNDERWOOD. Okay. Then for the record, we will probably submit a question, because I think I heard you say that the community clinician is allowed in before that handoff occurs to the VA facility, so I just want to really drill down on that, along with the other questions that we had.

Thank you so much to our witnesses for being here, I appreciate it.

Mr. CARROLL. Thank you.

Ms. UNDERWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Ms. Underwood; as always, you are very prepared and I admire your questioning.

Mr. Barr, you are recognized.

Mr. BARR. Thank you, Mr. Chairman, and I appreciate you holding this hearing on this very important topic.

I appreciate all of our witnesses for your work on preventing veteran suicide, which is just an absolute tragedy in our country. As we all agree, it is essential that the VA take every step possible to identify and address suicidal risk factors for veterans, especially in the care of the VA.

Before getting to my questioning, Mr. Chairman, I do want to raise a concern. On December 12th of last year, I sent a letter to you requesting a field hearing in Lexington in our district on the topic of equine-assisted therapy; a topic that you know I have been passionate about and advocating for Congress since—and this has received bipartisan support in this committee. Since then, though, my office has not received a response on this and our office was told last Friday to be expecting a call from your staff regarding the request, and despite multiple emails and calls, we have not received an answer. Ranking Member Roe has replied in support of the hearing, but we are awaiting your support.

At the VA Medical Center in our district, the veterans using equine therapy at the VA are in the Mental Health Residential Rehabilitation Treatment Program and I know, Mr. Chairman, you have equine-assisted therapy facilities in your own district that serve veterans.

I do think a field hearing on this therapy is in line with our suicide-prevention goals in this committee and I would just ask, Mr. Chairman—and I will yield to you—can we get a commitment that we will get an answer on that.

The CHAIRMAN. Mr. Barr, field hearings, in terms of our committee travel budget and our staffing, have been restricted to the chairman of committees and the ranking member. We have had—we usually have a reciprocal agreement among the chairman and the ranking member on top, if they want to choose. I am going to have to adhere to that tradition and precedent; however, as—so, I cannot support a field hearing.

I am interested in equine therapy, and I will look at my schedule and I will look at—you know, short of a field hearing, I can, perhaps, work with you on a visit.

Mr. BARR. Well, I know you are, Mr. Chairman. I appreciate that. I know Chairwoman Brownley is, as well, and I appreciate both of you all expressing interest in working with me on that, whether we have a field hearing or not.

Ms. Oshinski, I would like to welcome you and your colleagues this morning, and, again, thank you for your work to counter veteran suicide.

I am heartened to hear that since 2017, all VHA employees are getting training both, clinical and non-clinical, mandatory annual suicide-prevention training. I think it is important that we are giving veterans every opportunity to talk about suicidal ideations and get the help that they need.

I have heard, however, from veterans in my district that veterans are more hesitant to talk to staff at the VA because of a lack of shared experience if those staff are not veterans, themselves, and so my question is, would you or any of your colleagues see the benefit of a peer-support program enfolded within the VA where veterans can process their experiences with other veterans?

Ms. OSHINSKI. Thank you for that question.

About a third of our employees currently are veterans, so I think there is some possibility there, but we certainly recognize and are beginning to incorporate more and more peers within our treatment areas. I think, in particular, in mental health, we have made a huge effort there, as well as in that whole health initiative where we have peer-led groups for folks who come and are veterans who want to participate in some of those areas.

Dr. Carroll, would you like to expound on what we are doing with peers in mental health.

Mr. CARROLL. Sure. Within mental health we have over 1,100 peer-support specialists. These are veterans with the lived experience of mental health experience, themselves, as well as being certified, and we are also incorporating them into our primary care——

Mr. BARR. Well, that is great, and the more the better of that; that is the feedback from folks in the Sixth District Veterans Coalition.

Dr. Kroviak, kind of an overview, as the Inspector General's Office—overview—you know, I read about this terrible tragedy at West Palm Beach—are we getting better overall or are we getting worse? What is the trend line?

Dr. KROVIAK. Oversight gives you an incredible perspective in terms of how care is being delivered and the consistency with which policies are being carried out.

I think what our work highlights, as it did in West Palm, is that there are consistency issues with staff carrying out relatively understandable policies and procedures. We fault much of that or hold accountable, leadership in those situations—the multiple layers: the service line managers, the facility directors, up through the VISNs.

Looking at leadership vacancies, instability of leadership and other staff vacancies; it is ripe for issues like we report on.

Mr. BARR. Well, my time has expired.

Ms. Oshinski, I did just want to commend my friend Mr. Levin from California bringing up the VBA and interaction. Some of my veterans who are in difficult situations, they—their frustrations and their vulnerabilities are compounded by the difficulties that they have with their interactions with the VBA. I think we need

to watch those veterans, particularly, that are having trouble interacting with the VBA. Thank you.

I yield back.

The CHAIRMAN. Thank you, Mr. Barr.

Mrs. Lee, you are recognized.

Mrs. LEE. Thank you, Chairman, and thanks for your leadership on this incredibly important topic, and thank you all for being here.

As I have sat here and listened to all of your testimony and the questions, Dr. Coffey, I have one question for you. The Henry Ford Health System—how many hospitals, patients did that encompass?

Dr. COFFEY. I can not give you the number of patients. It is a very, very large, vertically integrated healthcare system in the Midwest. It owns and operates its own Health Maintenance Organization (HMO), which is sort of the test tube in which we did our measurement for the rates of suicide, but—and that was about a half a million people—but the system——

Mrs. LEE. Half a million people, population?

Dr. COFFEY. In that membership in the HMO——

Mrs. LEE. HMO, Okay.

Dr. COFFEY.—at one time. The system serves many, many more individuals who are not members of the HMO, so——

Mrs. LEE. Okay. Yes, I just—my question is really around sort of the complexity of the VA and the medical centers. We have 170 medical centers, 1,400 community-based clinics serving 9 million vets, and I certainly love the radical idea of perfect—a goal of perfect care, and I think that is certainly a goal that we should have when we are talking about men and women who have served this country to make sure that we are getting to a point of zero suicides a day. I certainly believe that that should be the goal.

My question is, as I sit here and listen to all of our members ask questions on oversight—we have the OIG—clearly, we hear our constituents with their frustration, whether it is with the VBA, the VHA, et cetera, and my question to you is when you talk about your roadmap, I imagine you were invited here because we are intrigued by this concept and are hoping that, potentially, we can implement this concept within the VA, especially as it pertains to suicides.

My question is, really, when you think about your roadmap, to me, the most part of it is your Just Culture and making sure you are asking why and how, instead of who?

Dr. COFFEY. Yes.

Mrs. LEE. The question I have to you is based on just the general concept of how the VA is run, how we provided oversight as Members of Congress, do you think that is possible?

Dr. COFFEY. Absolutely.

Mrs. LEE. Okay.

Dr. COFFEY. Of course it is, absolutely.

Mrs. LEE. I am glad to hear that. Now, my next question is—you know, basically, we have 6 veterans a day who are in care of the VA who commit suicide. When you talk about a roadmap—when we talk—I feel like this is such an overwhelming problem for us, because we are not only dealing with the 6 in our care, we are dealing with the 10 who are not in our care, and we are looking at the handoff between the DoD and us and then those men and women

who we failed at the handoff who are now in the population who are counting for that, as well.

I guess my question is, if you were to establish a roadmap, would your recommendation be to focus first on the 6 in our care and then if we can get to a 75 percent reduction or a 100 percent reduction, then look at the how do we get those 16 into our care——

Dr. COFFEY. Sure.

Mrs. LEE.—and, you know, I am just trying to wrap my head around a roadmap, because I sat here today and listened to the suicide-prevention strategy, the mental health sustainability initiative, the Solid Start. I mean, it is just so—I feel like we continue to pile on and on and on initiatives and yet, people who are running these facilities and people who are providing the care, and then the culture of when we ask who and the accountability and what we are doing about that, I just feel like we are on a hamster wheel here.

If we are, in fact, going to adopt a zero-tolerance, you know, a perfect-care policy, I would like to see us look at how we are putting that roadmap into place. You know, I am just more of a, what steps do we need to take to get to where we need to be going?

I think my question, I guess for Ms. Oshinski would be, what is it that this body can do to help promote the type of culture that would be needed to implement this type of perfect-care scenario?

Ms. OSHINSKI. Thank you. It is a challenge, and I agree with you, we are trying to do very many things.

I think what we heard today about supporting the Just Culture, that this is not about an individual failure; this is about how we need to change and work the system. As I said before, I can assure you, in terms of accountability, any provider or any person who has any interaction with a veteran who harms himself is forever remembering what happened.

I think this committee helping to spread that word that we need to make sure that we have a Just Culture, and that when we fix things, we are fixing things so that individuals are not the issue; the issue is, how do we make the system work for the betterment of the most number of veterans that we can?

I think by having this hearing, this is exactly what we need.

Mrs. LEE. Okay. Any recommendations, Dr. Coffey?

I am sorry, I am over my time.

Dr. COFFEY. Well, no. I feel you and I agree with all that you have said about complexity.

I can't specifically advise VA on this matter, but as the general strategy and what I would recommend is, where is the low-hanging fruit? Where is the biggest opportunity?

You know, I tell my team, There are a thousand things we could do this year. There are a hundred things we need to do this year. There are three things that we are going to be able to do this year, and our job as leaders is to make sure that we have identified the correct three things. You just go through your priority setting at that point and then go from there.

But I do think there is a balance between where is the low-hanging fruit—some quick wins—and then where is the big problem that we can begin to sort of chip away at.

Mrs. LEE. I yield back.

The CHAIRMAN. Thank you, Ms. Lee.

The Just Culture, that term, I think is very important. I want to mention it in light of the fact that we have some issues with the VA's Office of Whistleblower Protection. Making sure whistleblowers are protected is definitely a part of making sure that we have a Just Culture and it is about the culture.

Before we wrap this up, Dr. Roe—and I will also ask him to ask questions along the line if I do not get it completely answered—but Ms. Oshinski, to the extent possible—and I am throwing a curve ball at you because it is a—but I have to tell you that 213 passengers who were evacuated from Wuhan will—have already landed in the heart of my congressional district.

I did appreciate my chat last night—I had a briefing with the under secretary at U.S. Department of Health and Human Services (HHS) and an individual at the CDC—but here is what I think is of concern for this committee in this jurisdiction. In light of a grave public health concern, and I would say even threat, what plans are the VA—have the VA begun a planning process for taking care of our veterans?

As you know, we have a fourth mission at the VA, which is also disaster preparedness and operating the emergency caches. I want to know your thinking in terms of what sort of planning is starting to occur already with our primary role of providing healthcare to veterans and then we also have a community responsibility through our fourth mission.

Ms. OSHINSKI. Thank you. Actually, as I left for this meeting, I had to leave a planning process for how we are dealing with the coronavirus; however, I will tell you that we have been monitoring this on open-source, as well as in collaboration with HHS, since the initial reports began from China.

We have been identifying what are the requirements that we need to have in terms of laboratory testing as these cases present themselves. We have widely shared and had a conference call yesterday with chiefs of staff across the networks about how do we proactively deal with—what are things you need to make sure all the providers across your site know.

We shared last night making sure that all the modules from the CDC in regards to education and how we train people were distributed to all the medical centers all across the country.

We are likely going to—as things get closer, we will be giving—we are giving out more information and that was part of the meeting that I left today—what do we do, as you have said, when we have, now, people who are coming back from that part of the country?

Some of them may be providers. Some may be people who are within our system. We need to make sure that we are giving out the appropriate guidance.

We have—like I said, we are collaborating daily with HHS to find out what is going on and making sure that we are following everything that they are putting out and telling that to our folks. I think we are being very proactive. I would likely see an incident command being set up if we see a more significant spread.

The CHAIRMAN. Well, as you know, we have numerous veterans in the Philippines, American veterans that utilize the Foreign Med-

ical Program, and we also operate a clinic attached to the embassy there. We also, in the region, of course, have veterans on Guam and the Northern Mariana Islands, so closer in proximity to the epicenter of this epidemic.

Are you plans also taking account of our exposures there?

Ms. OSHINSKI. Yes, thank you.

We are—actually, we have been monitoring the Philippines very closely recently with the volcanic activities on that island and in our morning meeting, we have been looking at that situation on a daily basis for the last 2 weeks. We do continue to have monitoring with them.

The difficulty there with the change in time zones, but we have daily interaction with them about where we stand both, on the environmental situation there, as well as, what is happening with the coronavirus.

The CHAIRMAN. Dr. Roe, do you have anything that you want to ask?

Mr. ROE. Yes, we were—I mentioned this to the chairman during this that I hoped the VA—because we have already had in our local community, a shortage of gowns and that occurred before the coronavirus outbreak. We had to delay some elective surgery because of just sterilized paper gowns, a shortage of those already.

This reminded me of a couple of things that occurred that was sort of funny. There was a flight from Hong Kong or somewhere when the bird flu was going on—maybe it was Ebola—I can not remember which of the outbreaks it was—but this guy sitting in the airplane said, Well, I think I have this. What the airline did with this highly contagious disease is kept him on the airplane, but let all the other vectors go that had been exposed to it, which could have exposed the whole country to this problem. I think educating the public about this is extremely important and then being prepared for this, if it does.

What I always did when I went into the operating room was prepared for the worst disaster that I could think of, you know, a train wreck, and hope I went on a train ride, and I think that is what we need to do in this situation.

Ms. OSHINSKI. Thank you. You know, one of the things that we are doing is we are pulling out the things that we had put in place when the last pandemic flu outbreak came around and are looking at what we can quickly put into place; again, we have the procedures and processes from the last time around and I think we can quickly implement the things that we need to do.

Mr. ROE. This one is a little bit confusing because we do not know how it spread, quite frankly, yet. We do not have rapid turnaround testing. The CDC has got a nice test, but it will take a couple of days to get the results back. That is—those are the things that we need to beef up.

Can I just finish my statement and then I will turn it over to you?

The CHAIRMAN. Go ahead, sir. Go ahead.

Mr. ROE. Dr. Coffey, I wanted to compliment you, once again, on broken systems. They are a deterrent to us providing quality of care, and also what does not bring value.

I remember as a young doctor, I learned how to do a laparoscopy when I was in the Army and I came to Johnson City, Tennessee, and I was ready to do my first laparoscopic exam and I went in to see this patient before she went in and she had been shaved from here to her knees—I mean, there was not a hair—and I said, Well, why did we do that?

They said, Well, that is the way we have always done it.

I am afraid in healthcare that is a lot of what we do because of how we have always done something and never ask ourselves: Does this bring any value? Does this added step improve quality of care, outcomes, all that?

We need to step back and look at the whole system—I could not agree with you more on that.

I think the thing, also, that has disturbed me so much is that suicide is a national tragedy. It is not just the VA; it is a national tragedy for us. We lost—when you hear the number—50,000 people died of self-inflicted—either by—whatever method they chose to utilize to end their life—that is bigger than all but two towns in my whole district. I do not have a town, but two, that are that large, and I think about that when I drive through them, about how many people in America have done this.

Prostate cancer—31,000 people died of it. We have spent, you know, billions of dollars trying to cure that.

Breast cancer—42,000, same thing.

Colorectal cancer—less than the number of suicides.

It is a national tragedy and it is going to take—not at the thirty-thousand-foot level where we are—but I think you are going to have to solve this at the individual and the local, grassroots level, just like you did, Dr. Coffey, like the VA is trying to do.

I do believe the public health approach—when Dr. Vandell and I were in Johnson City we remembered—you remember the old thing, Smokey Bear: Only you can prevent forest fires; we taught everybody how to cough; "Friends Don't Let Friends Drive Drunk"—I mean, all those things that are catchy, but we need to do that for suicide so that you can look after your neighbor and your friend if they are having problems. That is where we are really going to have to really reduce the level. All these things we are doing are good, but it has got to be more organic than that.

I, personally, am agnostic about where someone gets care. When they are extremists and in trouble, I just want them to get the best care they can get wherever it may be, and I think you all feel the same way.

We mentioned facilities. I visited the new—of all the bumbles and stumbles that it had—out in Denver. They have a great inpatient facility there for psychiatric patients that really look at how to prevent.

I think what the VA should do is go to those places that have the best practices. Instead of trying to reinvent the wheel, take those best practices to each facility—here, this is what actually works; do this—and then hold people accountable, as I think many of our colleagues have asked.

Then I do applaud the VA for trying to contact—Dr. Carroll, you mentioned this—that is amazing when you put a touch on 3 veterans who leave every day. I know when I left the military, I just

left the military; there was not any touch, there was not anything. I applaud the VA for that, but also, I will mention that patients share some responsibility to reach out to you.

The VA can not do everything. You have to have the patient reach out and then we have to have rapid access to care that they need. I think that is one of the things that when the patient does reach out that we do not just blow them off—here, call 9–1–1 or call the suicide hotline—and leave them hanging.

I applaud, and I want to thank—the last person I talked to when I left was a fellow who was painting my house inside when I left and he said, Doc, I just want to tell you, I really get great care at the VA.

I hear that a lot. Through all of its misgivings, I hear that a lot, and I want to thank you all for that and everything that you are trying to do and all the panel members for being here, because I know you are all committed to the same thing that we are.

I yield back.

The CHAIRMAN. Thank you, Dr. Roe.

Ms. Oshinski, just before I launch into my closing statement, Dr. Roe reminded me when he said something about the shortage of paper gowns, one of the reasons why there was a decision to evacuate Americans and other nationals in Wuhan was an understanding that the medical system was highly stressed and that if these individuals did get sick, they would be facing an overwhelmed system.

This overwhelm is part of what I am concerned about, the ripple effect. The beyond the shortage of these gowns, my understanding is that China produces a huge share of our medicines and that the production facilities are not far from Wuhan, and the VA, as we know, is a major purchaser, a large purchaser of these medications and it would be helpful to know whether there is a concern of the VA leadership about our inventory of important medications, you know, in the planning process—if you could get back to the committee with some assessment of where we stand with that.

Ms. OSHINSKI. Yes, Congressman. I will do that.

The CHAIRMAN. Thank you.

Again, I would like to thank——

Mr. ROE. Mr. Chairman, I just referred to my friend Dr. Google and it said the FDA estimates that 13 percent of the world's Application Programming Interface (API) production facilities are in China, compared to 28 percent in the United States. It is a huge percentage.

The CHAIRMAN. It is a huge percentage.

Mr. ROE. Yes.

The CHAIRMAN. I would like to thank the witnesses for their appearances today and their testimony.

The crisis of veteran suicide is not new, but our solutions must be, and that is why I introduced the Veterans' Acute Crisis Care for Emergent Suicide Symptoms Act, or Veterans' ACCESS Act, that will mandate VA cover the costs of emergency mental health care for all veterans, regardless of their eligibility for VA history or level of service connection.

No veteran experiencing a mental health crisis should be deterred from seeking critical treatment because they fear a medical

bill. By removing this significant Bayer to care, my hope is that veterans can now focus on getting the help they need. I look forward to working with all my colleagues, the VSOs, and VA, to make this hope a reality for our veterans.

All members will have 5 legislative days to revise and extend their remarks and include extraneous material.

Again, I thank you for appearing before us today, and this hearing is now adjourned.

[Whereupon, at 12:25 p.m., the committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF WITNESSES

Prepared Statement of Renee Oshinski

Good afternoon Chairman Takano, Ranking Member Roe, and Members of the Committee. I appreciate the opportunity to discuss the critical work VA is undertaking to prevent suicide among our Nation's Veterans. I am pleased to be in attendance with Dr. David Carroll, Executive Director, Office of Mental Health and Suicide Prevention, and Frederick Jackson, Deputy Assistant Secretary, Office of Security and Law Enforcement.

Introduction

Suicide is a complex issue with no single cause. It is a national public health issue that affects people from all walks of life, not just Veterans. Suicide is often the result of a multifaceted interaction of risk and protective factors at the individual, community, and societal levels. All of us at VA are saddened by suicide among Veterans, and we are committed to ensuring the safety of our Veterans, especially when they are in crisis. Losing one Veteran to suicide shatters his or her family, loved ones, and caregivers. Veterans who are at risk or reach out for help must receive assistance when and where they need it in terms they value.

Thus, VA has made suicide prevention our top clinical priority and is implementing a comprehensive public health approach to reach all Veterans—including those who do not receive VA benefits or health services.

These efforts are guided by the National Strategy for Preventing Veteran Suicide. This 10-year strategy, published in June 2018, provides a framework for identifying priorities, organizing efforts, and focusing national attention and community resources to prevent suicide among Veterans through a broad public health approach with an emphasis on comprehensive, community-based engagement. This approach is grounded in four key focus areas as follows:

- Primary prevention that focuses on preventing suicidal behavior before it occurs;
- Whole Health offerings that consider factors beyond mental health, such as physical health, social connectedness, and life events;
- Application of data and research that emphasizes evidence-based approaches that can be tailored to fit the needs of Veterans in local communities; and
- Collaboration that educates and empowers diverse communities to participate in suicide prevention efforts through coordination.

Through the National Strategy, we are implementing broad, community-based prevention initiatives and clinical intervention driven by data to connect Veterans in and outside our system with care and support at both the national and local facility levels.

Clinical Intervention Strategies:

Care Coordination Across the Continuum of Services

VA provides a full continuum of care from crisis intervention services, screening, same day access to mental health care, outpatient, residential, and inpatient mental health services across the country. A 2019 RAND study[i] shows that VA is providing high-quality mental health care and that this care can improve recovery rates and is cost-effective. Points of access to care span VA Medical Centers (VAMC), community-based outpatient clinics (CBOC), Vet Centers, mobile Vet Centers, the Veterans Crisis Line (VCL), and through the network of Suicide Prevention Coordinators (SPC) and team members available at all VAMCs. Veterans and their family mem-

[i] High-Quality Mental Health Care for Veterans: What It Means and Why It Matters. Santa Monica, CA: RAND Corporation, 2019. https://www.rand.org/pubs/research_briefs/RB10088.html.

bers can connect with support through in-person appointments at local VA facilities, telehealth sessions, and online resources.

VA-Department of Defense (DoD) Collaboration for Suicide Prevention Care Coordination Among Servicemembers in Transition

VA collaborates closely with DoD to provide a single system of lifetime services for the men and women who volunteer to serve in the Armed Forces. Our partnership with DoD and the Department of Homeland Security (DHS) is exemplified by the successful implementation of Executive Order (EO) 13822, *Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life.* EO 13822 was signed by President Trump on January 9, 2018, and focused on transitioning Servicemembers (TSM) and Veterans in the first 12 months after separation from service, a critical period marked by a high risk for suicide.

The EO mandated the creation of a Joint Action Plan by DoD, DHS, and VA that provides TSMs and Veterans with seamless access to mental health treatment and suicide prevention resources in the year following discharge, separation, or retirement. VA provides several outreach programs and services that facilitate enrollment of Veterans who may be at risk for mental health needs, to include VA Liaisons stationed at 21 military medical treatment facilities as well as multiple outreach programs to support engagment in mental health services at VA or in the community. Some of our early data collection efforts point toward an increase in TSM and Veteran awareness and knowledge about mental health resources, increased facilitated health care enrollment, and increased engagement with peers and community resources through the Transition Assistance Program (TAP) and Whole Health offerings. TAP curriculum additions and facilitated enrollment have shown that in the third quarter of Fiscal Year (FY) 2019, 86 percent of 11,226 TSM respondents on the TAP exit survey reported being informed about mental health services.

VA and DoD are committed to delivering compassionate support and care, whenever and wherever a Servicemember or Veteran needs it. This includes collaborating to implement programs that facilitate enrollment and transition to VA health care; increasing availability and access to mental health resources; and decreasing negative perceptions of mental health problems and treatment for Servicemembers, Veterans, and providers. The most recent coordinated effort under EO 13822 began in December 2019, when VA launched the Solid Start call center, which proactively contacts all newly separated Servicemembers at least three times during their first year of transition from the military.

Although EO 13822 was established to assist in preventing suicide in the first-year post-transition, the completed and ongoing work of the EO effects suicide prevention efforts in the years following a Servicemember's transition. These efforts are demonstrated through increased coordinated outreach, improving monitoring, and increasing access to care beyond the first year. VA is working diligently to promote wellness, increase protection, reduce mental health risks, and promote effective treatment and recovery as part of a holistic approach to suicide prevention.

Care Coordination for Veterans at Risk of Suicide Across the Continuum of Care: The Role of Suicide Prevention Coordinators

Within the VA system, there is currently a network of over 400 SPCs. Overall, SPCs facilitate the implementation of suicide prevention strategies within their respective VAMCs and catchment areas to ensure that all appropriate measures are being taken to prevent suicide in the Veteran population, particularly Veterans identified to be at high risk for suicidal behavior. As an integral part of Veterans' care teams implementing VA suicide prevention programs, SPCs are experts on suicide prevention best practices. SPCs work closely with other providers to ensure that Veterans living with mental health conditions and experiencing difficult life events receive specialized care and support for their suicide risk.

SPCs also plan, develop, implement, and evaluate their facility's Suicide Prevention Program to ensure continual quality improvement and excellence in customer service. This work affects a wide range of agency activities and operations and directly affects the health and well-being of the Veterans served and relationships with community organizations and stakeholders.

An essential role of SPCs is to participate in outreach activities in local communities to increase awareness of suicide prevention and the resources available in the local community (a minimum of five events per month with increased efforts during September's Suicide Prevention month). These outreach activities include: (1) community suicide prevention trainings and other educational programs; (2) exhibits and material distribution to a wide variety of organizations and populations; (3) meetings with State and local suicide prevention groups, collaborations with Vet Centers, local Veterans of Foreign Wars (VFW) and American Legion branches; and

(4) suicide prevention work with Active Duty/Guard/Reserve units, college campuses, and American Indian/Alaska Native groups.

Suicide Prevention Crisis Services and Follow-up Care Coordination: VCL and Emergency Department

Established in 2007, VCL provides confidential support to Veterans in crisis. Veterans, as well as their family and friends, can call, text, or chat online with a caring, qualified responder, regardless of eligibility or enrollment for VA care. VA is dedicated to providing free and confidential crisis support to Veterans 24 hours a day, 7 days a week. VA has streamlined and standardized how crisis calls from other locations within VA reach VCL, including full implementation of the automatic transfer function that directly connects Veterans who call their local VAMC to VCL by pressing a single digit (7) during the initial automated phone greeting. SPCs also assist in coordination of follow-up referrals for Veterans after they call the VCL by assisting Veterans with accessing VHA care and assisting with evaluation, treatment, and or referrals to community-based care for those who decline VA services or are ineligible for services.

Veterans in crisis not only present to the VCL but also present in VA emergency departments (ED). Suicide Prevention in Emergency Departments (SPED) is an evidence-based strategy currently being deployed in VA. Veterans presenting to the ED, or for VA urgent care, who have been assessed as at risk of suicide, but are safe to be discharged home, receive suicide safety planning intervention prior to discharge and follow-up outreach to facilitate engagement in outpatient mental health care. Safety planning interventions (SPI) in EDs provide safety planning and lethal means counseling prior to discharge and follow-up contact after discharge with the Veteran to offer support until he/she has connected with outpatient mental health providers. Implementing an SPI and follow-up phone call for patients who visited participating VA EDs for suicide-related concerns reduces suicidal behaviors by almost half (45 percent) in the 6 months following the ED visit.[ii]

Suicide Risk Identification Process: Screening to Enhance Access to Treatment and Care Coordination

In addition to providing suicide prevention services during the time of crisis, VA provides proactive methods for identifying individuals at high risk for suicide. VA has implemented a standardized suicide risk screening and assessment process, providing Veterans with a high standard in preventive care. This process, known as the Suicide Risk Identification Strategy (Suicide Risk ID), was introduced in May 2018. The Suicide Risk ID is for all Veterans receiving VA care. The strategy is comprised of three components and implements population-based mental health screening for those with unrecognized risk (universal screening), for those who may be at risk (selected screening), and for those at elevated risk (indicated screening). The components include standardized primary and secondary screens specific to risk of suicide and a comprehensive suicide risk evaluation for Veterans with a positive secondary screen. Screenings occur at every ED and urgent care visit across VA. For Veterans presenting for other VHA services, VA has setting-specific guidance for screening and assessment.

The Suicide Risk ID integrates the recently published (2019) VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide (CPG). CPG is an update to the 2013 guideline and outlines five recommendations on screening and evaluation; the Suicide Risk ID uses part of the CPG's recommendations, including comprehensive screening, specifically:

- The use of a validated screening tool for universal screening to identify individuals at risk for suicide-related behavior;
- The use of the Patient Health Questionnaire-item 9, and
- An assessment of risk factors as part of a comprehensive evaluation of suicide risk.

From October 1, 2018, through December 4, 2019, more than 4.1 million Veterans have received a standardized risk screening.

Same Day Access: Getting to Care when Care is Needed

[ii] Stanley, Brown, Brenner, Galfalvy, Currier, Knox, Chaudhury, Bush, and Green 2018. Comparison of the Safety Planning Intervention With Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department. *Journal of the American Medical Association*, 75(9):894–900. Published online July 11, 2018.

A critical part of suicide prevention is ensuring same day access to mental health services. VA launched the My VA Access Initiative in 2016. This initiative provides same day access to primary care and mental health services. In mental health care clinics, the number of same-day scheduled appointments increased from 796,242 in Fiscal Year 2017 to 824,276 in Fiscal Year 2018. The percentage of new patients with same-day appointments increased from 29.5 percent (FY 2017) to 33.2 percent (FY 2018).

Suicide Prevention in Primary Care: Reaching Veterans through Early Identification

VA's Primary Care Mental Health Integration (PCMHI) is an initiative that provides collaborative care with embedded mental health providers within primary care clinics and collaborative care management. Through PCMHI, primary care providers are critical partners in VA suicide prevention strategies. The PCMHI model provides open access to Veterans, as well as mental health consultative advice to Primary Care staff, assessment, and brief interventions in a stepped approach within the Veteran's local health care clinic. Early identification, accurate diagnosis, and effective treatment of mental health conditions improves the chances for recovery.

As a result, VA primary care providers screen Veterans for depression, posttraumatic stress disorder (PTSD), problematic alcohol use, and difficulties related to military sexual trauma. It also provides an opportunity to deliver mental health services to those who may otherwise not seek them and identify, prevent, and treat mental health conditions at the earliest opportunity. Making mental health care a routine part of primary care helps reduce stigma and provides the right intensity of care to the Veteran as quickly as possible.

Suicide Prevention and Care Coordination through Outpatient Mental Health Services

Each Veteran receiving ongoing VA specialty mental health care is assigned a Mental Health Treatment Coordinator (MHTC) who ensures continuity of care and provides the Veteran with a consistent and reliable point of contact, especially during times of care transitions. The MHTC serves as a clinical resource for the Veteran and staff, generally as part of the Veteran's assigned mental health care team.

In addition, VA facilities throughout the country are utilizing teams to promote Veteran-centered, coordinated care to support recovery. One model for this team-based care is the Behavioral Health Interdisciplinary Program (BHIP), which coordinates collaborative, evidence-based, Veteran-centered care by an interdisciplinary team of providers and clerical staff in outpatient mental health clinics at all VAMCs. BHIP is guided by the evidence-based Collaborative Care Model, which focuses on six core elements: providing organizational and leadership support, anticipating care needs through process redesign, enhancing Veteran self-management skills, offering decision support for providers, managing clinical information about Veterans, and accessing support for Veterans in the community. Through its emphasis on team building, communication, and coordination, BHIP is demonstrating a meaningful, positive impact on patient care and teamwork—including improved staff relationships, job satisfaction, and Veteran access to care. Early data show that, compared to non-BHIP patients, patients who had depression, PTSD, and serious mental illness, who were seen by BHIP teams, were more likely to engage in three treatments over 6 weeks.

Suicide Prevention and Care Coordination Related to Inpatient and Residential Services

VA's most intensive services for mental health and suicide prevention are delivered through residential treatment and inpatient mental health programs, either the Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) or the Domiciliary Care Program, which is VA's oldest program—established in 1865, at the National Home for Disabled Volunteer Soldiers. Today, MH RRTPs provide intensive specialty treatment for mental health and Substance Use Disorders, as well as for co-occurring medical needs, homelessness, and unemployment. MH RRTPs are staffed 24 hours a day, 7 days per week, and provide access to both professional and peer support services. MH RRTPs identify and address Veterans' goals for rehabilitation, recovery, health maintenance, quality of life, and community integration. VA provides inpatient mental health care for Veterans at risk of harming themselves or others, or who require hospitalization to stabilize their condition and to facilitate recovery. Nationwide, 113 VA facilities offer acute inpatient psychiatry programs, and in Fiscal Year 2018, those programs served approximately 57,000 Veterans.

VA has several policies and guidance that require care coordination, and a clinical care team member follows up or provides *caring* communications across all VA medical facilities for Veterans after an inpatient mental health stay or hospitalization for suicide related concerns. According to VHA policies for post-discharge follow-up and enhanced care for patients at high risk of suicide, the type and frequency of the contact varies depending on inpatient stay setting (residential vs. inpatient mental health), type of discharge (regular or against medical advice), and the severity of suicide risk presentation. Follow-up contact may include phone calls, letters, and clinical visits and can be as soon as 24 hours or 7 days post-discharge, with potential subsequent clinical contacts weekly for the next 30 days or longer.

Mental Health Safety and Environment of Care on VA Campuses

Providing a safe environment of care is a critical part of suicide prevention. In a 2018 study, Williams and Schmaltz completed a study of Joint Commission Accredited Hospitals who voluntarily reported 505 suicide deaths to The Joint Commission between 2010 and 2016, including VHA. The data in The Joint Commission's possession may not reflect the actual occurrence of suicides in all U.S. hospitals; however, data collected included inpatient suicides, suicides in emergency departments, suicides that occurred post-discharge, and suicides in which the victim may not have been directly receiving treatment at the hospital. Based on this report, VA has been able to reduce the number of in-hospital suicides from 4.2 per 100,000 admissions to 0.74 per 100,000 admissions on mental health units, an 82.4-percent reduction, suggesting that well-designed quality improvement and safety initiatives can lead to a reduction in the occurrence of these tragic events.[iii]

One example of VA's safety initiatives is the requirement that each VAMC review its inpatient mental health units' environment every 6 months by using the Mental Health Environment of Care Checklist. To perform this task, facilities are expected to create Interdisciplinary Safety Inspection Teams (ISIT). ISITs are expected to provide their subject matter expertise on the environmental risks that facilities may face regarding suicide. ISITs use a risk assessment matrix to help determine the actions that need to be taken to improve facilities' mental health environments in accordance with Joint Commission Standards. In May 2019, VHA mandated that all VAMCs with an acute mental health unit install door top alarms. Door top alarms installed on swinging corridor doors of patient rooms in VA mental health inpatient units have proven to be effective in providing timely notification to staff and preventing completion of suicide attempts. As of August 2019, approximately 50 percent of VHA inpatient mental health facilities reported having door top alarms installed. Projects are underway to install door top alarms on the remainder of the inpatient mental health units, with a targeted completion date of March 1, 2020.

As part of its efforts to ensure all facilities are safe for both Veterans and employees, VA also requires all MH RRTPs to "stand down" or suspend clinical operations for 1 day each year to focus on safety, security, and quality of care. MH RRTP clinicians are required to undergo documented annual competency reviews for assessing risk for suicide. MH RRTPs are required to complete Annual Safety and Security Assessments of their environments before each Stand Down. SPCs are required to participate in both the Stand Down and the pre-Stand Down assessment of facility environments to assist with addressing suicide prevention content.

Responding to On-Campus Suicidal Behavior

VHA policy requires that all VHA employees must complete their required suicide risk and intervention training module (either Suicide Risk Management Training for Clinicians or Signs, Ask, Validate, and Encourage and Expedite (S.A.V.E.) training for non-clinicians) and, for providers/clinicians, pass the post-module test within 90 days of entering their position. VHA has also developed a Suicide Risk Management Training for registered nurses that may be assigned annually as an alternative training option to Suicide Risk Management Training for Clinicians, understanding that the roles may be different in some cases. Local facilities may assign training to appropriate staff and track this training through the Talent Management System. VA supports employees as well as external community providers by providing the VA Suicide Risk Management Consultation Program to consult on a specific case or talk about suicide risk management strategies more generally.

VA Police Officers receive specialized training at the VA Law Enforcement Training Center (LETC). LETC is accredited by the Federal Law Enforcement Training Accreditation Board, which emphasizes the use of non-physical techniques and is

[iii] Williams SC, Schmaltz SP, Castro GM, Baker DW, 2018. Incidence and Method of Suicide in Hospitals in the United States. https://www.jointcommissionjournal.com/article/S1553–7250(18)30253–8/fulltext.

recognized as meeting the highest standards in Federal law enforcement training. All VA Police Officers go through a 10-week basic course at LETC. They receive 30 hours of training specific to de-escalation and conflict management, with a special focus on suicide awareness and prevention. Officers also complete nearly 24 hours of de-escalation training in which they learn skills to affect positive outcomes in real-life scenarios.

Collaboration between law enforcement and health care professionals is crucial when responding to violent incidents, police calls for service in the field, or Veterans in suicidal crisis. VA Police and all VA employees work every day to recognize Veterans who may be in crisis and expedite getting them the help they need. Their diligence and specialized training have saved lives across the country on VA campuses when they have interrupted or responded quickly to Veterans in suicidal crisis. VA began tracking on-campus suicidal behavior in October 2017; as of January 2020, there have been a total of 566 incidents of suicidal attempts, of which 49 were suicide deaths.

Community Prevention Strategies

Communication Strategies

Preventing suicide among all of the Nation's 20 million Veterans cannot be the sole responsibility of VA; it requires a nation-wide effort. Suicide prevention requires a combination of programming and the implementation of strategies and initiatives at the universal, selective, and indicated levels. This "All-Some-Few" strategic framework allows VA to design effective programs and interventions appropriate for each group's level of risk. Not all Veterans at risk for suicide will present with a mental health diagnosis, and the strategies below employ a variety of tactics to reach all Veterans, which may include:

- Universal strategies that aim to reach all Veterans in the United States. These include public awareness and education campaigns about the availability of mental health and suicide prevention resources for Veterans, promoting responsible coverage of suicide by the news media, and creating barriers or limiting access to hotspots for suicide, such as bridges and train tracks;
- Selective strategies are intended for some Veterans who fall into subgroups that may be at increased risk for suicidal behaviors. These include outreach targeted to women Veterans or Veterans with substance use disorders, gatekeeper training for intermediaries who may be able to identify Veterans at high-risk, and programs for Veterans who have recently transitioned from military service; and
- Indicated strategies designed for the relatively few individual Veterans identified as having a high risk for suicidal behaviors, including some who have made a suicide attempt.

Guided by this framework and the National Strategy, VA is creating and executing a targeted communications strategy to reach a wide variety of audiences. VA uses an integrated mix of outreach and communications strategies to reach audiences. VA relies on proven tactics to achieve broad exposure and outreach while also connecting with hard-to-reach targeted populations. Our target audiences include, but are not limited to, women Veterans; male Veterans age 18–34; former Servicemembers; men age 55 and older; Veterans' loved ones, friends, and family; organizations that regularly interact with Veterans where they live and thrive; and the media and entertainment industry, who have the ability to shape the public's understanding of suicide, promote help-seeking behaviors, and reduce suicide contagion among vulnerable individuals.

VA proactively engages others to help share our messages and content, including Public Service Announcements (PSA) and educational videos. For example, in collaboration with Johnson & Johnson, VA released through social media a PSA titled "No Veteran Left Behind," featuring Tom Hanks. VA continues to use the #BeThere Campaign to raise awareness about mental health and suicide prevention and educate Veterans, their families, and communities about the suicide prevention resources available to them. During Suicide Prevention Month 2019, VA's #BeThere campaign reminded audiences that everyone has a role to play in preventing Veteran suicide. It also emphasized that even small actions of support can make a big difference for someone going through a challenging time and can ultimately help save a life. Through shareable content and graphics, VA reached over 200 entities through a news bulletin and quarterly newsletter emails. In collaboration with Twitter, a custom icon—an orange awareness ribbon—was linked to the #BeThere hashtag in tweets. This positioned Veterans as part of the global Twitter conversa-

tion about Suicide Prevention Month. Veteran-specific posts that used the #BeThere hashtag had almost 84 million potential impressions.

We are leveraging new technologies and working with others on social media events while continuing our digital outreach through online advertising. VA also utilizes its Make the Connection resource (www.MakeTheConnection.net) to highlight Veterans' true and inspiring stories of mental health recovery, connecting Veterans and their family members with local VA and community mental health resources. Over 600 videos from Veterans of all eras, genders, and backgrounds are at the heart of the Make the Connection campaign. The resource was founded to encourage Veterans and their families to seek mental health services (if necessary), educate Veterans and their families about the signs and symptoms of mental health issues, and promote help-seeking behavior in Veterans and the general public. Finally, VA continues to rely on Veterans Service Organizations, non-profit organizations, and private companies to help us spread the word through their person-to-person and online networks.

Working with Communities

VA is working with Federal partners, as well as State and local governments, to implement the National Strategy to reach all Veterans through community prevention. Community Prevention focuses on "upstream strategies" to address social determinants of health outside the VHA health care system to promote early awareness and prevention prior to times of crisis, while also expanding collaboration and coordination of services across all Veterans, families, non-VHA health care systems, other community partners, and VA. In March 2018, VA, in collaboration with the Department of Health and Human Services, introduced the Mayor's Challenge with a community-level focus, and in 2019, debuted the Governor's Challenge to take those efforts in Veteran suicide prevention to the State level. The Mayor's and Governor's Challenges promote VA's suicide prevention efforts by working with 7 Governors (from Arizona, Colorado, Kansas, Montana, New Hampshire, Texas, and Virginia) and 24 local governments; locations were chosen based on Veteran population data, suicide prevalence rates, and capacity of the city or State to develop plans to prevent Veteran suicide, again with a focus on all Veterans at risk of suicide, not just those who engage with VA. We will be expanding to 28 additional states in Fiscal Year 2020 with a goal of engaging all 50 states and the territories by the end of Fiscal Year 2022.

In addition to the Challenges, VA is developing models of community-based approaches for suicide prevention, including a pilot in Veterans Integrated Service Network 23, focused on community coalition-building and "Together with Veterans," a VA program focused on community coalition-building specifically in rural settings. The goal of "Together with Veterans" is to build and sustain local capacity to implement multiple coordinated suicide prevention strategies, following a science-based implementation toolkit. As part of these strategies, technical assistance is available to provide data reporting, evaluation, and consultation in support of local communities implementation of strategic plans to address Veteran suicide.

In addition to the proactive work by VA Police on campus, VA Police are actively involved in training other first responders in the community in life saving strategies. The VA National First Responder Outreach and Training Program is an innovative, common-sense, and cost-effective public health approach that addresses the Veteran community, spefically prioritizing Veteran suicide. At its foundation, the program utilizes community outreach engagements to facilitate collaboration with emergency first responders at the local, State, and Federal levels. To date, this program has trained over 3,500 community emergency first responders across the country. The feedback from the first responder community has been resoundingly positive, noting that the information is relevant and presented in a way that has direct practical application.

Partnerships with Organizations for Suicide Prevention

The National Strategy is a call to action to every community, organization, and system interested in preventing Veteran suicide to help do this work where we cannot. For this reason, VA is leveraging a network of more than 60 partners in the public, private, and non-profit sectors to help us reach Veterans, and our network is growing weekly. For example, VA and PsychArmor Institute have a non-monetary partnership focused on creating online educational content that advances health initiatives to better serve Veterans. Our partnership with PsychArmor Institute resulted in the development of the free, online S.A.V.E. training course that enables those who interact with Veterans to identify signs that might indicate a Veteran is in crisis and how to safely respond to and support a Veteran to facilitate care and intervention. Since its launch in May 2018, S.A.V.E. training has been viewed more

than 18,000 times through PsychArmor's internal and social media system and 385 times on PsychArmor's YouTube channel.

VA and DoD Veteran Suicide Data Tracking and Reporting

While implementing both clinical and community strategies for suicide prevention, VA aims to provide the most accurate report on the status of Veteran suicide in the Nation. Each year, VA and DoD produce separate annual reports on Veteran and current Servicemember suicide mortality, respectively. VA and DoD partner in preventing suicide for all current and former Servicemembers, but do not use the same data sources for suicide surveillance reporting, with VA reporting on Veterans and former Servicemembers, and DoD reporting on current Servicemembers. This allows VA's report to focus on former Servicemembers who most closely meet the official definition of Veteran status that is used by VA and other Federal agencies. For this report, a Veteran is defined as someone who had been activated for Federal military service and was not currently serving. In addition, the report includes information in a separate section on suicide among former National Guard or Reserve members who were never federally activated.

For VA suicide surveillance reporting, VA and DoD partner to submit a search list of all identified current and former Servicemembers to the Centers for Disease Control and Prevention's (CDC) National Death Index (NDI) each fall. After processing, which can take several months, NDI returns all potentially matching mortality information. Additionally, internal processing and coordination occurs between VA and DoD to identify Veteran and Servicemember deaths, finalize mortality information, conduct statistical analyses, and interpret results.

Due to the different data sources, DoD data on mortality among current Servicemembers are available in a timelier fashion. DoD uses the Armed Forces Medical Examiner System (AFMES) as its data source for current active duty Servicemember suicide mortality information. A data source similar to AFMES is not available to VA. VA relies on national reporting to identify dates and causes of death per State death certificates, through NDI, which are reported up through local medical examiners and coroners to respective states and territories.

VA 2019 National Veteran Suicide Prevention Annual Report

The 2019 National Veteran Suicide Prevention Annual Report is VA's most recent analysis of Veteran suicide data from 2005 to 2017. It reflects the most current national data available through CDC's 2017 NDI.

One of the key ways in which this year's report is different is that it sets Veteran suicide in the broader context of suicide deaths in America and the complex cultural context of suicide. From the report, we know the average number of suicides per day among U.S. adults rose from 86.6 in 2005 to 124.4 in 2017. These numbers included 15.9 Veteran suicides per day in 2005 and 16.8 in 2017. The report highlights suicide as a national problem affecting Veterans and non-Veterans, and VA calls upon all Americans to come together to take actions to prevent suicide.

The data presented in the report are an integral part of VA's comprehensive public health strategy and enables VA to use tailored suicide prevention initiatives to reach various Veteran populations. The report includes a section on key initiatives that have been developed since 2017 to reach all Veterans. The report is designed for action based upon a stratification with the public health classification of universal (all), selective (some), and indicated (few) population framework as noted in the National Strategy.

When we look at our data, there are indicators that trends among Veterans in VA care that offer anchors of hope upon which we can continue to build. For example, suicide rates among Veterans in recent VHA care (Veterans who had a VHA health encounter in the calendar year of interest or in the prior calendar year) with a diagnosis of depression have decreased from 70.2 per 100,000 in 2005 to 63.4 per 100,000 in 2017. After adjusting for age and sex, between 2016 and 2017, the suicide rate among Veterans in recent VHA care increased by 1.3 percent while increasing by 11.8 percent among Veterans who did not use VHA care. We have seen a notable increase in women Veterans coming to us for care. Women are the fastest-growing Veteran group, comprising about 9 percent of the U.S. Veteran population, and that number is expected to rise to 15 percent by 2035. Although women Veteran suicide counts and rates decreased from 2015 to 2016 and did not increase for women Veterans in VHA care between 2016 and 2017, women Veterans are still more likely to die by suicide than non-Veteran women. These data underscore the importance of our programs for this population. VA is working to tailor services to meet their unique needs and has put a national network of Women's Mental Health Champions in place to share information, facilitate consultations, and develop local

resources in support of gender-sensitive mental health care. Efforts are already underway to better understand this population and other groups that are at elevated risk, such as never federally activated Guard and Reserve members, recently separated Veterans, and former Servicemembers with Other Than Honorable (OTH) discharges.

We need to consider the social determinants of health, defined broadly as well-being (economic disparities, homelessness, and social isolation), and how these issues, may create a context that markedly increases someone's risk of suicide. Veterans who are employed, have a stable place to live, and are affiliated with a community of Veterans and others for support are more likely to be optimistic about their future. While there is still much to learn, there are some things that we know for sure: suicide is preventable, treatment works, and there is hope.

Update Progress and Challenges Toward Addressing VA OIG Recommendations

In collaboration with the Office of Security and Law Enforcement, a staffing model was developed. The new staffing model is currently under review. In addition, VHA has modernized the position descriptions for all of the Police Chiefs in the field. This is part of a larger workforce modernization effort underway for the VA Police force. This was a major accomplishment as it helps ensure our Police Chiefs are paid equitably. VA is in the process of continuing to develop modernized positions for all of our law enforcement professionals. The intent of the modernized positions is to create uniformity in the way work is distributed and carried out, thereby raising the technical standard of each position to ensure the best services are provided to our Veterans.

Conclusion

On March 5, 2019, EO 13861, *National Roadmap to Empower Veterans and End Suicide*, was signed to improve the quality of life of our Nation's Veterans and develop a national public health roadmap to lower the Veteran suicide rate. EO 13861 mandated the establishment of the Veteran Wellness, Empowerment, and Suicide Prevention Task Force to develop the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide and the development of a legislative proposal to establish a program for making grants to local communities to enable them to increase their capacity to collaborate with each other to integrate service delivery to Veterans and to coordinate resources for Veterans. The focus of these efforts is to provide Veterans at risk of suicide support services, such as employment, health, housing, education, social connection, and to develop a national research strategy for the prevention of Veteran suicide.

This EO implementation will further VA's efforts to collaborate with partners and communities nationwide to use the best available information and practices to support all Veterans, whether or not they are engaging with VA. This EO, in addition to VA's National Strategy, further advances the public health approach to suicide prevention by leveraging synergies and clearly identifying best practices across the Federal Government that can be used to save Veterans' lives.

VA's goal is to meet Veterans where they live, work, and thrive to ensure they can achieve their goals, teaching them skills, connecting them to resources, and providing the care they need along the way. Through open access, community-based and mobile Vet Centers, app-based care, tele-mental health, more than 400 Suicide Prevention Coordinators, and more, VA is providing care to Veterans when and how they need it. We want to empower and energize communities to do the same for Veterans who do not use VA services. We are committed to advancing our outreach, prevention, empowerment, and treatment efforts, to further restore the trust of our Veterans every day and continue to improve access to care. Our objective is to give our Nation's Veterans the top-quality experience and care they have earned and deserve. We appreciate this Committee's continued support and encouragement as we identify challenges and create innovative solutions to address the needs of Veterans.

This concludes my testimony. I am prepared to answer any questions you may have.

Thank you.

Prepared Statement of Julie Kroviak

Chairman Takano, Ranking Member Roe, and members of the Committee, thank you for the opportunity to discuss the Office of Inspector General's (OIG's) oversight of the mental health care and services provided by the Department of Veterans Affairs (VA) at Veterans Health Administration (VHA) facilities. The mission of the

OIG is to oversee the efficiency and effectiveness of VA's programs and operations through independent audits, inspections, evaluations, reviews, and investigations. For many years, the OIG has conducted reviews and inspections that have identified concerns with veterans' access to quality health care, including mental health care, provided at VHA facilities. Recent reports have identified ongoing concerns with the timeliness and delivery of quality mental health care, the challenges associated with the coordination of that care, the proactive measures that could reduce suicides, and the physical environment in which veterans receive mental health care.

Although veterans are a tremendously diverse community, they have a culture, set of experiences, and sense of duty associated with military service that can differ dramatically from civilians. Some veteran experiences can contribute to and challenge the management of often complex mental health needs. According to research, veterans experience mental health and substance abuse disorders, posttraumatic stress, and traumatic brain injury at rates disproportionately high when compared to their civilian counterparts.[1] This underscores the magnitude of responsibility VHA assumes in supporting the needs of this population. Responding effectively to their needs requires a holistic approach focused on each veteran's successful reintegration into civilian life. A truly integrated approach, while veteran-centric in design, can be effective only if families, caregivers, healthcare providers, and communities work together to support veterans' whole health. Perhaps most urgent is the need to mitigate the risk of suicide. VHA must continue to focus attention on outreach efforts that educate and provide all stakeholders with evidence-based tools that not only help identify high-risk veterans, but also encourage those veterans to engage in the care they need.

VHA has implemented several initiatives aimed at reducing the stigma surrounding mental health conditions, providing access to mental health services, and promoting public awareness of suicide. The focus on suicide prevention has included appointing a National Suicide Prevention Coordinator, establishing the Veterans Crisis Line, developing a patient record system to identify high-risk patients, and creating suicide prevention programs in each facility. In addition, VHA expanded facility suicide prevention coordinator roles, requiring them to participate in community outreach activities.

VHA's efforts in suicide prevention, including the Veterans Crisis Line, have been largely directed at crisis intervention. According to the medical literature, the opportunity for intervention between the decision to complete suicide and the attempt itself is extremely narrow, as short as 1 hour in over 70 percent of all suicide attempts.[2] Additionally, 69 percent of veteran suicide deaths are by the more likely lethal means of firearms, compared to 48 percent of civilian suicide deaths.[3] To significantly reduce suicide and improve the lives of veterans, prompt and effective behavioral health treatment must be paired with a wide range of additional approaches. For example, VA has promoted firearm safety by urging veterans to secure guns with locks, removing firing pins, or storing firearms where they are not easily and quickly accessed. The VA Suicide Prevention Program's Acting Director was recently quoted as saying, "The safety measures can slow a person's ability to follow through on suicidal thoughts and preempt an irrevocable choice."[4] It is being presented as just one element of a plan, in the hope that clinicians can include this topic as an aspect of self-care. Lethal-means safety counseling offers clinicians an evidence-based opportunity to erect a barrier to suicidal impulsivity. VHA has several current projects that address lethal-means safety, but each project requires additional resources to develop their concepts and evaluate effectiveness in the veteran community. VHA must take every opportunity—from the time of a servicemembers' transition to the community and throughout the veterans' life—to identify and address behavioral health conditions.

Despite VHA's recent efforts, there are significant challenges ahead. The OIG has published numerous reports in recent years that detail veterans' experiences with obstacles accessing and receiving high-quality mental health care within VHA. Trag-

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[1] Terri Tanielian et al., "Invisible Wounds: Mental Health and Cognitive Care Needs of America's Returning Veterans," (Santa Monica, CA: RAND Corporation, 2008), https://www.rand.org/pubs/research_briefs/RB9336.html; National Alliance on Mental Illness, "You Are Not Alone," https://nami.org/mhstats, accessed on January 27, 2020.

[2] E.A. Deisenhammer et al., "The Duration of the Suicidal Process: How Much Time Is Left for Intervention Between Consideration and Accomplishment of a Suicide Attempt?" *Journal of Clinical Psychiatry*, 70(1), 19–24.

[3] Department of Veterans Affairs, "VA National Suicide Data Report 2005–2016," VA Office of Mental Health and Suicide Prevention, September 2018.

[4] Martin Kuz, "Can Veterans Lead the Way on Preventing Suicide," *Christian Science Monitor*, December 31, 2019, https://www.csmonitor.com/USA/Military/2019/1231/Can-veterans-lead-the-way-on-preventing-suicide.

ic events such as suicides are the most publicized and typically understood to be the result of unrecognized, untreated, or undertreated mental health disorders. The OIG's focus, however, has also included the timely care and management of the wide variety of mental health needs for which veterans seek care. Report recommendations are meant to assist VHA in its efforts to be responsive at all levels to addressing the complex mental health care needs of veterans. The goal, ultimately, is to improve veterans' quality of life (as well as the lives of their families and caregivers) and to reduce the rate of veteran suicide.

Recognizing the importance of suicide prevention as VA's—and this Committee's—top clinical priority, the OIG has focused significant resources on conducting oversight of VHA's mental health treatment programs and other suicide prevention efforts.[5] This statement focuses on some of the more recent OIG reviews highlighting opportunities where VHA can strengthen its efforts to improve the quality and coordination of care as well as the environment in which veterans receive that care.

DEFICIENCIES IN VHA MENTAL HEALTH COORDINATION OF CARE

The OIG has reviewed a number of reported suicides and mental healthcare-related concerns that occurred on VA campuses. These involved veterans who were receiving, seeking, or may have needed mental health care from VHA providers. These reviews found deficiencies in care delivery that resulted in negative outcomes for patients experiencing a mental health crisis. The OIG's findings in this area can be categorized as deficiencies in coordination of care in the following contexts:

- Within a mental health treatment team
- With non-mental health providers
- During the discharge process
- By care providers with the patients or their family/surrogate

The OIG found inadequate coordination of care to be an underlying theme in every one of its recently conducted reviews. Relevant examples from these reports are discussed below.

Coordination of Care Within a Mental Health Treatment Team

Typically, a mental health treatment team is multidisciplinary and may involve a psychiatrist, a psychologist, mental health nurses, mental health social workers, mental health clinical pharmacists, and suicide prevention coordinators. Coordination within the team is vital to provide the patient with synchronized and complementary services. Failures in communication could result in conflicting information or gaps in care that may result in harm to the patient. The following reports involve deficiencies in coordination of care within a mental health team.

Alleged Deficiencies in Mental Health Care Prior to a Death by Suicide at the VA San Diego Healthcare System

The OIG conducted a healthcare inspection in response to allegations that staff failed to provide mental health care to a patient who subsequently died by suicide.[6] The OIG did not substantiate that the system failed to provide mental health care when the patient sought help. However, the OIG team found deficits in the decision-making process to deactivate a patient's High Risk for Suicide Patient Record Flag (PRF).[7] The assigned suicide prevention coordinator chose to deactivate the patient's PRF in spring 2018 without consulting the treatment team. In addition, the patient did not have any scheduled future appointments and had not been engaged in any mental health services for more than 2 months. VHA does not have clearly delineated requirements for the decisionmaking process to deactivate the High Risk for Suicide PRF; however, the then Executive Director of the Suicide Prevention Program told the OIG that there is an expectation that the suicide prevention coordinator will consult with the patient's treatment team, provide evidence of decreased

[5] Department of Veterans Affairs, "The VA is Making Real Progress on Suicide Prevention for Veterans," January 14, 2019, https://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=5177; House Veterans Affairs Committee, "Chairman Takano Announces New Compromise on Legislation to Address Veteran Suicide," December 3, 2019, https:/veterans.house.gov/news/press-releases/__chairman-takano-announces-new-compromise-on-legislation-to-address-veteran-suicide.

[6] *Alleged Deficiencies in Mental Health Care Prior to a Death by Suicide at the VA San Diego Healthcare System*, California, August 7, 2019.

[7] VHA established the High Risk for Suicide Patient Record Flag to alert staff to patients with immediate clinical safety concerns and is therefore only activated for those patients assessed at high risk for suicide and only for the duration of the increased risk. The suicide prevention coordinator works with the patient's clinicians to determine if the flag is needed, monitors its continued application, and deactivates the flag when the patient no longer has an elevated risk.

suicide risk factors, and document rationale for clinical judgment about mental health conditions and behaviors. The OIG recommended the Under Secretary for Health expedite the development of a National Suicide Prevention Program policy and procedure to delineate the deactivation process of High Risk for Suicide PRFs and monitor compliance.[8] The VHA action plan projected completion date was December 2019. OIG staff will monitor VA's progress until the proposed action is complete.[9]

The September 2018 Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide in the Minneapolis VA Health Care System

In September 2018, the OIG reported on the care of a patient who was admitted to the inpatient mental health unit and subsequently died from a self-inflicted gunshot wound less than 24 hours after discharge.[10] The OIG determined that the inpatient interdisciplinary treatment team failed to appropriately coordinate with the patient's outpatient treatment team. Specifically, inpatient mental health staff did not identify an outpatient prescriber and schedule an outpatient medication management follow-up appointment. Additionally, the system's suicide prevention coordinator did not collaborate with the inpatient interdisciplinary treatment team during admission. The OIG was unable to determine that identified deficits, alone or in combination, were a causal factor in the patient's death. However, the OIG did make recommendations related to interdisciplinary team collaboration, which are now closed.

Review of Two Mental Health Patients Who Died by Suicide at the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin

The review team assessed the care of a patient who committed suicide less than 48 hours after being discharged from the VA facility.[11] The OIG found that the mental health clinical pharmacists informally collaborated with facility psychiatrists but did not appropriately refer patients with complex mental health issues whose treatment was beyond the pharmacists' scope of practice. Specifically, mental health clinical pharmacists acted outside of their scope of practice in changing diagnoses and providing psychotherapy. The collaborations were insufficient to meet the requirements of mental health clinical pharmacists' scope of practice. Their independent decisionmaking without sufficient psychiatrist collaboration or supervision may have contributed to deficient mental health care. The OIG also identified similar deficiencies by a mental health clinical pharmacist in the care of another patient that died by suicide 13 months before the first patient's death. The OIG made recommendations related to prescribing practices, including the use of collaborative agreements, the assignment of prescribers for patients with complex mental health needs, and strengthening mental health clinical pharmacists' supervision processes. Based on a review of VA's corrective actions, the OIG has closed all report recommendations.

Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities

The seriousness of the risks identified in the prior report led the OIG to initiate a broader review of clinical pharmacists' practice in mental health outpatient care settings. The OIG assessed VHA facilities' use of clinical pharmacists who work under a scope of practice in a mental health outpatient care setting.[12]

Clinical pharmacists have advanced specialized education and training that allows them to provide comprehensive medication management that includes resolving pa-

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[8] The recommendations directed to the Under Secretary for Health are submitted to the Executive in Charge, who has the authority to perform those functions and duties.

[9] VA provides implementation plans and determines their projected dates for implementation when providing comments on OIG draft reports. At quarterly intervals starting 90 days after report issuance, OIG staff requests the VA office provide an accounting of actions taken to implement open recommendations, as well as whether the VA office believes a recommendation may be closed. After receiving the VA office's report, OIG staff reviews the materials and provides a final determination whether any recommendations have been satisfactorily implemented and can be closed. The decision to close a recommendation is based on a review of VA's supporting documentation or independent information obtained by OIG that indicates the corrective action has occurred and is sustained or progressed enough to show recommendation implementation.

[10] *Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide, Minneapolis VA Health Care System, Minnesota*, September 25, 2018.

[11] *Review of Two Mental Health Patients Who Died by Suicide, William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin*, August 1, 2018.

[12] *Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities*, June 27, 2019.

tient medication nonadherence and assisting patients in achieving medication-related therapeutic goals. Clinical pharmacists are not licensed independent practitioners and therefore must collaborate with licensed independent practitioners who have prescriptive authority, as outlined in a collaborative practice agreement. Each clinical pharmacist requests the types of services he or she will provide, which are reviewed and recommended by the relevant facility's service chiefs and executive committee of the medical staff, and then approved by the medical facility director.

The role of clinical pharmacists with a scope of practice in the mental health specialty practice area has been a focus of expansion for VHA in recent years. As VHA expands and increases its use of mental health clinical pharmacists, it is imperative that there are collaborating agreements in place and that scopes of practice clearly delineate duties and are standardized to maximize patient safety.

The OIG's review found that mental health clinical pharmacists' independence levels were not clearly identified by staff or facilities' bylaws. Guidance provided conflicting instructions regarding the requirements for collaborating agreements and lacked provisions for oversight by a specific physician. Facilities' scopes of practice were inconsistent in describing delegated duties that were specific to mental health. VHA policy also was insufficient to ensure the chief of mental health conducts reviews and endorses mental health clinical pharmacists' scopes of practice. Referral processes were not clear or standardized regarding how diagnoses were conveyed to mental health clinical pharmacists or whether involvement of a licensed independent practitioner with prescriptive authority was considered to determine appropriateness for patients' referrals. VHA policy does not require a defined process to consider a patient's clinical complexity. Policies lacked guidance on instructing mental health clinical pharmacists on when or how to refer patients to a higher level of care. The OIG made nine recommendations to the VHA Under Secretary for Health related to autonomy, collaborating agreements, working with licensed independent practitioners with prescribing authority, scopes of practice, and referrals. Recommendations are to be completed no later than May 2020, according to VHA action plans. OIG staff will monitor VA's progress until all proposed actions are complete.

Coordination of Care with Non-Mental Health Providers

Patients' mental health care must be managed together with any other medical conditions. Patients with complex medical histories require coordination between mental health and non-mental health care providers. Failures in communication may result in harm resulting from medication side effects or interactions or worsening of the underlying medical conditions. The following OIG reports found issues with the coordination of care between mental health and non-mental health care providers.

The January 2020 Report Deficiencies in Care Coordination and Facility Response to Another Patient Suicide in Minneapolis

In January 2020, the OIG released a healthcare inspection report assessing care coordination for a patient who died by suicide while admitted to an inpatient medicine unit at the facility.[13] The patient was assessed as at a heightened but not imminent risk for suicide. Facility emergency department staff failed to report the patient's suicidal ideation to the facility's suicide prevention coordinator. Two consulting staff members and an inpatient registered nurse completed required suicide prevention training but failed to involve clinicians when the patient verbalized suicidal thoughts and warning signs. Two of the three staff documented the patient's suicidal thoughts and warning signs in consult results notes, but the OIG did not find documentation that the inpatient medicine resident reviewed or acted on the consult results. The OIG made recommendations to the facility's director related to improving emergency department staff's notification to the suicide prevention coordinator when a patient presents with suicidal ideation. The recommendations also called on the facility director to ensure that inpatient consult results are acted upon by the responsible care provider or appropriate designee. All recommendations are to be completed no later than July 2020, according to VHA action plans. OIG staff will monitor VA's progress until the proposed actions are complete.

Alleged Deficiencies in Oncology Psychosocial Distress Screening and Root Cause Analysis Processes at a Facility in Veterans Integrated Service Network 15

[13] *Deficiencies in Care Coordination and Facility Response to a Patient Suicide at the Minneapolis VA Health Care System, Minnesota*, January 7, 2020.

In a December 2019 healthcare inspection report, OIG staff examined a Veterans Integrated Service Network (VISN) 15 medical facility in response to concerns identified in a June 2019 OIG healthcare inspection.[14] In part, this inspection evaluated the oncology service staff's adherence to the facility's psychosocial distress screening standard operating procedure in the care of two patients who died by suicide. The OIG team found that facility oncology service staff demonstrated compliance with psychosocial distress screening standard operating procedures. However, the OIG was unable to determine if a mental health evaluation completed prior to one of the patients' leaving the clinic would have changed the patient's outcome. Completion of a mental health evaluation may have identified additional risk factors and provided greater opportunity for suicide prevention interventions before the patient left the clinic. The OIG recommended that the facility director conduct an evaluation of radiation oncology clinic mental health consultation and treatment program needs and adjust mental health provider coverage as warranted. The VHA action plan projected completion date is May 2020. OIG staff will monitor VA's progress until the proposed actions are complete.

Coordination of Care During the Discharge Process

When patients transition between providers—whether this is due to changes in levels of care (inpatient to outpatient) or to changes in treatment settings (patient is moving or a provider leaving)—ethical care demands a transfer of information about the patient (or "handoff") between providers to facilitate continuity of medical and mental health care. Failure to provide such a handoff may lead to patient harm related to interruptions in treatment. It may also result in inappropriate repetition of previously completed testing or inappropriate medication because of the gaps in transferred information about previous intolerance or medication interactions. The following reports involve issues with coordination in the discharge process.

Deficiencies in Discharge Planning for a Mental Health Inpatient Who Transitioned to the Judicial System from a Veterans Integrated Service Network 4 Medical Facility

An OIG team responded to allegations related to the discharge of a patient from an inpatient mental health unit at a VISN 4 medical facility, and subsequent transfer to a Federal detention center where the patient died shortly after discharge and while incarcerated.[15] The OIG team determined that VA facility inpatient mental health staff failed to engage in proper discharge planning and proper treatment planning processes. The VA facility staff did not contact the receiving care providers at the detention center to provide any clinical information on a patient with serious chronic mental illness and severe medical comorbidities. Specifically, the OIG team determined that inpatient mental health staff neglected to provide clinical hand-off information to the patient's receiving mental health providers, and to assign a mental health treatment coordinator responsible for overall care and discharge planning coordination. The OIG made a recommendation to ensure the provision of a complete medical and psychiatric diagnostic summary to receiving providers. That recommendation remains open and the OIG will continue to follow up with the facility until it is fully implemented.

The September 2018 Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide in Minneapolis

In addition to the deficiencies in coordination of care with consultants and other non-mental health care providers previously mentioned, the September 2018 report also found issues related to discharge planning. The OIG team determined that VA's inpatient mental health staff failed to include the patient's outpatient treatment team in discharge planning, did not identify an outpatient prescriber, and neglected to schedule an outpatient medication management follow-up appointment. The OIG team noted that the system's suicide prevention coordinator did not collaborate with the patient's interdisciplinary treatment team during admission or participate in discharge planning. The OIG made a recommendation to the facility director to strengthen processes that will help ensure mental health interdisciplinary collaboration across levels of care in treatment planning, provision of clinical services, and discharge planning that includes medication management, as required by VHA.

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[14] *Alleged Deficiencies in Oncology Psychosocial Distress Screening and Root Cause Analysis Processes at a facility in Veterans Integrated Service Network 15, December 11, 2019; Delay in Diagnosis and Subsequent Suicide at a Veterans Integrated Service Network 15 Medical Facility*, June 26, 2019.

[15] *Deficiencies in Discharge Planning for a Mental Health Inpatient Who Transitioned to the Judicial System from a Veterans Integrated Service Network 4 Medical Facility*, July 2, 2019.

Based on a review of VA's corrective actions, the OIG has closed the recommendation.

Coordination of Care With the Patient or With the Patient's Family/Surrogate

Patient-centered care requires that providers involve the patient or a patient's family (or decisionmaking surrogate) in all treatment determinations. VA requires informed consent for all treatment options across all disciplines. Failure to coordinate treatment decisionmaking with patients or family represents a failure of ethical care. The following reports involving deficiencies in coordinating care with the patient or the patient's family or surrogate.

Two Patient Suicides, a Patient Self-Harm Event, and Mental Health Services Administrative Deficiencies at the Alaska VA Healthcare System in Anchorage

An OIG healthcare inspection reviewed allegations of deficiencies in quality of care and administrative processes that contributed to two patients' deaths by suicide and one patient's self-harm at the facility's Social and Behavioral Health Services.[16] Patient 1, who was assigned a High Risk for Suicide PRF, visited the same-day access clinic and noted on the triage form experiencing high anxiety, depression, and hopelessness, but denied suicidal thoughts or plans. The patient left the clinic without being seen by a mental health care provider. The OIG team substantiated that same-day access clinic staff failed to adhere to VHA and facility missing patient policies after this at-risk patient left without being seen. However, the OIG team was unable to determine that facility staff's lack of timely search and outreach to the patient directly contributed to the patient's death by suicide approximately 1 week later. Other potential contributing factors were unknown.

The OIG team substantiated that Patients 2 and 3 did not have appointments scheduled after visiting the same-day access clinic, as evidenced in the lack of providers' clinically indicated date, and return to clinic orders, respectively. Failure to schedule a follow-up appointment with a patient having active psychiatric symptoms can place a patient at risk for adverse outcomes. The OIG team, however, was unable to determine that the unscheduled appointments contributed directly to Patient 2's self-harm and Patient 3's death by suicide.

The OIG made recommendations related to the Behavioral Health Service's policies and procedures, same-day access clinic coverage, and scheduling processes. All 11 recommendations are currently open and OIG staff will monitor VA's progress until the proposed actions are complete.

Deficiencies in Discharge Planning for a Mental Health Inpatient Who Transitioned to the Judicial System from a Veterans Integrated Service Network 4 Medical Facility

This previously discussed report also had findings related to inadequate coordination of care during discharge planning. The OIG team found that the VISN 4 facility staff did not obtain consent for voluntary admission from the patient's surrogate as required for patients who lack decisionmaking capacity or are subject to the State law involuntary commitment options. Additionally, facility staff did not discuss or consider issues such as guardianship, competency, surrogacy, or alternative placements for the patient who may have lacked decisionmaking ability. The family was not allowed to participate in treatment team meetings and was not informed about discussions that took place during these meetings despite numerous attempts to obtain information regarding the patient's treatment and discharge plan. Finally, although facility staff knew of the patient's pending arrest 1 day prior to the discharge, staff did not inform the patient, nor contact the patient's family member until after the patient had been removed from the facility and transported to the prison. The OIG made a recommendation to the facility director to strengthen inpatient mental health unit processes to include the patient, family members, or surrogate in treatment and discharge planning decisions. That recommendation remains open and the OIG will continue to follow up with the facility until it is fully implemented.

DEFICIENCIES IN VHA'S MENTAL HEALTH ENVIRONMENT OF CARE

While most suicides occur in the community, some do occur in the hospital, most commonly by hanging. In 2017, The Joint Commission noted that approximately 425 suicides within healthcare settings (not just VA facilities) had been reported over

[16] *Two Patient Suicides, a Patient Self-Harm Event, and Mental Health Services Administrative Deficiencies at the Alaska VA Healthcare System, Anchorage, Alaska*, November 19, 2019.

the previous 5 years.[17] For 2012 through 2017, VHA's National Center for Patient Safety told OIG staff there were 37 inpatient suicides at VA facilities, including two in locked mental health units. A patient suicide in a healthcare facility is a "never event," a largely preventable tragic event of deep concern to both the public and healthcare providers.

OIG Hotline Reviews Related to Mental Health Environment of Care

OIG's hotline reviews are inspections of VA facilities to review specific allegations or concerns that have been submitted to the OIG, or that are discovered during the course of other OIG oversight projects.[18] Many hotline reviews focus on vulnerabilities in the healthcare environment and are meant to identify and report on ways that VHA can reduce and control environmental hazards that can help prevent accidents, injuries, and suicide for patients, staff, and visitors. The most recent OIG report (2019) related to the environment of care examined a patient suicide at the West Palm Beach VA Medical Center. It highlights the facility's failure to maintain a safe environment for patients with mental illnesses and to take adequate steps to mitigate physical risks.[19]

Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center in Florida

In August 2019, the OIG reported on its review of the care provided to a patient who died by suicide while in the locked mental health unit at the West Palm Beach VA Medical Center.[20] The inspection examined whether there were deficient conditions, and if so, their effect. The patient (who previously received VA outpatient treatment) was placed on "close" observation status after being involuntarily admitted to the medical center's inpatient unit, requiring observation every 15 minutes. Over the stay of several days, the patient was cooperative and engaged in activities. By day four, the patient was planned to be discharged to visit a family member, after first returning home, and was updated as "low risk" of suicide. That afternoon, the psychiatrist told the patient that because staff had been unable to contact the spouse, the patient's discharge would be delayed. The patient became significantly agitated. An hour later, after declining medication to decrease agitation, the patient was in the day room using the telephone, denied having suicidal ideations, and hopeful of discharge the next day. The patient was noted as being in their room for the rest of the afternoon.

At 5:45 p.m., a nursing assistant documented seeing the patient, who refused dinner due to lack of appetite. The staff reportedly did not enter the room. At approximately 6 p.m., a fellow inpatient went to the patient's room, found the door closed, and encountered resistance when trying to open it. A nursing assistant was called and found the patient unresponsive with a garment tied around the neck—the other end of which was wedged over the top of the door. After lifesaving efforts, the patient was declared dead at 6:37 p.m. Inpatient mental health unit staff care for some of the most high-risk patients with serious mental illnesses, which requires special safety measures to prevent harm. Given the need for those measures, the Mental Health Environment of Care Checklist (MHEOCC) was designed to help VHA facilities identify and address environmental risks for suicide and suicide attempts for patients in acute inpatient mental health units. It consists of criteria applicable to all rooms on the unit, as well as specific criteria for areas such as bedrooms, bathrooms, seclusion rooms, and staff work stations. The checklist was implemented in 2007 and research has associated it with a substantial decrease in the rate of inpatient suicides.[21] The OIG team found that while the medical center did conduct risk assessment rounds of the unit every 6 months, per VHA policy, the medical center was not handling other responsibilities:

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[17] The Joint Commission, "Special Report: Suicide Prevention in Health Care Settings," *Joint Commission* Perspectives, November 2017, 37(11):1 and 3–7.

[18] The OIG operates a hotline that accepts any complaints, concerns, or allegations related to VA. The hotline website can be accessed at https://www.va.gov/oig/hotline/.

[19] Prior OIG reports demonstrate that concerns with a safe environment for mental health patients are not new. For example, in 2013, the OIG substantiated allegations that the leadership at the Atlanta VA Health Care System in Decatur, Georgia, did not have effective polices and did not properly monitor inpatients at that mental health unit. *Mismanagement of Inpatient Mental Health Care, Atlanta VA Medical Center, Georgia*, April 17, 2013.

[20] *Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center, Florida*, August 22, 2019.

[21] Bradley Watts et al., "Sustained Effectiveness of the Mental Health Environment of Care Checklist to Decrease Inpatient Suicide," *Psychiatric Services* 2017, 68:4, 405–407.

- The facility did not meet VHA expectations by designating an Interdisciplinary Safety Inspection Team to identify environmental hazards and develop abatement plans.
- Facility leaders failed to ensure that Mental Health Environment of Care team members and other responsible staff received the relevant checklist training. Staff members who are permanently assigned to or have responsibilities on the mental health unit must be trained, including housekeepers, chaplains, outpatient providers, and police officers.
- Facility staff did not consistently identify noncompliant or unsafe environmental conditions. Staff did not identify that corridor doors were a risk, claiming that prior oversight inspections did not cite the doors. While true, that does not eliminate a need for critical thought and risk mitigation. A proper inspection team is expected to consider hazards beyond the checklist.
- The facility did not complete the waiver process for issues such as lack of seclusion room flooring cushions and cameras to mitigate seclusion room blind spots. The OIG found no waiver requests from the facility on these issues.
- Oversight and follow-up did not consistently occur at the facility, VISN, and VHA central office levels.

The report also presented findings and related recommendations in four other areas regarding clinical care, risk mitigation, unit staffing, and leadership responsiveness.[22] Of particular concern, the medical center's Police Chief, Associate Director, Associate Director for Patient Care Services, and Assistant Director told OIG staff that they were unaware of the facility's requirement for cameras. Leaders did not understand the risks associated with the unit's corridor doors. One leader told OIG that the facility was going "above and beyond" to prevent further incidents by counting eating utensils, which, in fact, is a long-standing, basic safety requirement.

The current Patient Safety Manager reported to facility leaders in a group forum that some of the unit's physical environment conditions represented an "immediate threat to life." The Associate Director reportedly cautioned the Patient Safety Manager that using the term "immediate threat to life" was "strong" and to "be careful what you say."

The OIG made 11 recommendations. One recommendation was to the Under Secretary for Health to ensure that the MHEOCC work group reviews and ranks hazards in mental health units and monitors abatement plans or waiver requests. Another recommendation focused on ensuring VISN-appropriate staff comply with semiannual report reviews and follow up on abatement of issues identified in the checklist assessment. The other nine recommendations were directed to the facility to improve compliance with VHA's guidelines for inspections, operations, safety, and training.

The Under Secretary for Health, the VISN director, and the medical center director concurred with the recommendations and provided acceptable action plans for implementation. All recommendations were to be completed no later than September 2019, according to the action plans. The OIG will follow up and review implementation actions to determine if the recommendations can be closed in accordance with OIG policy.

Inpatient Mental Health Clinical Operations Concerns at the Phoenix VA Health Care System

The OIG conducted a healthcare inspection in response to allegations received in 2016 and 2017 related to the clinical operations of the inpatient mental health unit

[22] Additionally, the OIG found (1) the patient received reasonable screening, clinical care, and level of observation given the circumstances, although the patient's record did lack a unifying treatment plan with measurable goals as required; (2) risk mitigation findings included that no documentation was found in the unit's rounding sheets that identified the corridor doors as a risk, patient observation rounds were not conducted and documented in a manner that could reasonably assure patient safety, and cameras, while installed, were nonfunctional for years; (3) unit staffing was sufficient on the day of the suicide, but one of the nursing assistants assigned to conduct 15-minute safety rounds also performed other duties during that time, contrary to protocol described by the unit nurse manager; and (4) OIG staff found that facility leaders and managers knew, or should have known, about lapses in the unit's physical environment, staff training, and the MHEOCC inspections. Further, there was no indication they took steps to educate themselves on these issues or solve them, and leaders and staff accepted noncompliance and unsafe conditions. While the OIG team determined that the facility responded promptly after the patient's suicide, the actions only occurred after this "never event."

regarding patients admitted with a diagnosis of dementia.[23] Among other concerns, the OIG substantiated that inpatient mental health unit staff did not consistently follow the facility's patient safety observer policy that outlined one-to-one care. The OIG reviewed patients requiring one-to-one care during January 2017 and found patient safety observer—to-patient ratios were not one-to-one, patient safety observers did not maintain constant visual observation of patients, and documentation was inconsistent. Additionally, due to the facility's incomplete documentation, the OIG was unable to determine whether nurse staffing was adequate to meet patient care needs.

In 2017, the OIG team substantiated that the inpatient mental health unit was not a therapeutic environment due to the absence of cleanliness and interior updates, patients not wearing personal clothes, and a noncompliant patient advocacy program. In 2018, the OIG team noted a satisfactory improvement in the cleanliness after the facility contracted with an external company that provided cleaning services.

The OIG made seven recommendations to the facility. The OIG has closed the recommendations related to patient safety observer policy compliance, inpatient mental health unit nurse staffing methodology, the cleanliness of the inpatient mental health unit, and use of the Patient Advocate Tracking System. While six of the seven recommendations are closed, the OIG continues to monitor compliance with training and improvements to the therapeutic environment of the unit.

Inpatient Security, Safety, and Patient Care Concerns at the Chillicothe VA Medical Center in Ohio

The OIG reviewed the care of a patient who fell to his death from a window at the Chillicothe VA Medical Center in 2017.[24] The OIG determined that there were not adequate security and safety measures in place, and these deficiencies contributed to the patient's death. The OIG also found that the facility's attempts to provide an institutional disclosure to the family were inadequate. Although the patient was not cared for in an inpatient mental health unit because of other medical conditions, generally the patient received appropriate care.

The OIG found, however, that the inpatient unit's external windows were not secured shut or limited in their opening width, in violation of VHA policy. Each VHA facility is required to conduct an Annual Workplace Evaluation with occupational safety and health staff examining safety and industrial hygiene issues. VHA experts had previously sent out guidance on installing brackets to limit opening width, and the facility took no action to resolve this issue despite a previous attempt by a patient to jump out of a window that opened fully. In this case, the patient had been placed on special observation, where the observer must remain within arm's length of the patient at all times. The observer lost sight of the patient and, in a few moments, the patient climbed out of the bathroom window after entering the bathroom and closing and locking the bathroom door. The observer attempted to grab and rescue the patient, but the patient's fall resulted in death. The OIG determined that staff did not adhere to the facility's observer policy related to the content, frequency, and hand-off documentation requirements. Moreover, facility leaders failed to monitor staff compliance with the special observer documentation requirements. The OIG also reviewed training records and found unit staff did not complete the Prevention and Management of Disruptive Behavior training, the special observer competencies, and other required trainings. The OIG found that facility leaders' failure to ensure that staff were trained in key competencies likely contributed to staff being unaware of the guidelines and duties.

The OIG made four recommendations to the facility director regarding exterior windows being made compliant with VHA's guidelines, compliance with observation policies and training competencies, and reviewing the discussion of the institutional disclosure that took place with the next of kin. All recommendations have been closed.

The OIG's Comprehensive Healthcare Inspection Program Focus on Inpatient Mental Health Units' Environment of Care

The OIG uses its Comprehensive Healthcare Inspection Program (CHIP) to provide cyclical, focused evaluations of the quality of care delivered in the inpatient and outpatient settings of VA facilities. OIG CHIP teams evaluate areas of clinical and administrative operations that reflect quality patient care, with focused review

[23] *Inpatient Mental Health Clinical Operations Concerns at the Phoenix VA Health Care System, Arizona*, May 7, 2019.

[24] *Inpatient Security, Safety, and Patient Care Concerns at the Chillicothe VA Medical Center, Ohio*, September 12, 2018.

areas changing every fiscal year.[25] These inspections are one element of the overall efforts of the OIG to ensure that the Nation's veterans receive high-quality and timely VA healthcare services.

OIG staff determine whether facilities maintain a clean and safe healing, recovery-oriented environment, particularly in selected areas often associated with higher risks of harm to patients, such as in locked mental health units.

Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018

In Fiscal Year (FY) 2018, OIG staff completed 51 CHIP inspections, with the results summarized in a report that, among other topics, highlighted inpatient mental health units' environment of care deficiencies at those facilities inspected from April to September 2018.[26] Generally, VA facilities met requirements associated with infection prevention, general safety, privacy, and availability of supplies. Construction and Nutrition and Food Services areas, locked mental health units, and emergency management programs met many of their respective requirements. However, the OIG identified concerns with environmental cleanliness, installation and testing of panic alarms in high-risk areas, seclusion rooms in locked mental health units, and emergency management processes.

In Fiscal Year 2018, VA inspected 27 mental health units that yielded the following findings:

- Twenty-three had evidence of monthly alarm system testing, but only 17 of those 23 documented evidence of VA police response times.
- Four had dirty ventilations grills and/or floors.
- Five of 19 applicable locked mental health units with seclusion rooms lacked flooring made of a material that provides cushioning.

In Fiscal Year 2019, during continued physical inspections of 27 additional VA inpatient mental health units' environment of care, OIG staff found these deficiencies:

- Four of the 27 units did not document evidence of panic alarm testing. Of the 23 units that had evidence of panic alarm testing, three did not include VA police response times.
- Five units had cleanliness issues.
- Four of 22 applicable units' seclusion rooms did not have flooring made of a material that provides cushioning. Facility managers reported a lack of awareness of these requirements and admitted to their lack of oversight in ensuring a safe environment of care.

The Fiscal Year 2018 Summary Report made four recommendations to the Under Secretary for Health to improve the environment of care nationally, based upon aggregate data collected during the related CHIP site visits. VHA, VISN, and facility leaders concurred with OIG recommended improvements and set their completion timeframes to accomplish and monitor compliance with the following:

- Ensure that facility managers maintain a clean and safe environment (June 2020 projected completion date).
- Confirm that VA police test panic alarms and document response times to alarm testing in locked mental health units and high-risk outpatient clinic areas (November 2019 projected completion date).
- Make certain that facility managers install floor cushioning in locked mental health unit seclusion rooms (June 2020 projected completion date).
- Verify that facility managers annually review emergency operations plans and resource and asset inventories (November 2020 projected completion date).

OIG staff will monitor VA's progress.

Other OIG Work Related to VHA Mental Health Care Experience

The OIG has released reports on other issues that can directly affect VHA's ability to provide effective mental health care. The following recent reports highlight areas within VHA that require attention to help ensure a supportive environment and appropriate coordination for effective mental health care.

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[25] The nine areas for Fiscal Year 2018 were leadership and organizational risks; quality, safety, and value; credentialing and privileging; environment of care; medication management; mental health; long-term care; women's health; and high-risk processes. For Fiscal Year 2019, medical staff privileging was substituted for credentialing and privileging. Fiscal Year 2020 is the same as Fiscal Year 2019 except care coordination was substituted for long-term care.

[26] *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*, October 10, 2019.

OIG Determination of VHA's Occupational Staffing Shortages, Fiscal Year 2019

Since January 2015, the OIG has reported on VHA clinical staffing shortages as required by the *Veterans Access, Choice, and Accountability Act of 2014* (PL 113–146).[27] Although the 2018 report was the fifth OIG report on staffing shortages within VHA, it was the first report that included facility-specific data reported by leaders at 140 VA medical centers. Users can examine the particular self-reported needs of an individual facility as opposed to only national data.

It was also the first report to include nonclinical positions, such as police and custodial personnel, as required by the **VA Choice and Quality Employment Act of 2017** (PL 115–46).[28] These nonclinical occupations also can affect the ability of VHA facilities to provide quality and timely patient care in a safe and clean environment. The results of the review underscore the extent to which mental health care and related shortages are a widespread issue across VHA.

Medical center directors most commonly cited the need for medical officers and nurses, which is consistent with the OIG's five previous VHA staffing reports. The data showed that 131 of 140 facilities listed the medical officer occupational series (or a related VHA assignment code) as experiencing a shortage, with the psychiatry and primary care positions being the most frequently reported. Of the 140 facilities, 102 listed the nurse occupational series (or a related VHA assignment code) as experiencing a shortage, with practical nurse and staff nurse as the most frequently reported. Within nonclinical occupations, the OIG found that police occupations, general engineering, and custodial workers were among the most often cited as shortages. Overall, 99 out of 140 VHA facility directors reported at least one severe shortage in mental health occupations.[29]

Inadequate Governance of the VA Police Program at Medical Facilities

The safety of VA personnel, veterans and their families, and visitors to VA facilities is not just a responsibility for clinical and administrative VHA personnel but also VA's police service. Veterans may have interactions with VA police during their care at a VA facility—in some cases it may be the first interaction they have upon entering a facility. These interactions underscore the importance of an appropriately governed, well trained, and adequately staffed VA police service, particularly when they interact with veterans experiencing a mental health crisis.

The OIG in this report did not focus on VA police encounters with individuals in mental health crisis. It examined the effectiveness of the police program governance structure and the challenges in staffing and overseeing its police workforce.[30] Accordingly, there is some concern about how overall governance and police staffing might affect a broad array of facility duties, including those related to mental health concerns.

ONGOING OIG WORK RELATED TO VHA MENTAL HEALTH CARE

In addition to the recent work highlighted in this statement, the OIG has many other ongoing and planned projects related to VHA mental health care. The OIG recognizes the tremendous importance of mental health care and suicide prevention and is coordinating and focusing efforts across the OIG to ensure effective oversight of VHA's efforts. For example, the OIG is conducting an audit to determine whether suicide prevention coordinators are effectively managing crisis line referrals to connect at-risk veterans with needed services. Specifically, the audit will assess whether VHA provided oversight and established processes for suicide prevention coordinators to ensure veterans are reached to assess their needs.

Additionally, the OIG is in the final stages of developing a focused review that will evaluate the quality of care provided at Readjustment Counseling Services clinics, also known as Vet Centers. The review will cover key clinical and administrative processes at Vet Centers that are associated with promoting quality care such as effective governance, appropriate environment of care, VHA care coordination and collaboration, and suicide prevention. The OIG also has ongoing reviews of re-

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[27] OIG Determination of Veterans Health Administration's Occupational Staffing Shortages reports were previously published on June 14, 2018; September 27, 2017; September 26, 2016; September 1, 2015; and January 30, 2015.

[28] *OIG Determination of VHA's Occupational Staffing Shortages, Fiscal Year 2019*, September 30, 2019.

[29] Mental health occupations include Psychiatry; Registered Nurses – Inpatient and Outpatient Mental Health; Nurse Practitioner – Mental Health/Substance Use Disorder; Clinical Nurse Specialist – Mental Health/Substance Use Disorder; Social Science/Licensed Professional Mental Health Counselor; Psychology; Psychology Aid and Technician.

[30] *Inadequate Governance of the VA Police Program at Medical Facilities*, December 13, 2018.

cent incidents in which there are allegations that veterans experiencing a mental health crisis did not receive appropriate or adequate care. This includes incidents that have occurred at VA medical centers and at the Veterans Crisis Line. The OIG hotline continually works with expert staff to triage incoming information and remains vigilant to issues that could undermine appropriate and timely mental health care, and investigate thoroughly allegations of patient harm, suicide, and related concerns at VHA facilities.

CONCLUSION

This Committee and VA have made it a priority to improve the mental health care and suicide prevention capabilities of VHA. All OIG staff share your sense of urgency in addressing these issues. Recent OIG work has detailed the challenges some veterans face accessing and receiving high-quality mental health care within VHA. However, we should not lose sight of the good work that dedicated mental health care providers and other professionals are doing within VA. There are tremendous numbers of patients and providers who have had positive experiences that should be valued and applauded. The reports highlighted in this statement show that there are still considerable challenges however, particularly regarding deficiencies in the environment and coordination of mental health care that have persisted and led to negative outcomes for veterans experiencing mental health crises. The OIG is committed to providing recommendations that flow from our oversight work to help VHA improve its programs and veterans' experiences. The OIG will continue to monitor the many aspects of mental health care and suicide prevention provided by VHA to help ensure the improvements sought by this Committee and our Nation are realized.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or other members of the Committee may have.

Prepared Statement of C. Edward Coffey

Good morning, Chairman Takano, Ranking Member Roe, and Members of the Committee. Thank you for inviting me to participate in this very important hearing on suicide prevention for America's veterans. I am Dr. Ed Coffey, a neurologist and psychiatrist, and Affiliate Professor of Psychiatry and Behavioral Sciences at the Medical University of South Carolina, in Charleston, SC.

You requested that I share insights about the efforts of non-VA health care systems to establish comprehensive suicide prevention approaches. I am happy to do so. While as a physician I have always viewed suicide prevention as a key priority for my patients, my involvement in suicide prevention at a healthcare systems level began over 20 years ago, when I served as Vice President for Behavioral Health Services at the Henry Ford Health System in Detroit, MI (1996–2014). In that capacity I had the great pleasure to lead a team of incredible individuals who set out to radically transform a large mental health care delivery system by participating in the Robert Wood Johnson Foundation's "Pursuing Perfection National Collaborative." We chose to focus our initiative on "perfecting" the care of persons with depression, and by leveraging the power of an audacious goal – the elimination of suicide – we achieved dramatic and sustained reductions in patient suicide, as well as improved performance of our entire delivery system. Our approach to achieve these results has since been endorsed by numerous organizations – including The Joint Commission and the U.S. Surgeon General's 2012 National Strategy for Suicide Prevention – and recently SAMHSA has funded the implementation of the Zero Suicide model by numerous states, tribes, and health care systems across the US. In addition, the vision of "Zero Suicide" has inspired an international movement, and I am pleased to be supporting such implementation which is underway in Canada, Australia, New Zealand, the Netherlands, and the United Kingdom.

In my remarks today, I will briefly review the origin of our Zero Suicide model and discuss its key components. But first, by way of background I want to review some statistics that highlight the growing suicide crisis in our country.

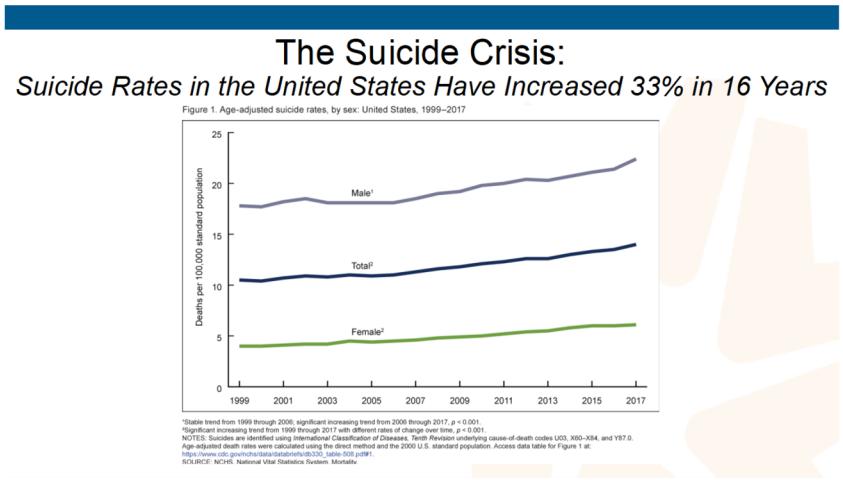
The Suicide Crisis in America

This Committee is well aware of the growing tragedy of suicide in America.

- While deaths from cancer and heart disease have declined in the US, the rate of death by suicide has increased 33 percent in the past 16 years (1999 – 2017) (Figure 1). That rate is actually accelerating more recently, and it is disproportionately higher in women and in people living in rural areas.

- The statistics are worse for veterans, where the incidence of suicide is 50 percent higher than the general adult population, and 80 percent higher in female veterans.
- Suicide is the 10th leading cause of death in the US, and the second leading cause of death between ages 10 – 34. In 2017, we lost ~50,000 Americans to suicide, ~6100 of whom were veterans.
- Many more Americans – ~1.4 million – report having attempted suicide each year, and over 10 million report seriously considering suicide.

In light of these grim statistics, a new approach to suicide prevention is clearly needed.



The Origin of the Zero Suicide Model

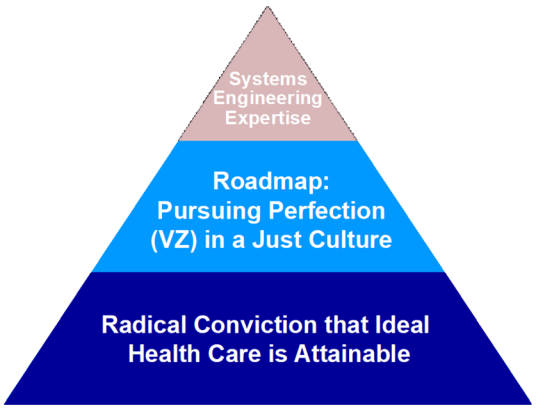
In 2001, the Institute of Medicine's *Crossing the Quality Chasm* report called for sweeping reform of the American health care system, and the Robert Wood Johnson Foundation together with the Institute for Healthcare Improvement responded with a $26 million national demonstration project – known as the "Pursuing Perfection National Collaborative" – that challenged health care systems to dramatically improve patient outcomes by redesigning all major care processes in order to deliver ideal care. At Henry Ford Health System, our participation in the first phase of Pursuing Perfection (we were not ultimately awarded an implementation grant) challenged us to create a workplace culture in which the performance goal was *perfection*, not just incremental improvement.

We selected for transformation the care of persons with depression, but we struggled initially to articulate what a vision of "perfect depression care" would look like. Finally, one of our staff suggested that if depression care was truly perfect, no patient would die from suicide. That stunning idea set in motion a debate that continues even today. Some have argued that a goal of no suicide is not realistic or achievable (e.g., How can we stop it if someone really wants to do it?), that it is overly simplistic, and that it could provoke distress among patients, family members, and health care providers that would only make matters worse. Our team challenged these assumptions and asked, If zero is not the right goal for suicide occurrence, what number possibly could be? Very quickly we came to realize that because of its radicalism, the goal of Zero Suicide provided the requisite galvanizing force essential to drive the hard work of transformation.

It should be noted that the concept of "zero defects" has been around since at least 1966, spreading to industries throughout the world, and recently, innovating to zero was called 1 of 10 megatrends for innovation. High-reliability organizations aggressively pursue perfection, an approach that has driven commercial aviation to achieve remarkable levels of safety. Why shouldn't this same approach be applied to health care?

The Zero Suicide Model

In our view, the Zero Suicide Model is an approach to system transformation that consists of three essential components (Figure 2):



- A radical conviction that ideal (perfect) health care is attainable.

  Such a conviction is fundamental to the model, as it provides the driving force essential for the hard work of relentless transformation. Absent such a radical conviction, implementing multimodal suicide prevention strategies is less likely to be effective and sustainable.
- A roadmap to achieve that vision.

  Performance is about "pursuing perfection," not simply incremental improvement. Such performance is made possible by a "just culture." A "just culture" is one that embraces the radical goal of perfect care, and that makes the pursuit of that care possible by viewing errors or near misses as system failures from which to learn and rapidly improve. In response to errors, a just culture asks "What happened and how?", not "Who did it?" A just culture seeks recovery, restoration, and improvement, not blame, punishment, or retribution.
- A requisite expertise in systems engineering.

  Teammates must be expert in promoting and implementing systematic evidence-based approaches. In our Perfect Depression Care Initiative, we focused on three key strategies: safety planning (particularly safe gun ownership), rapid access to definitive care, and managing the transitions of care. Teammates must also be quick learners when mistakes happen, so that they can rapidly correct system defects and continually improve to achieve zero defects.

With this model we were able to reduce the rate of suicide among our patients by 75 percent, even while over that same 10-year period the rate of suicide actually increased in the general population of the State of Michigan. As noted earlier, others are now adopting iterations of the Zero Suicide model and are describing similar positive results. Additionally, research (funded by NIH and SAMHSA) is underway to formally study the effectiveness of the Zero Suicide model.

Conclusion

As noted by the Institute of Medicine in its report *Crossing the Quality Chasm*, "In its current forms, habits, and environment, American health care is incapable of providing the public with the quality health care it expects and deserves. ...The current care systems cannot do the job. Trying harder will not work. Changing systems of care will."

Zero Suicide is an example of how we might change our systems of care, and it provides a potential model for achieving dramatically improved performance, including the audacious goal of eliminating suicide. To be sure, suicide prevention is a very complex issue that involves clinical and socio-cultural-political components. Still, the Department of Veterans Affairs is in a position to address such complexity, and there is no reason why it couldn't become the world leader in dramatically improving systems issues such as health engagement, healthcare access, and the social determinants of health, among others. In addition, because veterans and service members are venerated in our society and widely acknowledged as expert in injury prevention, they have the opportunity to serve as the model for safe gun ownership

in our broader society, and in so doing, catalyze a movement that would save thousands of lives.

Thank you again for the opportunity to participate in this hearing today, and to represent my many colleagues around the globe who have courageously embraced a vision of ideal care and Zero Suicide. I am happy to respond to any questions you may have.

Selected Supporting Documents

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Building a System of Perfect Depression Care in Behavioral Health

C. Edward Coffey, M.D.
For the "Blues Busters" of Behavioral Health Services

Behavioral Health Services, a division of the Henry Ford Health System (HFHS; Detroit), provides a full continuum of mental health and substance abuse services through a large integrated delivery system of 2 hospitals, 10 clinics, and more than 500 employees that serves southeastern Michigan and adjacent states. Through its department of psychiatry, Behavioral Health Services is also engaged in a large academic enterprise, which includes numerous education, training, and research programs.

In 2001, the Institute of Medicine (IOM) report, *Crossing the Quality Chasm: A New Health System for the 21st Century,*[1,2] served as a wake-up call to American health care. While praising the unparalleled advances in medical science in the United States, as well as health care workers' skill, dedication, and self-sacrifice, it indicted the health care delivery system for not translating those strengths into meaningfully better care for each and every patient.

The Chasm Report spotlighted behavioral health care, identifying depression and anxiety disorders on the short list of priority conditions for immediate national attention and improvement. Annually, depression affects about 10% of adults in the United States. The leading cause of disability in developed countries, depression results in substantial medical care expenditures, lost productivity, and absenteeism. Untreated or poorly treated, it can be deadly; each year as many as 10 percent of patients with major depression die from suicide.[3]

Shortly after publication of the Chasm Report, the Robert Wood Johnson Foundation (RWJF) issued a challenge to American health care leaders to "pursue perfect

Article-at-a-Glance

Background: Depression, a common, serious disorder, may result in suicide in up to 10% of afflicted persons.

Methods: In 2001, the Division of Behavioral Health Services of the Henry Ford Health System (Detroit) launched an initiative to completely redesign depression care delivery using the Six Aims and the Ten Rules from the Institute of Medicine report *Crossing the Quality Chasm.* This "Perfect Depression Care" initiative, whose key goal was the elimination of suicide, entailed performance improvement activities in four domains—partnership with patients, clinical care (planned care model), access, and information flow.

Results: The rate of suicide in the patient population decreased by 75% (p = .007), from ~89 per 100,000 at baseline (2000) to ~22 per 100,000 for the four-year follow-up interval (the average rate for 2002–2005).

Discussion: This sustained reduction in suicide rate suggests that the process improvements implemented as part of the Perfect Depression Care initiative substantially improved the care of persons with depression. The initiative is the prototype for a comprehensive redesign of behavioral health care. Work is under way to "perfect" the care of persons with anxiety or psychotic disorders, and similar care systems are being developed for violence prevention and medication safety, with a particular focus on perfecting communication between providers. Pursuing perfection is no longer a project or initiative but a principle driving force embedded in the fabric of our care.

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Table 1. Contents Page for the Suicide Prevention Guideline*

Henry Ford Health System Behavioral Health Services Suicide Prevention Guideline

1. What is the Planned Care Model?
   - Background & Definition
   - Planned Care Model for HFBH Perfect Depression Care
2. Decision Support: Evidence-Based Guidelines
   - HFBH Suicide Prevention Guideline
     - — Risk Assessment–Key Definitions
     - — Protocol to Remove Weapons
     - — Family Interventions
       Handout: "Understanding and Helping Someone Who Is Suicidal"
     - — Psychotherapy
3. Delivery of Care Design
4. Patient Self-Management
   - Handout: "If you are thinking about suicide…read this first"
   - HFBH Depression Web site
   - Self-Help Books
5. Community Resources and Support
   - List of Community Support Groups
6. IT Support / Clinical Information Systems
7. Measurement
   - Six Dimensions of Care
   - Risk assessment and outcome measures
   - Patient Satisfaction
   - Ambulatory Chart Audits
8. Guideline Review Schedule
9. Appendix
   A. Key Articles
   B. APA Practice Guidelines for the Treatment of Patients with Major Depression

* HFBH, Henry Ford Behavioral Health; IT, information technology; APA, American Psychiatric Association. A full copy of the guideline is available on e-mail request from the author

care" by embracing the IOM framework of the Six Aims (Table 1, above) and then Ten Rules for redesign (for example, care based on continuous healing relationships, customization based on patient needs and values)[2] as an approach to achieve "perfect" care. We accepted the RWJF challenge, choosing as our overall goal the pursuit of a system of perfect care for persons with depression. Through a competitive process, behavioral health services was selected from among approximately 300 applicants as one of 12 demonstration projects ("finalists") for Phase I of "Pursuing Perfection." Participation in this national collaborative in 2002 provided our Perfect Depression Care initiative focus, structure, discipline, and visibility in the start-up phase.

Today we can report a large and sustained reduction in suicide that is, to our knowledge, unprecedented in the clinical and quality improvement literature.

Methods

Planning

Our Goal–No Suicides! The overarching goal in the Perfect Depression Care initiative was to eliminate suicide. This audacious goal was a key lever in a broader aim: to achieve breakthrough improvement in quality and safety by completely redesigning depression care delivery using the Six Aims and Ten New Rules articulated in the Chasm Report. To communicate our bold vision, we called the initiative "Perfect Depression Care."

Our Strategy

Our approach to achieving Perfect Depression Care consisted of the following six major tactics:

1. Commit to "perfection" (zero defects) as a goal.
2. Develop a clear vision of how each patient's care will change.
3. Partner with patients to ensure their voice in care redesign.
4. Conceptualize, design, and test strategies for improvement in four high-leverage domains identified when we mapped our current care processes:
   - Patient partnership
   - Clinical practice (planned care model)
   - Access to care
   - Information systems
5. Implement relevant measures of care quality, continually assess progress, and adjust the plan as needed.
6. Communicate the results, communicate the results, and communicate the results again, and celebrate the victories.

We extensively redesigned depression care, which included the development and implementation of a suicide prevention protocol across both outpatient and inpatient

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Table 2. Perfect Depression Care: Key Goals and Indicators*

IOM Aim	Goal	Measure	Data Source
Safety	Eliminate inpatient falls Eliminate inpatient medication errors	Inpatient falls/1,000 days of care Inpatient medication errors/1,000 days of care	Incident reporting system
Effectiveness	Eliminate suicides	Number of suicides/100,000 network members	Incident reporting system
Patient-centeredness	100% of patients completely satisfied with their care	Overall patient satisfaction	PressGaney survey, Assessment of care survey
Timeliness	100% complete satisfaction	Patient satisfaction with timeliness	Assessment of care survey
Efficiency	100% complete satisfaction	Patient satisfaction with efficiency	Assessment of care survey
Equity	100% complete satisfaction	Patient satisfaction with equity	Assessment of care survey

* The Six IOM (Institute of Medicine) Aims are drawn from Institute of Medicine: *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, D.C.: National Academy Press, 2001.

facilities. This protocol has become a central component of our evidence-based depression care guidelines (Table 1).

Perfect Depression Care as an Organizing Strategic Planning Concept

We leveraged Perfect Depression Care as a core strategy to drive quality. By using our strategic and operational planning process to target and plan for Perfect Depression Care, we ensured that the initiative was aligned with overall organization priorities, fully integrated into the work of leaders and others across the organization, and subject to ongoing review of progress and "lessons learned."

Implementing the Perfect Depression Care Initiative

In 2001, the vice president of the Division of Behavioral Health Services [C.E.C.], as leader of the Perfect Depression Care initiative, formed and led a 15-member steering team, which set the initiative's vision and strategic goals; conceptualized, planned, and launched the initiative; and provided initial leadership direction and oversight. The team consisted of key members of the executive team (chief operations officer, medical directors of inpatient and outpatient services, director of quality management), as well as other key clinicians and managers (for example, inpatient nursing leader, several key physicians, therapists, and clinical managers). When possible, the chair chose members known to be leaders and change agents; both leadership and front-line caregiver perspectives were represented.

Early on, the team adopted a name and logo (Figure 1, page 196) and after some vigorous discussion, united in a commitment to pursuing perfection. We captured that commitment in a promise we make to our patients. These critical first steps helped unite our Blues Busters team and gave our purpose an identity within the department and the larger health system.

The psychiatry department's board of trustees, an advisory board composed of 20 volunteer community leaders, also played a key leadership role in Perfect Depression Care. The board and its quality committee reviewed progress quarterly, provided encouragement to leaders and staff, recognized accomplishments in written communications, and undertook major philanthropic efforts to support the initiative, in particular raising substantial sums of money to support the development of critical information technology, including a Depression Care Web site accessible to registered patients.

All psychotherapists were provided training to develop competency in Cognitive Behavior Therapy and the suicide prevention protocol. Nonclinical staff had important roles in practice changes such as access improvements and information systems innovations.

Fiscal and Staff Resources

The Perfect Depression Care initiative required one-time financial support in three key areas:

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Blues Busters Logo

Our promise to each and every patient:

"We will work with you to achieve the best possible care, always respecting your individual wants and needs."

Figure 1. *The logo for the Perfect Depression Care initiative is shown.*

1. Project management: One full-time equivalent (FTE) of project management support for one year
2. Departmentwide competency in Cognitive Behavior Therapy, as stated above
3. Information systems development: Depression Care Web site (substantially funded by the board of trustees), departmental Intranet, electronic medical record (EMR) enhancements

We received considerable guidance and support from faculty at the Institute for Healthcare Improvement and the RWJF during our participation in "Pursuing Perfection," as well as others (see Acknowledgments).

Performance Measurement

As a participant in Phase I of the Pursuing Perfection initiative in 2001, Behavioral Health Services set goals and indicators to drive and monitor improvement during the Perfect Depression Care Initiative in terms of the IOM's Six Aims (Table 2, page 195) to drive and monitor improvement. Consistent with the concept of pursuing "perfection," the Blues Busters team conceptualized goals in terms of "zero defects"—that is, eliminating suicides, not merely reducing them incrementally—and "complete satisfaction" of every patient every time, not merely appeasing some of them some of the time.

Defining the goal for effectiveness of care stirred controversy in our department. Some members of the Blues Busters team who embraced the "pursuing perfection" concept argued that truly effective care could only mean no suicides. Other team members challenged such a goal, viewing it as unrealistic for a network of approximately 200,000 members. The debate was finally resolved when the question was asked, "If zero is not the right number of suicides, then what number is? 1? 4? 40?" This debate was a milestone in the Blues Busters' development—a galvanizing issue that helped skeptics see the "logic" of striving for perfection and launched our initiative to transform depression care.

Data Analysis

We compared the incidence of suicide between the baseline period (the year 2000), the start-up period (the year 2001) and the follow-up interval (the years 2002–2005). Poisson regression was used for testing using each quarter of data for the three time periods.

We displayed the suicide data using a run chart, which plotted the running 12-month rate of suicide (Figure 2, page 197). The chart also shows the annual rate of suicide in the general population (~11 per 100,000 population, based upon the 2000 U.S. Census), as well as the reported rate in patients with a history of a mood disorder who are currently in remission (~4X–10X the rate in the general population). The rate of suicide in patients with an active mood disorder is estimated at 80–90X the rate in the general population, and the suicide rate in patients with a history of suicide attempts is 100X the rate in the general population.

Data Dissemination

From the start of the initiative, the Blues Busters team regularly reviewed results with leaders and managers of Behavioral Health Services as part of its ongoing strategic and operational performance review. The Blues Busters also designed a communication strategy that leveraged the department's array of established communication methods, ensuring that results, analyses, and lessons learned were widely shared with staff and other stakeholders.

Through Web sites and participation in national meetings and conferences, department leaders also shared the results of the Perfect Depression Care initiative with a broader health industry audience, including such groups as the American Psychiatric Association and the American Medical Group Association.

Performance Improvement Activities

Our first step in the Perfect Depression Care initiative was to use the IOM's Six Aims and Ten Rules to develop a clear vision of how each patient's care would be different and to drive bold and innovative thinking about optimal care. If

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we aimed to eliminate suicide, we asked ourselves, what would it mean to offer a continuous healing relationship (Rule 1) or to anticipate needs (Rule 8)? We concluded that perfect depression care must be barrier free and that we must consistently provide for timely and accurate recognition of suicide risk. We found all ten rules useful as design specifications, and our care process changes indeed reflect them all.

We mapped our current care processes and identified four domains of activity that offered an opportunity for high-leverage changes to close the gap between current and perfect care—partnership with patients, clinical care (planned care model), access, and information flow. The components of these domains of activity are shown in Table 3 (page 198).

Throughout the initiative we maintained a focus on improving the entire system of behavioral health care not simply on managing a particular disease such as depression. Some needed improvements were obvious at once—the suicide prevention protocol, for example. Other improvements already under way now assumed new priority, such as establishing department-wide competency in Cognitive Behavior Therapy. Still others emerged over time, as team members examined the literature and benchmarked processes in high-performing organizations across the United States worth emulating—such as advanced access and the drop-in group medical appointment, each of which has only rarely been implemented in a behavioral health care setting.

In change management, whenever possible, we test changes on a small scale initially, through a pilot project involving one or a few clinicians. Depending on the pilot results, we may test the change again or begin implementation and spread. In addition, whenever possible, we build the internal capacity to make and sustain the change. For example, we equipped a small clinical team with the knowledge and skills to train and certify their colleagues in Cognitive Behavior Therapy. Finally, we have implemented a measurement system that is integrated into ongoing organizational performance review and reporting as a means of assessing the short- and long-term success of our changes.

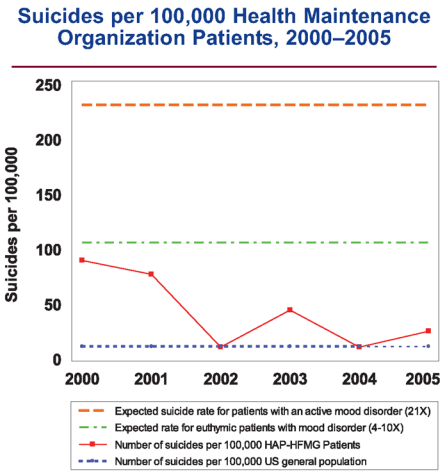

Figure 2. *This run chart shows the running 12-month rate of suicide for each year since inception of the Perfect Depression Care Initiative. The annual rates of suicide are also shown for reference populations.*

Results

As shown in Figure 2, the observed suicide rates ranged from 89 per 100,000 for baseline (2000), 77 per 100,000 for the start-up (2001), and 22 per 100,000 for the follow-up interval (the average rate for 2002–2005). The overall Poisson regression model (2 degrees of freedom, Chi-square test for a period effect) was statistically significant, $\chi^2 = 8.0$, $p = .018$. The difference in suicide rate between baseline and start-up years was not significant ($p = .768$), but the suicide rate for the follow-up period was significantly lower than that for both the baseline year ($p = .007$) and the start-up year ($p = .022$).

Discussion

During the period of 2001–2005 we designed, tested, and implemented multiple practice improvements, so it is difficult to determine which contributed most to our achievement. Yet we are confident that beyond our practice improvements, our determination to strive for

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Table 3. Performance Improvement Activities in Four Domains

Partnership with Patients

- Established a consumer advisory panel to ensure the "voice of the customer" in care redesign
- Redesigned the treatment planning process, with input from the consumer advisory panel, to ensure that every patient has a voice in the design of his or her care working in an active partnership with clinicians

Clinical Care (Planned Care Model)

- Developed and implemented an evidence-based suicide prevention protocol, which has been embedded in the depression care guidelines.* The suicide prevention protocol stratified patients into three levels of risk, each of which required specific interventions. In every case, we focused heavily on the availability of weapons.
- Revised the depression care guidelines to ensure a systematic and evidenced-based approach to coordinating our array of somatic and psychotherapeutic treatments, including psychotherapy, psychopharmacology, and brain stimulation techniques such as electroconvulsive therapy
- Partnered with a therapy and research organization to establish and maintain departmentwide competency in Cognitive Behavior Therapy.
- Implemented standardized evidence-based clinical protocols to reduce the risk of falls (modified from the American Geriatrics Society and the American Medical Directors Association) and medication errors (modified from the Institute for Safe Medication Practices) in our inpatient facilities.

Access

- Implemented three access innovations: drop-in group medication appointments, advanced (same-day) access, and e-mail "visits." Each outpatient site offers one or more 90-minute drop-in group appointment(s) weekly, led by a psychiatrist and a social worker. This approach provides temporary additional access and group support on short notice.
- Physically reintegrated a number of our stand-alone behavioral health outpatient clinics into the medical group's outpatient clinic buildings, to improve access and continuity of care.

Information Flow

- Created an electronic medical record for behavioral healthcare that complies with legal and institutional confidentiality policies, ensures that complete behavioral health information (including suicide risk) is immediately available to the behavioral health clinician at any site at which the patient is seen, and gives our group practice colleagues access to critical data for safe patient care through the health system's electronic medical record for medical-surgical care
- Partnered with David Gustafson, Ph.D. and the CHESS Consortium of the University of Wisconsin to develop and implement a state-of-the-art depression Web site for patients and family members that includes evidence-based information via patient videos and "ask the expert" forums as well as secure chat rooms for information and support
- Established secure e-mail communication for the growing number of patients who prefer this vehicle for at least some interactions with their behavioral health care provider.
- Partnered with the health system's information technology department to develop an intranet to disseminate depression guidelines to all clinicians, as well as a patient registry and other electronic tools to improve the quality and efficiency of our care.

* Shown in Figure 2 (page 197).

perfection, rather than incremental goals, had a powerful effect on our results.

Studies such as ours, which rely on a time-series design, are susceptible to potential bias. The main threat to internal validity is "history," that is, the concern that an observed change might be due to an event that is not the treatment of interest. In the context of our study, suicide rates might have reflected major shifts in the community in factors known to be associated with suicide, such as unemployment and socioeconomic downturn or declining family "connectedness" (for example, declining marriage rates). We are compiling statistics for our primary service area to formally evaluate such time trends. A preliminary analyses revealed relatively stable marriage rates (~44%-59%, depending upon county) but unemployment has increased dramatically (from 3.2% in 2000 to 7.3% in 2003). Yet the actual suicide rate in our state and tri-county service area remained relatively stable from 1999 to 2003 (~9.8 to 10.0 per 100,000).

A second threat to validity arises due to the potential for maturation-selection bias. In the context of this study, suicide rates could have changed if characteristics of our patient population (the denominator population), such as age, sex, and race-ethnicity, were changing over time in a

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manner likely to affect suicide rates. For example, suicide is more common among men, the elderly, and whites and Native Americans. We are evaluating the extent to which such characteristics may have changed over time in our patients. Preliminary analyses have revealed no clear changes in age, sex, and race-ethnicity.

The encouraging results of the Perfect Depression Care Initiative suggest that the Chasm Report can be a highly effective model for achieving and sustaining breakthrough quality improvement in mental health care.

Energized by this success, we remain focused on driving our suicide rate down to zero, and we are spreading our success and lessons learned both within and beyond our department. The Perfect Depression Care initiative is the prototype for a comprehensive redesign of behavioral health care across the psychiatry department. Work is under way to "perfect" the care of persons with anxiety or psychotic disorders, and similar care systems are being developed for violence prevention and medication safety, with a particular focus on "perfecting" communication between providers. Essentially, pursuing perfection is no longer a project or initiative but a principle driving force embedded in the fabric of our care.

Beyond the psychiatry department, we are also partnering with our health system and community. We have implemented an initiative to spread "perfect depression care" to the primary and specialty medical care settings of our health system. We are also collaborating with the insurance division of our health system to develop a depression care management product designed to provide major employers (in particular the automotive manufacturers in Detroit) with a system of depression care that will improve their employee productivity and lower health care costs. We have received funding to leverage information technology to help the State of Michigan develop and implement evidence-based guidelines for the care of persons with mood disorders throughout the state. Finally, we are consulting with numerous mental health care providers, insurers, and professional organizations throughout the United States to support their efforts to improve their behavioral health care services.

Summary and Conclusions

Striving for perfect depression care set the Blues Busters and our entire department on a transformational journey. "Perfect" care required audacious goals—goals that could only be accomplished by challenging the most basic assumptions. Usual care and incremental approaches were taken off the table. Although the business case for pursuing perfection is complex, we found it is possible to dramatically improve care and financial performance at the same time. This approach is not only economically viable but is readily applicable to other behavioral health care delivery systems. J

The author thanks David Gustafson, Ph.D., who pioneered the CHESS patient Web site at the University of Wisconsin, for his help in the creation of the Henry Ford Health System Depression Care Web site, and Judith Beck, Ph.D., The Beck Institute for Cognitive Therapy and Research, Philadelphia, for her work in the Cognitive Behavior Therapy project.

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term *abortion* appeared sufficient; nevertheless, some disclosures may have been missed. Whether the low proportion of hospitals that did not cite health care restrictions reflects a lack of transparency or nonadherence to the directives is unknown. In addition, some of the hospitals that cited the directives may provide reproductive services. How often patients consult hospital websites for such information is also unknown.

Greater transparency about religious affiliation and care restrictions may allow patients to make more informed choices.[1] In the state of Washington, hospitals must provide their reproductive health and end-of-life care policies on publicly available websites.[6] Further research on the effect of this initiative on patient satisfaction and health care choices is warranted.

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Disclaimer: The views expressed in this article are those of the authors and do not necessarily represent the views of the Society of Family Planning.

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COMMENT & RESPONSE

Challenges in Research on Suicide Prevention

To the Editor In a Viewpoint, Drs Sisti and Joffe[1] expressed concern that interventions to reduce suicide have not been well studied in clinical trials and proposed inclusion of actively suicidal individuals in trials. The US Food and Drug Administration (FDA) provides regulatory advice on clinical trials for psychiatric drug development. We wish to comment on several issues in the article.

In the recent FDA draft guidance to industry on antidepressant drug development,[2] inclusion of patients with suicidal ideation and behavior in clinical trials was encouraged. Other conditions with increased risk of suicidal ideation and behavior, including bipolar disorder and schizophrenia, were not mentioned because separate guidances are pending; however, the FDA agrees with the inclusion of such patients in trials. To the extent possible, study populations should reflect the full severity range of patients encountered in clinical practice.

However, we do not believe that including patients with suicidal ideation or behavior in clinical trials obviates the need to provide standard-of-care treatment for acutely suicidal patients. In a previous FDA guidance,[3] it was recommended that patients with suicidal ideation (ie, Columbia-Suicide Severity Rating Scale[4] score ≥4) should be excluded or discontinued from most clinical trials so that they can receive immediate psychiatric intervention. We have additional concerns about including patients with suicidal ideation or behavior in trials for nonpsychiatric indications because psychiatric monitoring is limited in these settings. Nevertheless, such inclusion may be possible with appropriate precautions.

In recent years, some drug development programs have proposed reduction of suicidal ideation or behavior as a treatment indication. Such studies are ethically supportable if patients receive standard-of-care interventions based on severity of suicidal ideation or behavior, although they may require inpatient settings. Unlike the authors, we believe that adverse events related to suicidal ideation or behavior should be reported as adverse events in these studies, but only if the events are more severe than at baseline. This recommendation would permit appropriate safety monitoring while avoiding overreporting. Moreover, events reported as adverse events could still be included in the efficacy analyses.

As the authors noted, death due to suicide is not a practicable primary end point for trials of interventions to reduce suicidal ideation or behavior. The FDA is open to considering surrogate end points to support indications for treatment of suicidal ideation or behavior. We agree that data on suicidal behavior and deaths should be collected with suicidal ideation because the relationship between them is not yet fully characterized.

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To the Editor Drs Sisti and Joffe[1] described challenges in conducting research on suicide. We agree that such research should include individuals with suicidal behavior and that suicide attempts and death are appropriate outcomes for trials. We also agree that conceptualizing the outcome of suicide as an adverse event might trigger objections by regulatory bodies that jeopardize the feasibility of such investigations.

We disagree, however, that the zero suicide model might "paradoxically constrain" research.[1] As previously described,[2,3] the zero suicide model is a comprehensive quality improvement approach that organizations can use to improve health care delivery. The zero suicide model consists of 3 essential components: a conviction that ideal health care is attainable, a road map to achieve that vision, and requisite expertise in systems engineering to rapidly achieve zero suicides.

Following its introduction in 1966,[4] the concept of zero defects spread to industries throughout the world, and recently, innovating to zero was called 1 of 10 megatrends for innovation.[5] High-reliability organizations aggressively pursue perfection, an approach that has driven commercial aviation to achieve remarkable levels of safety. Twenty years ago, the Henry Ford Health System adopted this approach, setting goals for mental health care and achieving an 80% reduction in suicides, which was maintained over a decade.[3]

In our view, the success of the zero suicide model depends on a just culture, one that views errors or near misses as system failures from which to learn and rapidly improve. In response to defects, a just culture asks "What happened and how?", not "Who did it?" A just culture seeks recovery, restoration, and improvement, not blame, punishment, or retribution.

Thus, we disagree that a corollary of the zero suicide model "is that every suicide represents a culpable failure on the part of health professionals."[1] Quite the contrary, the zero suicide model views a suicide as a system defect that provides an essential opportunity for learning and rapid improvement. This approach is constructive and productive and will not only improve care but enable clinical research. The Substance Abuse and Mental Health Services Administration and the National Institute of Mental Health have recently provided funding to study the effectiveness of the zero suicide model.

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In Reply We are gratified to know that the FDA is developing guidance that supports inclusion of individuals with suicidal ideation or behavior associated with serious mental illnesses, including schizophrenia and bipolar disorder, in clinical trials. We agree that trial participants with acute suicidal ideation or behavior, including those in the control groups of clinical trials evaluating suicidal ideation or behavior as an end point, be provided with standard-of-care (including emergency) interventions or with investigational approaches hypothesized to be as good as or better than the standard of care. However, mandating participant exclusion when suicidal ideation or behavior passes a predetermined threshold is a step backward: drawing conclusions about new treatments for the population most at risk would be impossible.

The question of whether worsening of suicidal ideation or behavior should be reported as an adverse event merits further discussion for at least 2 reasons: (1) the importance of distinguishing between lack of efficacy of an intervention and its toxicity and (2) the risk that sponsors, data and safety monitoring committees, or institutional review boards will take actions because of unjustified concerns about toxicity that undermine ongoing trials.

The issue of nonpsychiatric research involving suicidal participants is an important one but is beyond the scope of our argument.

We appreciate the clarification offered by Dr Coffey and colleagues, who provide additional details about the aims and mission of the zero suicide model and the importance of a just culture in ensuring safety. As we noted in our article, the zero suicide model is a laudable goal in clinical settings.[1] Furthermore, we strongly agree that a just culture and a nonpunitive approach are essential to understanding root causes and preventing sentinel events in clinical care.

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Our concern is that the zero suicide model might be inappropriately applied in research settings in which the aim is to identify evidence-based suicide reduction interventions that can bring the zero suicide vision closer. Engaging in such research entails a forthright acknowledgment that some participants will attempt suicide and that despite investigators' best efforts, some of those attempts may be successful. It is important to clarify that such events, assuming adherence to protocol and standards of care, do not represent culpable failures on behalf of investigators or institutions.

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Reducing the Burden of Fellowship Interviews

To the Editor The Viewpoint by Dr Melcher and colleagues[1] raised concerns regarding time expenditures, incurred costs, and loss of clinical coverage caused by interviewing for surgical fellowships and proposed an interview match as a way to decrease the overall amount of interviews. They referenced a survey of pediatric surgery program directors that showed the median rank at which programs matched was less than 4.[2] There is a flaw in this justification: one cannot assume that the top 4 candidates on a rank list were all applicants who would have been granted interviews through an interview match.

I echo the authors' concerns that such a system would unfairly favor candidates who look good on paper and conversely could be detrimental to candidates who excel in personal interviews. Likewise, it would not allow for the serendipitous connection between an applicant and representatives from a program.

Technology may provide an alternative strategy to decrease the time and expense of interviews. Telephone interviews have been used in other disciplines as a less expensive alternative to the traditional interview process. After an application is received, telephone interviews might be used as an additional screening prior to or in place of the interview process. This would allow for a true interaction between an applicant and representatives from a program in an efficient, less costly manner.

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To the Editor Dr Melcher and colleagues[1] accurately described the challenges of the current surgical fellowship application system and proposed a match within the match solution. The essence of their proposal centers on limiting the number of interviews that an applicant can participate in and that programs can conduct.

Before adopting the interview match system proposed by the authors, other approaches should be considered. Industrial organizational psychology (the science of human behavior related to work) may suggest a solution. Industrial organizational psychologists conduct research on employee behaviors and attitudes and how these can be improved through hiring practices and training programs. Other high-risk professions and most Fortune 500 companies use industrial organizational psychologists to improve personnel selection by their organizations.[2]

Industrial organizational psychology suggests that there are 2 problems with the current surgical training selection process. First, applicants lack information that can help them determine their fit into a program and candidacy for selection. Second, programs lack tools that credibly separate one candidate from another.[3] As a result, applicants cast a wide net to improve their chances of selection, and programs conduct many interviews to try to obtain more information. Industrial organizational psychology would suggest that candidates complete prescreening assessments (situational judgment tests, personality profiles, integrity tests, etc) that evaluate competencies identified to be required for success in the position. The results would then be used by programs to determine who to invite to interview.

Some surgery programs have worked with industrial organizational psychologists to address the problems associated with interviewing for fellowships. Preliminary studies have shown improved efficiency, a reduction in interview numbers, improved candidate satisfaction, and improvement in the diversity of candidates considered.[4,5]

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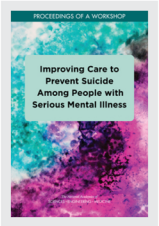

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Improving Care to Prevent Suicide Among People with Serious Mental Illness

PROCEEDINGS OF A WORKSHOP

Steve Olson, *Rapporteur*

Board on Health Care Services

Health and Medicine Division

Board on Children, Youth, and Families

Division of Behavioral and Social Sciences and Education

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PLANNING COMMITTEE ON IMPROVING CARE TO PREVENT SUICIDE AMONG PEOPLE WITH SERIOUS MENTAL ILLNESS[1]

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[1] The National Academies of Sciences, Engineering, and Medicine's planning committees are solely responsible for organizing the workshop, identifying topics, and choosing speakers. The responsibility for the published Proceedings of a Workshop rests with the workshop rapporteur and the institution.

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REVIEWERS

This Proceedings of a Workshop was reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise. The purpose of this independent review is to provide candid and critical comments that will assist the National Academies of Sciences, Engineering, and Medicine in making each published proceedings as sound as possible and to ensure that it meets the institutional standards for quality, objectivity, evidence, and responsiveness to the charge. The review comments and draft manuscript remain confidential to protect the integrity of the process.

We thank the following individuals for their review of this proceedings:

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Although the reviewers listed above provided many constructive comments and suggestions, they were not asked to endorse the content of the proceedings nor did they see the final draft before its release. The review of this proceedings was overseen by **PATRICK DELEON**, Uniformed Services University of Health Sciences. He was responsible for making certain that an independent examination of this proceedings was carried out in accordance with standards of the National Academies and that all review comments were carefully considered. Responsibility for the final content rests entirely with the *rapporteur* and the National Academies.

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CONTENTS

1	INTRODUCTION AND OVERVIEW	1
2	PATTERNS OF RISK AND THE PREVENTION LANDSCAPE	7
3	SUICIDE PREVENTION IN HEALTH CARE SYSTEMS	23
4	MILITARY SERVICE MEMBERS AND VETERANS	35
5	NATIVE AMERICANS AND ALASKA NATIVES	43
6	CONNECTING PREVENTION ALONG THE CONTINUUM OF CARE	55
7	PERSPECTIVES ON THE FUTURE ALONG THE CONTINUUM	63
8	IDEAS FROM THE BREAKOUT SESSIONS	71
9	REFLECTIONS ON THE WORKSHOP	75
APPENDIXES		
A	WORKSHOP AGENDA	79
B	BIOGRAPHICAL SKETCHES	83

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1
Introduction and Overview[1]

On October 5, 2002, Taryn Hiatt, a founding member of the Utah chapter and area director for Utah and Nevada of the American Foundation for Suicide Prevention, lost her father to suicide. He had lived with serious mental illness that went untreated for most of his life. Her family knew that he was ill. Over the course of his life, he had more than 22 surgeries to treat his esophagus from the effects of acid reflux. In the weeks before his suicide, he was taking 30 Ambien per day in addition to a variety of other medications. "His depression was always treated with medication," Hiatt said, some of which were probably needed and some of which were probably not needed. But, Hiatt added, he never received any behavioral treatments so that he would better understand what he was grappling with, and neither did his family.

Hiatt's father was ashamed "for having an illness that he thought was somehow his fault," she said. After his death, her family was ashamed, too. They wondered what to tell people. They talked about whether they should say he had died from a heart attack. "I remember saying no," said Hiatt. "I wanted to share the word. We're done doing this. We're done being quiet."

On September 11–12, 2018, the National Academies of Sciences, Engineering, and Medicine (The National Academies) held a workshop in Washington, DC, to discuss an issue that could have saved Hiatt's father and the lives of thousands of other people every year in the United States: preventing suicide among people with serious mental illness. Suicide prevention initiatives are part of much broader systems, said David Rudd, president of the University of Memphis and member of the workshop planning committee. Such initiatives are connected to activities like the diagnosis of mental illness, the recognition of clinical risk, improving access to care, and coordinating with a broad range of outside agencies and entities around both prevention and public health efforts. Yet suicide is also an intensely personal issue that continues to be surrounded by stigma, Rudd pointed out. "Sometimes it is hard to remember that behind every number is a person, is a family, is a network, and that many people and many lives are touched in each and every one of these instances." It is a national problem, he said, yet it remains hard to have these conversations. "I can think of case after case after case where we have a difficult time saying *suicide*."

The workshop was designed to illustrate and discuss what is known, what is currently being done, and what needs to be done to identify and reduce suicide risk among people with serious mental illness. Box 1-1 provides the statement of task for the workshop. Appendix A contains the workshop agenda, and Appendix B provides biographical sketches of the workshop speakers, panelists, facilitators, planning committee members, staff, and consultants. A video

[1] The planning committee's role was limited to planning the workshop, and the Proceedings of a Workshop was prepared by the workshop rapporteur as a factual summary of what occurred at the workshop. Statements, recommendations, and opinions expressed are those of individual presenters and participants, and are not necessarily endorsed or verified by the National Academies of Sciences, Engineering, and Medicine, and they should not be construed as reflecting any group consensus.

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archive of the workshop can be accessed on the Health and Medicine of the National Academies' project page.[2]

BOX 1-1
Workshop Statement of Task

The workshop presentations and moderated discussions will examine opportunities to prevent suicide among people with serious mental illness (SMI), including, at minimum, bipolar disorder, major depression, schizophrenia, and borderline personality disorder, as well as mood, anxiety, or other disorders that result in significant functional impairment.
The workshop will:

- Highlight the patterns of mortality by suicide among people with SMI,
- Consider the implications of the relationship between SMI and suicide, and
- Examine interventions that can reduce the high risk of suicide in this population.

The workshop will also consider ways to:

- Improve and implement early interventions,
- Improve access to care among vulnerable populations with SMI, and
- Effectively target interventions to specific populations with unique needs.

THE NEED FOR INFORMATION AND COMMUNICATION

Individuals and families need the same education to prevent suicide that they would receive for other health issues, Hiatt said in her presentation during the opening session of the workshop. If her father had been living with cancer, diabetes, dementia, or Alzheimer's, Hiatt noted, his family would have received the information they needed to support him and encourage him to get the help that he needed. But they did not receive the information they needed. Today, others reach out to Hiatt for help, and she refers them to the resources that are available. "But we need more," she said, adding:

> I love the movement that's taking place in our nation where we're finally addressing suicide as a health issue. But, again, if we're going to treat it as the health issue it is, we need to do that on all aspects. There's no shame in getting help for it. There's no shame in admitting that that's what I'm thinking.

Suicidal behavior is an attempt to cope, as is all behavior, she said. A person in that moment of intense pain and crisis has a belief system that is altered. The workshop began on September 11, and she drew an analogy to the event that occurred 17 years earlier on that date. As the Twin Towers in New York City began to burn, people at the tops of the towers began to jump.

[2]See http://nationalacademies.org/hmd/Activities/MentalHealth/SuicidePreventionMentalIllness/2018-Sep-11/Videos/Opening-Videos/1-Welcome-Video.aspx (accessed November 27, 2018).

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> By definition, they took their own life. They died of suicide. Yet none of us sat on our couch and said, "Oh my gosh, you coward, how selfish of you. How could you do that to your friends and family?" Did they jump because they wanted to die? No. They jumped because they were desperate to escape pain and anguish. They jumped because their thinking was anything but rational in that moment and their crisis point had been reached.

People who are thinking of suicide need the same level of compassion, Hiatt said. They have reached a point where they feel they cannot live, whether because of their mental illness, their life experiences, or their trauma. Hiatt made her own suicide attempts as a teenager, she said. "I understand what it's like to live in that dark night of the soul." When she tried to end her life as a teenager, she did not want to die, but she did not know how to live with what was happening to her. Yet she survived and has gone on to live a full and meaningful life. "There's hope in that. There's hope for recovery, and that's the message we need to continue to get out there. Suicide can be prevented."

Everyone needs to know the warning signs for suicide the same way they know the signs for heart attacks and strokes, she observed. Everyone needs to be capable and willing to administer the care that people need in their moments of crisis. Her father is someone who would have benefited from the sharing of electronic health records, Hiatt said, so that the emergency room doctor he saw on the day of his suicide would have seen that he had attempted suicide before and that he was getting medications from multiple doctors. It would have been an opportunity, she added, for a physician to talk with him about his pain and not simply prescribe the medications that he used to end his own life. Hiatt now has her own suicide safety plan. When she needs help, she gets in to see a therapist.

A few weeks before the workshop, the Church of Jesus Christ of Latter-day Saints in Utah, where Hiatt lives, said that it will no longer consider suicide a sin. Crying in her car when she heard the news, Hiatt was immensely grateful for the progress of recent decades that made such a decision possible. But she also recalled that society continues to put a great burden on suicidal individuals. "We're talking about a person who's desperate to escape unbearable pain." Telling them not to take their own lives, she observed, is like telling someone with cancer to choose to live without giving them the tools, treatment, and care they need to do that.

"I decided 16 years ago I wasn't going to rest until we stopped suicide," Hiatt said. "I want this to no longer be the health issue of our time. We do that by these conversations. We do that by taking note. We do that by creating awareness. We're aware suicide is a problem. We need to take action."

SUPPORT FOR THE WORKSHOP

Richard McKeon, chief of the Suicide Prevention Branch in the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA), briefly spoke about why SAMHSA supported the workshop. Suicide rates have increased significantly in the United States in recent years, he observed. A recent report from the Centers for Disease Control and Prevention (CDC) showed that suicide had increased in 49 of 50 states between 1999 and 2016, and in half the states examined the increase was greater than 30 percent (Stone et al., 2018). "There is clearly a need for us to do more and better," said McKeon, "to increase the effectiveness of our suicide prevention efforts and to try to save as many lives as possible."

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Rates of suicide are significantly elevated among those with serious mental illness and serious emotional disturbance, McKeon observed. This has practical implications for SAMHSA, since its mental health programs are by statute required to focus on adults with serious mental illness or youth with serious emotional disturbance. Currently, SAMHSA has an array of suicide prevention initiatives. These include support for the Zero Suicide approach described in Chapter 2. SAMHSA recently made 14 suicide prevention grants to states, health care systems, and tribes. It also has a significant youth suicide prevention initiative, the Garrett Lee Smith grants, that have gone over the past 12 years to each of the 50 states.

SAMHSA is interested in identifying those who are at risk for suicide who may also experience serious emotional disturbance, how best to intervene with them once they are engaged in the health care system, and what are the best approaches to use. These "are vitally important issues for SAMHSA," said McKeon, and he welcomed the "advice, guidance, wisdom, and discussion that I'm sure all of you will provide."

OVERVIEW OF THE WORKSHOP

The workshop consisted of six plenary panel presentations, a breakout session on the second day, and opportunities to report back from the breakout sessions and comment on the major themes and messages that emerged from the workshop.

In the first panel presentation, which is summarized in Chapter 2, Holly Wilcox, associate professor in the Bloomberg School of Public Health's Department of Mental Health and the Johns Hopkins University School of Medicine's Department of Psychiatry, and Christine Moutier, chief medical officer of the American Foundation for Suicide Prevention, provided broad overviews of the prevalence of suicide, changes in prevalence over time, and the links between suicide and serious mental illness. Critical windows exist for suicide risk, such as the week after discharge from a psychiatric admission or emergency department presentation for suicidal ideation or attempt, the first weeks after starting an antidepressant, and during significant life transitions. Both universal and targeted interventions have proven effective in improving suicide rates, but they require continued support and attention to the quality of implementation, the presenters observed.

During the second panel (summarized in Chapter 3), C. Edward Coffey, professor of psychiatry and behavioral sciences and of neurology in the Baylor College of Medicine, traced the origins of the Zero Suicide movement back to the 2001 Institute of Medicine (IOM) report *Crossing the Quality Chasm: A New Health System for the 21st Century*. Initially successful at the Henry Ford Health System, this approach, which uses a care protocol for suicide risk and quality improvement principles, has since been adopted in other locations around the world, as pointed out by David Covington, chief executive officer and president of Recovery Innovations, Inc. It is an especially effective way, noted Mike Hogan of Hogan Health Solutions, to ensure that people with suicidality do not make their way through successive gaps in care and to integrate care for those with both serious mental illness and suicidality.

The third and fourth panels of the workshop looked at two groups at high risk for suicide: military service members and veterans, and American Indians and Alaska Natives. In the third panel (summarized in Chapter 4), both Mike Colston, captain in the U.S. Navy Medical Corps and director of Mental Health Programs in the Health Services and Policy Oversight Office of the Department of Defense, and Keita Franklin, national director of suicide prevention for the Office of Mental Health and Suicide Prevention in the Department of Veterans Affairs (VA),

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pointed out that the suicide rate among active duty service members has increased in recent decades. Colson described the range of effective interventions that are now available that can save lives. Franklin discussed the universal, selective, and indicated prevention components of a comprehensive public health campaign to prevent suicide among veterans. She also advocated for a "whole of government" and "whole of industry" approach that could coordinate and intensify suicide prevention work with this population, including those veterans who are not enrolled in care with the Veterans Health Administration.

The next panel (summarized in Chapter 5) considered Native American and American Indian communities, many of which have especially high levels of unmet health needs. The panel highlighted examples of approaches for suicide prevention and mental health in both communities and health systems. All four presenters—Allison Barlow, director of the Johns Hopkins Center for American Indian Health; James Allen, professor in the Department of Family Medicine and Biobehavioral Health at the University of Minnesota Medical School; Jennifer Shaw, a senior researcher at Southcentral Foundation; and Laurelle Myhra, director of behavioral health at the Native American Community Clinic—made the point that effective suicide prevention is culturally tailored to the population it serves. Shaw, for example, observed that interventions need to be targeted at all levels of human experience, respect autonomy, and honor community, which requires that they be tailored to or developed from within local cultures and patterns of being, communication, and relationship. In addition, Myhra noted that meeting the mental health needs of Native communities requires workforce development, including the training of Native behavioral health providers, community health workers, and people who can provide peer support.

In the fifth panel (summarized in Chapter 6), Nikole Jones, a suicide prevention coordinator with the VA Maryland Health Care System; Alfreda Patterson, a substance use counselor and housing coordinator with Concerted Care Group in Baltimore; T.J. Wocasek, a clinical supervisor for the Southcentral Foundation in Anchorage, Alaska; and Keith Wood, clinical director of an intensive outpatient service with Emory University School of Medicine, described the approaches they and their organizations take toward individuals with suicidality, including those with serious mental illness. Several of the presenters had their own personal experiences with suicide, which have served as a guide and inspiration for them in developing relationships with their clients.

The final panel (summarized in Chapter 7) offered perspectives ranging from the direct patient experience of systems of care and outreach to the design of behavioral health systems at the state and city levels. Marcus Lilly, an outreach worker for Concerted Care Group, observed that partnerships between health care providers, mental health services providers, and community-based self-help groups could increase the availability of suicide prevention services and provide for long-term comprehensive treatment. Julie Goldstein Grumet, director of health and behavioral health initiatives at the Suicide Prevention Resource Center and director of the Zero Suicide Institute at Education Development Center, pointed out that investments both upstream and downstream from suicide prevention could link public health and mental health. Arthur Evans, chief executive officer of the American Psychological Association and previously the commissioner in Philadelphia for the Department of Behavioral Health and Intellectual Disability Services, called for approaches that address the challenge at the levels of providers, systems, and the community. He also made the point that the implementation of evidence-based treatment, including provider training in suicide prevention for people with serious mental illness, will require substantial investments of resources.

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On the second day of the workshop, participants broke into two sessions to discuss major issues that arose over the course of the first day's discussions. Participants in one session discussed the financing and other policy issues associated with integrating suicide prevention into care for people with serious mental illness. Participants in the other session discussed issues associated with a focus on what providers need, which also encompassed political leadership. Chapter 8 summarizes the reports from those breakout sessions and the discussion that followed in the subsequent plenary session.

The final session of the workshop (summarized in Chapter 9) provided an opportunity for workshop participants to identify what they considered to be important messages they were taking away from the workshop.

In follow-up to the workshop, a Twitter chat was hosted on October 4, 2018, by the National Academies' Health and Medicine Division (@NASEM_Health). This was a moderated public discussion in real time tied to the hashtag #SuicidePreventionChat. It continued the conversation about the intersection between suicide prevention and serious mental illness. The following questions were posed to participants in the chat:

- How does what is known about how to prevent suicide need to be adapted for people with serious mental illness?
- What can be done to better equip providers in behavioral health and mental health care for suicide prevention?
- How can more comprehensive disposition planning and follow-up after acute crises help stop suicide for those with serious mental illness?
- How can health systems improve tracking of suicide-related outcomes to inform better care for those with serious mental illness?
- What is your key message about improving suicide prevention for those with serious mental illness?

A link to the chat can be found on the website of National Academies' Health and Medicine Division.[3]

[3]http://nationalacademies.org/hmd/Activities/MentalHealth/SuicidePreventionMentalIllness/2018-Sep-11/twitter-chat-suicide-prevention.aspx (accessed November 27, 2018).

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3
Suicide Prevention in Health Care Systems

Points Made by the Presenters

- Health care settings provide an important opportunity to intervene for suicide prevention. (Hogan)
- Evidence for the effectiveness of suicide-focused care demonstrates that, for those with serious mental illness and risk of suicide, interventions for mental illness are important but not sufficient. Integrated care that treats both the underlying mental disorder and suicidality is more likely to be more effective. (Hogan)
- The Perfect Depression Care Initiative and its goal of Zero Suicide dramatically reduced suicide rates at the Henry Ford Health System and provided a proof-of-concept model that other systems have adopted. (E. Coffey)
- The Zero Suicide model is a comprehensive evidence-based approach to improving health care quality that has three essential components: the conviction that ideal health care is attainable, a road map to achieve that vision, and a requisite expertise in systems engineering to achieve the vision. (E. Coffey)
- A standard protocol for managing suicide risk in health care settings can ensure that people with suicidality do not make their way through successive potential gaps in care: asking people about suicide, providing a safety planning intervention, reducing lethal means, treating suicidality, and ensuring that interpersonal, structured support is available. (Hogan)
- Suicide prevention activities have previously been out of scope for health care; health care and behavioral health professionals have not received training on them; and securing reimbursement for these activities takes works. Leadership is needed for health care to adopt these responsibilities. (Hogan)
- Suicide is a worldwide problem that requires a worldwide response. (Covington)

NOTE: These points were made by the individual workshop presenters identified above. They are not intended to reflect a consensus among workshop participants.

During the second panel of the workshop, three presenters talked about major initiatives in health care systems that have had major effects on suicide rates. These initiatives point toward the possibility of making much more extensive changes in health care systems, both in the United States and abroad, that could achieve for suicide prevention the successes achieved through prevention initiatives targeting health issues such as smoking or heart disease.

THE ORIGIN OF THE ZERO SUICIDE MODEL

In 2001 the Institute of Medicine (IOM) released the report *Crossing the Quality Chasm: A New Health System for the 21st Century* (IOM, 2001). As C. Edward Coffey, professor of psychiatry and behavioral sciences and of neurology in the Baylor College of Medicine,

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recounted, the report observed that health care providers are well trained, are working as hard as they can, and are trying to do the right thing. But, as the report stated,

> In its current form, habits, and environment, the health care system is incapable of giving Americans the health care they want and deserve.... The current care systems cannot do the job. Trying harder will not work. Changing systems of care will.

The report laid out six dimensions of ideal care. Such care is:

- Safe,
- Effective,
- Patient centered,
- Timely,
- Efficient, and
- Equitable.

The report also provided 10 rules for designing a system that would achieve ideal care:

- Care equals relationships.
- Care is customized.
- Care is patient centered.
- Share knowledge.
- Manage by fact.
- Make safety a system priority.
- Embrace transparency.
- Anticipate patient needs.
- Continually reduce waste.
- Professionals cooperate.

After the report was published, the Robert Wood Johnson Foundation (RWJF) partnered with the Institute for Healthcare Improvement (IHI) to launch the RWJF Pursuing Perfection Program, which had as its goal to demonstrate that ideal health care is attainable. Using the IOM report as a guide, the foundation sought applications for transformative plans to create health care systems that would approach ideal care within a timeframe of 2 years. From about 300 applications submitted in 2001, 12 finalists were selected, including the Perfect Depression Care Initiative proposed by the Behavioral Health Services Division of Henry Ford Health System in Detroit, Michigan. "We celebrated for about 10 seconds," said Coffey, who was then chief executive officer of behavioral health services for the system and the principal investigator on the Perfect Depression Care Initiative. "Then we started thinking, what in the world are we going to do to try to transform our mental health care system?"

The finalists were required to develop "perfection" goals for each of the six dimensions of ideal care. The Henry Ford Perfect Depression Care Initiative accordingly established the following goals (Coffey, 2006, 2007):

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- Safe care: Eliminate inpatient falls and medication errors.
- Effective care: Eliminate suicides.
- Patient-centered care: 100 percent of patients will be completely satisfied with their care.
- Timely care: 100 percent complete satisfaction.
- Efficient care: 100 percent complete satisfaction.
- Equitable care: 100 percent complete satisfaction.

The goal for effective care was initially unclear until a staff member, in one of the many meetings held to discuss the goals, said, "Well, perhaps if we were doing perfect depression care, nobody would die from suicide. Nobody would kill themselves." Recounted E. Coffey: "At that moment, after we all got our breath back, our department was transformed.… That moment, essentially, was the birth of Zero Suicide."

With zero suicides becoming the overarching goal, E. Coffey's group adapted a planned care model designed to create productive interactions (see Figure 3-1). These interactions result from an informed and activated patient working closely with a prepared and proactive practice team. The elements of these interactions correspond closely with the goals of the IOM report.

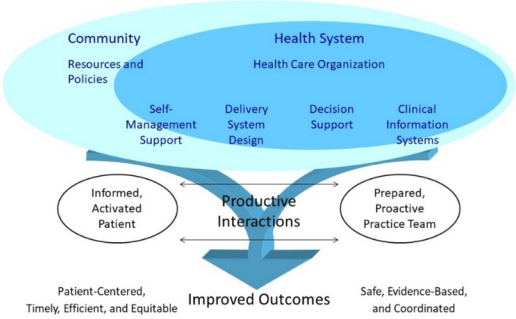

FIGURE 3-1 The planned care model implemented by the Henry Ford Health System.
SOURCE: Presented by C. Edward Coffey on September 11, 2018, at the Workshop on Improving Care to Prevent Suicide Among People with Serious Mental Illness.

During the first decade of the 21st century, the suicide rate was increasing in Michigan. However, after implementation of the Perfect Depression Care Initiative, the suicide rate for patients receiving mental health care in the Henry Ford Health System dropped by more than 75 percent, though the rate rose again in 2010 when the recession that began in 2008 was especially severe in Michigan (Coffey et al., 2015). In most years, the suicide rate for the system was close to that of the general population in Michigan, even though the expected suicide rate for people with an active mood disorder is approximately 21 times the rate for the general population, E. Coffey observed.

E. Coffey emphasized that depression is not the only risk factor for suicide. All the major mental disorders raise the risk of suicide, especially if they are comorbid with substance use

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disorder. "If you're trying to bend the curve on suicide risk, you don't want to focus just on depression." They therefore worked to ensure that all their patients received "perfect" care.

Improvement projects are not complete until their results have been described and disseminated, noted Coffey. To address this need, the Perfect Depression Care team produced a series of articles describing the initiative and its results over time (Coffey, 2006, 2007; Hampton, 2010; Coffey et al., 2013; Ahmedani et al., 2013; Coffey and Coffey, 2016). The public feedback was very positive, including recognition as a best-in-class innovation by the Malcolm Baldrige examiners when they awarded the Henry Ford Health System the 2011 Malcolm Baldrige National Quality Award. In 2012 the Perfect Depression Care Initiative was invited by Mike Hogan and David Covington to partner with the National Action Alliance for Suicide Prevention, a partnership which has yielded a "hugely productive" collaboration that has embraced the goal of Zero Suicide (see the following section of this chapter). Other organizations, including the National Institute of Mental Health and the Centers for Disease Control and Prevention (CDC), have subsequently embraced the goals of the Zero Suicide Model. International Zero Suicide summits beginning in 2014 have provided a way to exchange information and spread the program to other health care systems (see "International Actions on Suicide Prevention" later in this chapter). Early adopters of the Zero Suicide Model have included an organization in Tennessee known as Centerstone, as well as the National Health Service, the Mersey Care Trust, and Zero Suicide Alliance, all in Britain.

Such initiatives are desperately needed, said E. Coffey. As pointed out earlier in the workshop by Wilcox and Moutier, suicide rates have increased 30 percent over the past 15 years, with an even greater increase in some states (see Figure 3-2). "Despite all the great work that is being done, and all the great progress scientifically, and even despite Zero Suicide, the curve is moving in the wrong direction in this country." A possible explanation for this discrepancy may lie in the distinction between zero suicide as an aspirational goal versus Zero Suicide as a firm goal that serves as an innovative driving force for transformation to ideal health care (Coffey, 2003). As an innovation, the Zero Suicide Model has three key elements. The first is a radical new conviction that ideal health care is attainable. The second is a road map to achieve that vision ("pursuing perfection within a just culture"). The third is expertise in systems engineering to implement the vision.

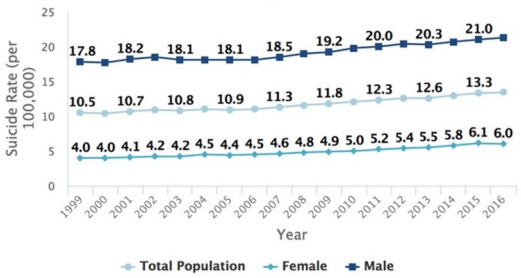

FIGURE 3-2 Age-adjusted suicide rates rose 30 percent in the United States between 1999 and 2006. SOURCE: Presented by C. Edward Coffey on September 11, 2018, at the Workshop on Improving Care to Prevent Suicide Among People with Serious Mental Illness. From CDC, 2018.

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The challenge today, said E. Coffey, is that Zero Suicide may be seen as a stand-alone aspirational goal rather than as an essential component in this tripartite model of transformation. "I don't want to complain about any goal" that seeks to lower the suicide rate, he said, and a goal to reduce suicides by 20 percent before 2025 is great and should be encouraged. "But it may be that as long as we view Zero Suicide as an aspiration, we are backing away from being 'all in,' from being convinced that ideal health care is possible." Experience with Perfect Depression Care suggests that audacious goals such as "Zero Suicide" are essential components in driving transformation, said E. Coffey, and that transformation rather than incremental improvement is what is needed to bend the curve on suicide and give patients the care they want and deserve.

DISSEMINATION AND EVIDENCE FOR ZERO SUICIDE

Even as the suicide rate has increased in the past 15 years, the age-adjusted death rates for heart disease, cancer, and stroke have fallen. Why has prevention for other causes of death been successful while suicide prevention has not been successful, asked Mike Hogan of Hogan Health Solutions.

With deaths from cardiovascular disease (CVD), the reduction in smoking accounts for 20 to 25 percent of the improvement. However, targeted preventive interventions with people who have well-established CVD risks had an even greater effect. The Zero Suicide movement seeks to establish suicide prevention as a goal and a priority in health care. The model, like the successful efforts to reduce CVD deaths, emphasizes effective preventive interventions for those with elevated risk. But the health care system has not yet taken that goal to heart, Hogan said. Even in hospitals, a recent analysis found that the estimated number of inpatient deaths by suicide that occur each year ranges from 49 to 65 (Williams et al., 2018).

The Zero Suicide movement is also a care innovation, Hogan observed. It combines a quality improvement with a bundling of care, as has been the case with innovations applied to other health conditions. This point is made in the report *Suicide Care in Systems Framework* (Clinical Care and Intervention Task Force and National Action Alliance for Suicide Prevention, 2011), which looked at the applicability of the Henry Ford initiative in the larger health care system.

Research has shown that suicidal behavior is distinct from mental disorders (Van Orden et al., 2010). Many people have suicidal thoughts, but relatively few progress to attempts (Millner et al., 2017; Klonsky et al., 2018). "For the average person [in the Millner et al. study], it was 2 years between ideation and attempt," observed Hogan. "That's a lot of time to intervene, but only if we know. And since we tend to not ask, we don't know." However, once people have reached a tipping point, the time to an attempt was short—from a few minutes to a few weeks. Developing the "capability" to kill oneself is the dangerous step, said Hogan—both the internal capability and the physical capability to act. In addition, no single pathway from ideation to suicide exists. "Life is complicated, genetics are complicated, genetic–environmental interactions are complicated."

Health care settings provide places to intervene. First, more than 80 percent of people dying by suicide and more than 90 percent with attempts had health care visits in the previous 12 months. Of people who died from suicide, 45 percent had a primary care visit in the month before death, 19 percent had contact with mental health services in the month before, and 10

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percent had an emergency department visit in the previous 60 days. The rates are even higher for older men, with 70 percent seeing a general practitioner within 30 days of a death by suicide. The risk of suicide death following inpatient psychiatric discharge is 44 times the population rate, observed Hogan. In short, the health care system has ample time to intervene. The question is whether it does.

The second reason why suicide prevention in health care settings makes sense, said Hogan, is that evidence exists for effective—often brief—interventions that can be deployed feasibly in health care organizations. Hogan presented a mental model that is used by Zero Suicide to illustrate how people who die by suicide fall through successive gaps in the health care system (see Figure 3-3). The first gap, said Hogan, is whether people are asked about suicide. The second is whether health care providers engage and provide a safety planning intervention to give people the skill set and tools they need. Successive steps involve reducing lethal means, treating suicidality, and ensuring that interpersonal, structured support is available when needed. "These actions need to be done in a routine way within a health care setting," said Hogan. "It's a care pathway. Not doing this would be the equivalent of having people in care for diabetes and never getting an A1C level."

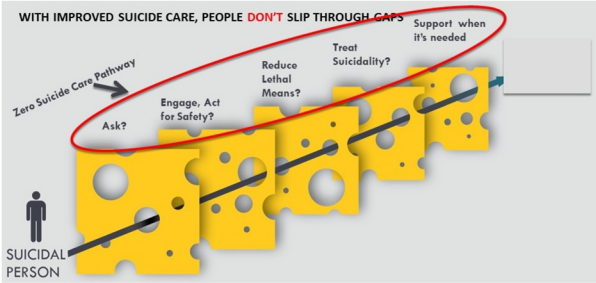

FIGURE 3-3 Improved care can keep people with suicidality from slipping through successive gaps in the health care system.
SOURCES: Presented by Mike Hogan on September 11, 2018, at the Workshop on Improving Care to Prevent Suicide Among People with Serious Mental Illness. From Zero Suicide Institute, Education Development Center, 2018.

Simon et al. (2013) examined the subsequent history of more than 75,000 people who completed the Patient Health Questionnaire 9 to screen for depression. Of those who subsequently died by suicide, 60 percent indicated elevated thoughts on question 9, which asks about "thoughts that you would be better off dead or hurting yourself in some way." The suicide field has had a debate about whether it is possible to predict who is going to die, and "we shouldn't be interested in predicting who's going to die," observed Hogan. "We should want to know who needs help. Cardiologists are not worried about [whether they can] predict when people are going to die of a heart attack and who that's going to be. They identify risk factors and then they take action." Based on the Simon et al. (2013) study, prediction of who needs

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suicide prevention are much better then high cholesterol scores are to predict a heart attack, Hogan said. "This is good enough evidence to act."

Safety planning makes sense, is feasible, and has become widely used, but until recently it had not been well tested, said Hogan. However, Stanley et al. (2018) recently did an emergency department matched cohort comparison study with 1,640 patients with a suicide-related visit and 1,186 in the intervention group. They tested a brief safety planning intervention plus telephone follow-up and found that the patients receiving the intervention had 45 percent fewer suicidal behaviors and were twice as likely to participate in follow-up care.

Means restriction is a critical part of a safety plan, and evidence and experience at a population level indicates that it works, said Hogan. In communities with a dominant means of suicide, restricting that means reduced suicide rates by about 40 percent. In addition, caring contacts, including phone calls, letters, texts, postcards, and visits, are effective. Denchev et al. (2018) found that caring letters work better than usual care and cost less, phone calls work even better, and cognitive behavioral therapy is also effective.

Evidence for the effectiveness of suicide-focused therapies over usual care comes from dialectical behavior therapy, cognitive therapy for suicide prevention, collaborative Assessment and Management of Suicide (CAMS), postattempt counseling (from Denmark), and the Attempted Suicide Short Intervention Program (from Switzerland). This evidence from randomized controlled trials demonstrates that such therapies are as effective as acute care interventions for cardiovascular disease, said Hogan. The idea of directly treating suicidality is "fundamentally relevant" to the workshop, he observed. "If somebody is suicidal and has a major mental illness, it's no longer acceptable to just treat the major mental illness and hope that the suicidality resolves."

The critical issue, said Hogan, is that the usual care for people at risk of suicide is unacceptably bad—"people are dying." Importantly, this is not because of clinician error but because health care programs and systems have not put proven methods in place, leaving clinicians to manage care on their own. The Henry Ford Health System, Centerstone, and the Institute for Family Health have demonstrated reductions from baseline suicide rates of 60 to 80 percent. Hogan also made the point that Zero Suicide is a package made up of elements, each of which is known to be effective. "It makes sense that the overall package would work, because the elements work if they're done with fidelity." The Zero Suicide model includes an organizational assessment that is also a fidelity tool, Hogan said. A New York study of about 200 clinics found that clinics with higher fidelity scores had fewer suicides. This makes sense, he said. but we need more data to shift the late adopters."

The website zerosuicide.com lays out the basic tools needed to advance. In addition, leadership and elbow grease are critical, Hogan said. "The really big problem is getting health care to say it's our responsibility to keep our patients alive" from this form of preventable death. Behavioral health settings are "starting to get up the adoption curve," but primary care, emergency departments, and health care systems are "just at the beginning."

Suicide risk is linked to but is distinct from other mental disorders, Hogan concluded. Interventions aimed at depression or bipolar disorder are important but not sufficient. Well-established interventions for suicide care now exist, and integrated treatment that attends to both mental illness and suicidality is likely to be more effective. Successful programs like Zero Suicide provide a care pathway and a protocol for treating and managing suicide risk that are embedded within clinics. These interventions need to be integrated "into the work of every mental health practitioner" and into health systems and settings, Hogan stated.

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INTERNATIONAL ACTIONS ON SUICIDE PREVENTION

How does a movement spread, how does it produce action, how does it inspire people, asked David Covington, chief executive officer and president of Recovery Innovations, Inc. One way is through international declarations.

In 1989 a small group of people with diabetes, policy makers, and physicians gathered in a rural Italian village and conceived of an audacious proposal: that diabetes management should consist of comanagement between an individual and a physician. "This vision has largely been realized," said Covington. Many people no longer remember "when you had to go to a physician to get a blood level." Today people with diabetes are, as expressed in that 1989 statement, coresponsible for their treatment.

In 2002 a small group gathered in the United Kingdom and decided to follow the model of the diabetes pioneers. They proclaimed that an individual having a first episode of psychosis would quickly move from diagnosis to treatment to recovery and live an ordinary life. Though the United States is still making progress on early intervention programs, the time to treatment after a first episode of psychosis in the United Kingdom has been slashed to a target of 22 days, "in large part because of an audacious vision and a pathway for beginning to make that happen."

The 2011 report *Suicide Care in Systems Framework* (Clinical Care and Intervention Task Force and National Action Alliance for Suicide Prevention, 2011) could have gathered dust on a shelf, said Covington. But people involved in the production of the report were inspired by the declarations emerging from international summits. In 2015, representatives of 13 countries produced the document "Zero Suicide: International Declaration for Better Healthcare," which has been viewed many thousands of times throughout the world.[1] At the same time, a series of global zero suicide summits began in 2014 in England, and the summits have grown in size and scope ever since. Subsequent summits have been held in Atlanta (2015), Sydney (2017), and Rotterdam (2018), and the next summit is scheduled for England in 2020.

About the time of the first summit, peer leader Eduardo Vega said at a meeting Covington attended: "I don't know that I am so much against suicide. But here is what I am definitely against: people dying alone and in despair." This statement has become a platform for work going on around the world. In addition to the website zerosuicide.com mentioned by Hogan, the website zerosuicide.org is simultaneously creating a hub for innovation, Covington observed. It brings together not just the people normally involved in suicide prevention but educators, designers, and innovators who can help create an international dialogue and move the process forward.

Today, 90 organizations are part of the Zero Suicide Alliance in the United Kingdom, forming a confederation of providers who can exchange information and guidance. A current challenge is to take the movement into middle- and low-income countries and especially into Africa and South America.

FUNDING ISSUES

[1]The declaration is available at http://riinternational.com/wp-content/uploads/2016/03/zerosuicidedeclaration_2015draft.pdf (accessed November 27, 2018).

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In response to a question about securing adequate funding for such initiatives, Hogan pointed out that Substance Abuse and Mental Health Services Administration's (SAMHSA's) suicide prevention grants now provide more funding than has been the case previously. Also, a small but important part of the 21st Century Cures Act was an adult suicide prevention program authorized for funding of $10 million per year. "This is a starting point," said Hogan.

In addition, much of the progress to be made depends on redesigning the care that now exists, he explained. The suicide prevention activities that need to be done are not complicated, he added, but they have previously been out of scope and health care professionals, including behavioral health professionals, have not received training on them.

Finally, ways need to be found to get reimbursement for these activities, Hogan said. Currently, providers need to figure out setting by setting how to bill for suicide prevention activities. How do they bill for the development of a safety plan? How do they bill for follow-up?

Covington discussed the initial fear among some of the leaders of health care organizations that more screening and assessment would identify more individuals at risk, which would lead to a reduction of profitability. However, he and others had a hypothesis that the opposite would occur: that when health care professionals do not feel confident in their skills they unnecessarily push people in directions that result in increased and avoidable psychiatric inpatient hospitalization. The zero suicide approach can produce a significant reduction in more intensive services for those most in need, he said. Furthermore, the savings may be ever greater at a system level.

Coffey responded by saying that more funding to address this problem cannot be expected. Therefore, "we're going to have to fix it ourselves, we're going to have to find the dividend in the work that we're doing currently." Stopping things that do not work will provide savings that can be invested in things that do work. He also mentioned the "heretical" idea that more screening is not necessarily the answer. "Screening has a place," he said, but providers can spend "way too much time worrying about screening and the precise [risk] number.... Instead cut back on that and devote the resources to safety planning and getting much better at means restriction."

RESISTANCE TO THE IDEA OF A ZERO SUICIDE GOAL

Nadine Kaslow, professor of psychiatry and behavioral sciences at the Emory University School of Medicine, asked about the unanticipated consequences of zero suicide initiatives. Could they be a setup for failure and lead critics to question the overall initiative? On a related note, does the identification of people at risk of suicide in hospitals, with the constraints it puts on their autonomy and their identification as high risk, lead to humiliation and stigmatization, she asked.

Hogan responded that "I'm getting pretty old, I don't have that much time, which leads me to say I don't have time for [resistance]. I'm only interested in who wants to do something and what do you want to do now." The other panelists had similar responses. Covington drew a distinction between half measures and full measures. For 70 years the Golden Gate Bridge did some things that saved lives, but it remained a very unsafe place. Finally, after many deaths and considerable pressure, the operators of the bridge decided to install nets extending from the sides of the bridge to stop people from using it for suicide. "They decided in their backyard they were

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going to take full ownership and do everything they could do. That's what we're really talking about for health care for which we're responsible."

E. Coffey responded that the zero suicide movement needs skeptics and that it is okay to be skeptical about zero suicide from a scientific perspective. But dealing with these criticisms takes time, and "as leaders we have to make a distinction between whether what we're hearing is healthy skepticism versus cynicism." This cynicism is not conducive to building a culture where people are asked to swing for a home run every time they come up to bat. "We have to build a safe environment where people are encouraged to innovate and be bold and audacious, but also at the same time to learn from mistakes."

On the issue of stigmatization, Hogan lamented the sterile environments in hospitals that can result from suicide prevention efforts, such as eliminating ligatures that might be used in suicide attempts. But "morally, we can't not eliminate that." Health care systems also need to replace the things missing because of suicide prevention with other things that will be supportive and relationship centered, he said. Covington pointed out that the company for which he is chief executive officer runs 50 crisis programs and wellness programs in about 5 states, and these programs look different as a result of people with lived experiences being a substantial part of the staff. The people who are in the programs are referred to as guests rather than patients. "It's more like a retreat than it is an institution, more like a home."

Many people, including health care providers, have a fear of suicide and try to distance themselves from patients who are at risk, Hogan said. The presence of this fear suggests two fundamental tasks, he added. One is to create a culture that seeks perfection but does not cast blame. "That's hard leadership work, but it's foundational." The second thing is to include people with lived experience in the planning, design, oversight, and conduct of this work:

> We all felt that we were changing and learning something as we listened to Taryn. She's not the only person who is a genius about this. A lot of people who have been through this experience have that to contribute.

ACTING ON THE EVIDENCE

Richard McKeon of SAMHSA said that a central part of the Zero Suicide Initiative has been its recognition of the accumulating evidence that focusing only on an underlying mental health condition is insufficient to prevent suicide among those with such conditions. Suicide prevention needs to be a specific focus, he maintained. At the same time, behavioral health treatment within the health care system takes place in many contexts other than zero suicide programs, and these other contexts may have implications for preventing suicide among those with serious mental illness. "Should we be looking for ways to insert suicide prevention into those initiatives that are going to continue with or without suicide prevention?" he asked. "Is there a way that standard care for depression in primary care could be made more suicide mindful, or early intervention for psychosis?"

E. Coffey responded that one way to embed such care across the health care system is to focus on the safety plan:

> I don't think safety planning should be limited to people who are patients in the mental health care system. I would argue that every patient needs a safety plan. Aren't those with cancer at risk for suicide? I would start there. If you were to do

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> one thing today that would make a difference in suicide care, I'd take becoming very serious about safety planning for every patient in our health care system.

Hogan responded with an anecdote about a Zero Suicide training boot camp, which they call Zero Suicide academies. One of the people attending the training was an internist in a small practice who seemingly would not need to know this level of detail about suicide prevention. When Hogan asked him at the end of the day what he thought, the internist responded, "Well, I don't deal with this every day, but here's what I'm thinking. The risk of this looks a lot like the risk for my patients of prostate cancer. There's not a lot of that, but where there is, it's pretty important." He said that he was planning to add the suicide question to his Patient Health Questionnaire. Most of the time the responses will be negative. "But if there's a concern, my staff will bring it to my attention, and I'll make that the main focus of what I do with that patient in that visit." Hogan thought that this was a brilliant response. "This is the big lift in primary care."

With regard to specialty care, Hogan responded that the evidence demonstrates that anyone with a diagnosed mental disorder or receiving a behavioral treatment should be asked about suicide. If this generates a concern, actions need to be taken. "That's a big change in primary care in emergency department settings, but we think that's what the evidence today suggests."

Finally, the moderator of the panel, Justin Coffey, vice president and chief information officer at the Menninger Clinic, commented on the safety provisions that have been installed at the Golden Gate Bridge. The netting installed beneath the bridge is not just about aesthetics. "It's about what the net says, and what the net says is that we have a serious problem in this country. People don't want to have to be reminded of that when they look at the netting, but it's a reminder that we have a serious cultural problem, and it's on one of our most significant engineering achievements. It's such a contrast that people can't accept it, and that's at the heart of their problem." The Zero Suicide effort has a similar issue. E. Coffey said:

> Part of my worry personally about zero suicide is that when you talk about diabetes and about heart disease, those are natural consequences of health conditions and aging. They can be seen and framed within the natural process. When we start to talk about suicide and mental health, people don't see it the same way. It's about culture and the impact of our culture, and I'm concerned about our willingness to accept those things.

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9
Reflections on the Workshop

At the end of both days of the workshop, individual workshop participants discussed the main messages they heard emerging from the workshop.

THE ELEMENTS OF EFFECTIVE INTERVENTIONS

Research over the past 15 years has demonstrated the need to build on the commonalities of effective interventions, said David Rudd, president of the University of Memphis and member of the workshop planning committee. Mike Hogan identified several of these in his presentation, Rudd noted, including "ask," "engage and act for safety," "reduce lethal means," "treat suicidality," and "provide support when needed" (see Figure 3-4 in Chapter 3). To these, Rudd added compliance facilitation, which is "a part of everything you do." Whenever providers in his institution ask a patient to do something, they have the patient rate on a scale of 1 to 10 how likely they are to do it. If the patient responds with a 1, meaning that the patient is not going to do it, they ask the patient why. "Tell us exactly why you can't do that element of treatment." They then explain why that element is important. "We go back to the model and explain why this is a critical element of treatment and what role it serves."

Another feature of the common elements of effective interventions is they are relatively simple and straightforward, though they may be delivered differently by individuals and organization with different theoretical perspectives. The one modification Rudd suggested is that, as part of safety planning, health care providers teach people how to ask for help. "You can't assume that somebody knows how to ask for help. You have to role play it, you have to walk through scenarios, and you have to help them understand the language of asking for help." Shame "is one of the biggest barriers to compliance," he noted. He and his colleagues elevate that issue and address it with every single person with whom they work.

In addition to the commonalities of effective interventions, Rudd identified three major topics discussed at the workshop: education, clinical delivery, and systems integration. Clear evidence pointing to what should be done exists in each area. The challenge now is not what to do but how to do the right thing organizationally and politically. "We have good foundational places to start; we just need to start implementing." Saying that the problem is complex tells Rudd that someone is ashamed of it, because that means "we'll never solve it, we're not accountable for it, we're not responsible for it, and as a result we don't know what to do." Rudd said that he was encouraged not to have heard a single time at the workshop that the problem is complex.

Rudd observed that the range of material presented at the workshop "demonstrates not only the breath but the creativity of people who are working to meet these challenges—and these are very significant challenges." The task before the field is now to integrate innovative interventions into the care of people struggling with serious mental illness. For example, are innovations more effective within a Zero Suicide initiative or within an integrated wellness effort? Does that help with some of the shame and stigma that prevent people from getting help?

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FUNDING AND FOLLOW-UP NEEDS

Andrey Ostrovsky, chief executive officer of Concerted Care Group (CCG), cited the need to fund both research and service delivery. "Suicide prevention, and in particular suicide prevention in people with serious mental illness, is grossly underfunded in order to get the comprehensive approaches that are needed to meaningfully move the needle." One concrete idea emerging from the workshop is bundled payments to help align financing with the desired outcomes. "The more I've been tweeting about it and researching analogs, the more I get optimistic at how doable this will be—especially now [with] the political winds that are blowing." What needs to happen, he said, is to get the people who control policy in the same room with those who oversee the funding of programs to figure out how to implement the science.

Another critical need that he identified is to reduce stigma. The presence of people at the workshop who were willing to talk publicly about their experiences is exciting, he said, because "most people will not talk about [this] publicly, and we have to talk about it publicly. If we don't talk about it publicly, it'll just keep getting stigmatized."

Ostrovsky said that he and CCG are willing to follow up on the ideas presented at the workshop, whether reaching out to governors or implementing the knowledge that already exists. "We may fail, and that's fine, but let's fail fast, fail cheap, fail often. We have to get out there and do it, not just talk about it, not just publish, but get out there and do it."

COLLABORATION AND TRAINING

Nadine Kaslow, professor of psychiatry and behavioral sciences at the Emory University School of Medicine, wondered why the two main topics discussed at the workshop—suicide prevention and serious mental illness—remain such different worlds when they overlap so extensively. A major way to reduce the distance between them is to create collaborations among stakeholders that represent suicide prevention and the treatment of serious mental illness.

This split is reflected in clinical training, she pointed out. In psychology training, working with people who are suicidal or have a serious mental illness is generally ruled out, while psychiatry training follows the opposite model, giving new trainees responsibility for people with the most serious mental illnesses. Neither of these models "makes a lot of sense to me," said Kaslow. "We need to begin to think in a different way of how do we train people to be prepared to do this work," not just asking them if they are ready to treat people with serious mental illness. One of the reasons Kaslow became interested in suicide was from losing a patient to suicide early in her career, after which she participated in a program run by the American Foundation for Suicide Prevention to meet with others to discuss what happened, including the psychiatry resident with whom she had treated the patient. "It was a pivotal experience for us in terms of healing."

Suicide prevention requires that providers adopt an ecological model encompassing the individual, the family, the clinician, and society, she continued. In that respect, root cause analysis that tries to determine what went wrong "is extremely problematic and difficult." It encourages providers to feel that they have failed and to avoid treating people at high risk of suicide again. An ecological model also emphasizes the importance of culture in treatment, assessment, and prevention, including cultural adaptations to interventions or interventions that emerge from a particular cultural group.

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The workshop demonstrated the need to include people with lived experience at the table. In most settings, people still do not feel safe to share their stories, Kaslow said. Creating this safety is critical so meetings do not consist of people who have been identified as having lived experiences and people who have been identified as not having those experiences, since suicidality occurs on a continuum and "we all live on that continuum somewhere."

STAKEHOLDERS, RESEARCH, AND INFRASTRUCTURE

Lisa Jordan argued for the need to include nurses at the table as well, because caring is central to their profession. Some of the first community health workers were nurses, she said, and nurses have constructed models of caring that incorporate patients into the plan of care. In addition, nurses can help other health care providers care for themselves when a patient ends his or her life. "We have to be there with you, because we believe as nurses that we are the conduits to get many of the other professionals that are working with a patient together and to keep everybody abreast."

Scott Dziengelski from the National Association for Behavioral Health Care called attention to the fact that people with serious mental illness have a much higher mortality rate than the general population. "These individuals are dying 25 years sooner than everybody else in the population," he said. "They've been left out of the longevity revolution.... This is part of a greater conversation about serious mental illness and mortality."

James Allen, professor in the Department of Family Medicine and Biobehavioral Health at the University of Minnesota Medical School, mentioned the need to align the Substance Abuse and Mental Health Services Administration's (SAMHSA's) research with that of the National Institutes of Health to study the implementation of the ideas discussed at the workshop. Suicide is a low base rate event, he said, but many distal indicators can be used to identify effective prevention and treatment approaches. Work in fields as distant as process engineering can lead to innovative methods in suicide prevention, he added, which points to the value of collaboration among professions.

Amy Loudermilk, state initiatives manager for the Suicide Prevention Resource Center, emphasized the role of the infrastructure developed by the states for suicide prevention. Working on this infrastructure can elevate the issue and reflect its multidisciplinarity, which Ostrovsky added could be done through such organizations as the National Association of State Medicaid Directors.

COMMITMENTS TO ACTION

Arthur Evans, chief executive officer of the American Psychological Association, like Ostrovsky of the CCG previously, committed his organization to following up on the major issues and ideas raised at the workshop. He also observed that the subject matter discussed at the workshop needs to be disseminated as widely as possible so every community has someone who is involved in the issue. Getting people in government, system administrators, and many others involved will be required to influence the social determinants that affect suicide, he said, which will require leadership within many different communities.

In follow-up to the workshop, Christine Moutier of the American Foundation for Suicide Prevention committed her organization to stay engaged in actionable strategies as an outgrowth of the workshop. She reiterated her observations made during the first panel: that the openness

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and readiness of the nation is ripe, and that health care systems, payers, and policy makers must make the changes needed to meet the public health crisis and the growing demand on the part of patients and families. She observed that the American Foundation for Suicide Prevention is well positioned to advocate for changes like bundled payments for postdischarge care, to cooperatively fund research related to suicide prevention, and to catalyze health systems to implement suicide prevention training and system changes.

OUTCOMES AND TECHNICAL ASSISTANCE

Richard McKeon, chief of the Suicide Prevention Branch in SAMHSA's Center for Mental Health Services, discussed the need to track outcomes. Part of the reason the Department of Veterans Affairs and the Department of Defense have focused on suicide prevention is they have the data about the people they are losing to suicide, and many health care systems do not have those data. In addition, the Interdepartmental Serious Mental Illness Coordinating Committee has recommended generating these data more quickly, he reported, which could further increase accountability. "That information potentially can be made available more quickly than the 2-year wait for the Centers for Disease Control and Prevention (CDC) statistics that specify suicides."

On the data issue, Ostrovsky mentioned a treasure trove of data is available in the form of claims data held by Centers for Medicare & Medicaid Services (CMS). These data are available after just 1 month for every state and territory in the nation and could be made available through the Transformed Medicaid Statistical Information System if they were accessed by researchers or other government agencies.

Finally, McKeon cited the new regionally based technical assistance centers being established by SAMHSA as a source of information. The stakeholders in suicide prevention could help guide what the most productive role of these centers would be.

The link between suicide and serious mental illness "will be an abiding concern for SAMHSA over the next number of years," McKeon concluded. "We need to be able to have more of these conversations."

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8
Ideas from the Breakout Sessions

At the beginning of the second day of the workshop, the participants broke into two sessions that discussed major topics emerging from the first day's discussions. Participants in one session discussed issues with a focus on what providers need, which also encompassed political leadership. Participants in the other session discussed the financing and other policy issues associated with integrating suicide prevention into care for people with serious mental illness.

CREATING MOMENTUM AT THE STATE LEVEL

Oscar Morgan, project director for the Central East Mental Health Technology Transfer Center, who reported for the first breakout session, noted that many important observations made by individuals participating in the breakout session have been operationalized by the National Action Alliance for Suicide Prevention in its report *Crisis Now: Transforming Services Is Within Our Reach.*[1] Extending these observations, participants in the breakout session discussed the possibility that the Substance Abuse and Mental Health Services Administration (SAMHSA) might send a letter to the governor of each state quantifying the crisis for the nation and for that state. The letter then would suggest implementing the recommendations contained in *Crisis Now* and offer free technical assistance from SAMHSA to do so. SAMHSA's technical assistance centers could develop a uniform implementation strategy that may differ from state to state but that would lead to implementation of a zero suicide approach for people with serious mental illness.

In response to the report from the breakout session, Richard McKeon, chief of the Suicide Prevention Branch in SAMHSA's Center for Mental Health Services, noted that an important issue is the nexus of responsibility between the Centers for Medicare & Medicaid Services (CMS) and the states. "When I talk to colleagues at CMS, one of the things that they emphasize, at least in terms of Medicaid funding, is how much it's a state issue." Clear guidance would be helpful to states, for example, in Medicaid plans. One way to provide this guidance is through strong relationships between mental health commissioners and Medicaid commissioners, he noted. However, he questioned how feasible it would be for SAMHSA to send a letter to all of the governors of the states, though he noted that letters to Medicaid directors have come jointly from SAMHSA and CMS. Perhaps the state secretaries of health and human services would be the most appropriate recipients of such letters, though engaging the nation's governors would also be "critically important."

In this regard, Christine Moutier, chief medical officer of the American Foundation for Suicide Prevention, noted that the American Federation for Suicide Prevention has been building a mechanism to encourage all the states to have a state suicide prevention day in which all the evidence and needed steps could be presented at the state level.

[1] The report is available at https://theactionalliance.org/sites/default/files/crisisnow.pdf (accessed November 27, 2018).

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TRANSITIONS IN CARE AND BUNDLED PAYMENTS

The participants in the second breakout session spent much of their time discussing transitions in care—and in particular the transition from an emergency department contact or a psychiatric hospital into the community. Health systems need incentives to focus resources on people with serious mental illness who are at risk for suicides during these transitions, observed Andrey Ostrovsky, chief executive officer of Concerted Care Group, who provided a report from the session. Measuring the factors associated with a good transition raises challenges, he noted. Such a transition involves not just a medical model but consideration of the community, family, and other resources that are involved, along with the provision of adequate support for a good transition.

Participants focused in particular on the use of bundled payments to ensure care continuity across transitions. Precedents exist for such bundled payments, both with public funding mechanisms and with commercial insurance. One challenge noted by several participants is to bring an evidence-based approach to the population of people with severe mental illness who are at risk for suicide. Important factors identified by various participants in the breakout session include appropriate assessment for people at risk of suicide, establishing a safety plan, and making sure that a person has an adequate number of contact points, including family members and community providers.

Participants in the breakout session also discussed ways of providing financial incentives upstream of transitions, such as during contacts with the primary care system or an emergency hotline. As a specific example, could organizations be incentivized to adopt electronic health records in the behavioral health care space, which would facilitate transitions?

Ostrovsky pointed out that bundled payments would be "perfect grounds for an 1115 demonstration" under the Medicaid program. It would have to be done on a state-by-state basis, though the Center for Medicare and Medicaid Innovation (CMMI) could also promote a model that is more comprehensive than Medicaid. He also thought commercial group insurance was a possibility, so long as the financial case can be made either by care savings or by increased market share. If "you get a progressive group or employer-based insurer to take this up, you don't have to wait for a model to be designed by CMMI or through the long process of getting an 1115 demonstration approved."

McKeon agreed that the evidence is solid regarding things that need to be done during the transition period. However, whether this evidence translates to populations other than the ones studied to date remains unknown. For example, does it apply to people with schizophrenia, bipolar disorder, or other serious mental illness? "That's a piece that we don't know as much about."

McKeon added that bundled payments would be "useful and important." In addition, they would provide an opportunity to learn from innovations and move forward. For example, different people have different needs, and some of these needs could be met at little cost, such as text message interventions, while other needs may require face-to-face contact or home visits, "presuming that you have a home."

COMMENTS ON IDEAS FROM THE BREAKOUT SESSIONS

As part of the plenary session following the breakout session, workshop participants commented on several issues raised during the breakout discussions and earlier in the workshop.

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Nadine Kaslow, professor of psychiatry and behavioral sciences at the Emory University School of Medicine, pointed to the need to collect data to see how effective different approaches are with people who have serious mental illness and to modify those approaches accordingly. Greater knowledge could bring other funders into the room besides people who fund health care policies, she said.

Amy Loudermilk, state initiatives manager for the Suicide Prevention Resource Center, asked where the responsibility for suicide prevention among those with serious mental illnesses resides organizationally. Is there a need for an organization or formalized collaboration to focus on suicidality and people with serious mental illness, she asked. This population is the responsibility of several different professions but not of a single one.

Jim Allen noted that implementation science has shown the difficulty of getting professionals to buy in, which is crucial to implementing or changing a system of care. He also pointed out that a thoughtful rollout requires local decision making. "There are many models of how you respond to an actively suicidal individual. They all have an evidence base. The important issue is that the provider community in the state pick one so everyone shares the same pathway and shares the same vocabulary. They'll do that if they feel they were part of the decision process in arriving at that." He suggested involving consumers in that decision as well.

Jennifer Shaw, a senior researcher at Southcentral Foundation, reminded the group that people are very diverse and one size does not fit all. While the evidence may be strong in one population, "we need to be very thoughtful about who was included and how it was evaluated for the diverse populations that make up our United States." Research needs to be validated in minority communities (even though they are often majorities) and also be culturally grounded and culturally driven.

Shari Ling, Deputy Chief Medical Officer, CMS, advocated identifying bright spots that are working "no matter where they are." Integrated care offers tremendous opportunities, she said, but people working today have worked out important parts of the answer, and "we can learn from what is working."

Julie Goldstein Grumet, director of health and behavioral health initiatives at the Suicide Prevention Resource Center and director of the Zero Suicide Institute at the Education Development Center, described seeing many best practices and good outcomes occurring on the local level, "but people have a hard time publishing those results and sharing those practices." As a result, these practices and outcomes remain siloed and hidden. One solution would be for journals to reach out and solicit articles about the intersections of people with serious mental illness and suicide. They also could cultivate authors who do not typically submit articles. "We have many state suicide prevention coordinators, tribal elders and leaders, and people in rural areas who have been heroic in finding ways to combat suicides in their communities and have outcomes but have a hard time getting it onto a national stage."

Mike Hogan of Hogan Health Solutions called attention to SAMHSA's new program to provide technical assistance through the National Dissemination Center and HHS region-specific centers. This new technical assistance structure could be extremely helpful because the field is still at an early adoption stage where targeted information is very useful. The evidence base for people with high suicidality is "pretty clear, but it's also new and … hasn't been synthesized," Hogan observed. Because suicide is a low base rate event, a randomized controlled trial with suicide as one outcome would be prohibitively large. The existing evidence rests largely on the concept that effective interventions "have achieved bigger reductions in suicide than anything

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else in the world." Also, suicide prevention programs are made up of components that all have an evidence base.

In addition, Hogan observed that the Interagency Serious Mental Illness Coordinating Committee was considering some of these issues at the same time as the workshop, and it may be a valuable partner in considering these issues. The National Mental Health and Substance Use Policy Laboratory is another innovation-oriented organization that could help drive policy changes.

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Biographical Sketches

SPEAKERS, PANELISTS, AND FACILITATORS

Margeaux Akazawa, M.P.H., is a program analyst in the Office of Technology at the U.S. Department of Health and Human Services, Office of the National Coordinator for Health IT (ONC). In this role, she is responsible for advancing health IT strategies and approaches to combat the nation's opioid epidemic. Ms. Akazawa previously worked with ONC's Consumer eHealth and Engagement Division where she led efforts to improve patients' access to their health information through technology. Ms. Akazawa has human-centered design expertise and experience facilitating design thinking trainings including serving as a coach for the Department of Health and Human Services (HHS) Idea Lab Ignite Accelerator program and as a workshop facilitator for the Better Government Movement. Prior to joining ONC, Ms. Akazawa was a Presidential Management Fellow at the U.S. Department of Housing and Urban Development where she served as a Desk Officer for Promise Zones, a place-based community revitalization initiative. Ms. Akazawa received her M.P.H. in Behavioral Science and Health Education from Emory University, Rollins School of Public Health, and her B.A. in Anthropology from the University of California, Berkeley.

James Allen, Ph.D., is professor in the Department of Family Medicine and Biobehavioral Health and senior scientist with the Memory Keepers Medical Discovery Team for American Indian and Rural Health Equity at the University of Minnesota Medical School, Duluth campus. He was previously Associate Director at the Center for Alaska Native Health Research and graduate faculty in the clinical-community psychology program with indigenous and rural emphasis at the University of Alaska Fairbanks, a Fulbright Scholar at University of Oslo Medical School, and graduate faculty in the clinical psychology program at the University of South Dakota. Research interests include American Indian and Alaska Native community resilience and prevention of youth suicide and substance use risk, community-based participatory research, multilevel intervention, and research methods for small populations. He currently works with Alaska Native communities developing an evidence base for a culturally grounded multilevel intervention promoting protective factors to prevent youth suicide and alcohol risk, and documenting community-level resilience structures promoting youth well-being and protection from suicide.

Allison Barlow, Ph.D., M.P.H., M.A., is Director of the Johns Hopkins Center for American Indian Health. She has worked at the Center since 1991 to co-create and evaluate ecologically sound, evidence-based and culturally resonant interventions with tribal communities to address behavioral and mental health disparities. Projects to date have spanned the design and demonstration of preventive interventions targeting adolescent suicide, depression, and substance abuse, as well as the design and evaluation of a tribal-specific early childhood home-visiting intervention, Family Spirit, to promote parenting and early child development—with the latest iteration including modules to address early childhood obesity and water insecurity. Other lines

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of research have included obesity and diabetes prevention, and most recently, youth entrepreneurship to address the twin problems of poverty and poor health trajectories. Her team has succeeded in disseminating successful interventions to more than 120 tribal communities across 19 states. They have also produced pioneering evidence to support the effectiveness of Native community health workers to promote behavioral and mental health, overcome access barriers in low-income communities, and build local human capital through an indigenous workforce.

Ed Coffey, M.D., is a neuropsychiatrist and Professor of Psychiatry & Behavioral Sciences, and of Neurology, at the Baylor College of Medicine, Houston, Texas. Dr. Coffey is an accomplished physician (board certified in both Neurology and Psychiatry) with expertise in neuropsychiatry and brain stimulation, and is consistently listed as a "Top Doctor" by numerous organizations. He is also an award-winning health care executive, recognized for leading high-quality, financially successful, academically based systems of integrated health care. Dr. Coffey's innovative work on "Perfect Depression Care" has been widely cited as a model for health care transformation, and its audacious goal of "zero suicides" has become an international movement, honored by The Joint Commission (2006 Codman Award), the American Psychiatric Association (2006 Gold Achievement Award), the Malcolm Baldrige National Quality Award (2011), and by his appointment to the National Action Alliance for Suicide Prevention (2011).

Captain Mike Colston, M.D., is the Director for Mental Health Programs in the Department of Defense's (DoD's) Health Services Policy and Oversight office. This office seeks to improve the lives of our nation's service members and families through oversight, strategy management, program evaluation, and policy regarding DoD's care of psychological health and substance use disorders, traumatic brain injury, and the clinical management of suicidality. Previously, Captain Colston served as the Director of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. As Director of the Mental Health Program in the Office of the Assistant Secretary of Defense for Health Affairs, Captain Colston oversaw a project that reviewed more than 200,000 cases involving posttraumatic stress disorder (PTSD) and depression diagnoses, led a mental health team in the independent investigation of the Washington Navy Yard tragedy, and cochaired DoD's Addictive Substances Misuse Advisory Committee. As Chair of the Mental Health Department at Naval Hospital Great Lakes, he oversaw a large-scale clinical integration of Department of Veterans Affairs and DoD services at the Lovell Federal Health Care Center in the Chicago metro area. During deployment in support of Operation Enduring Freedom, he led a combat and operational stress team that supported a catchment of 10,000 service members. Captain Colston holds a B.S. in Industrial and Management Engineering from Rensselaer Polytechnic Institute and a master's degree in Marine Affairs from the University of Rhode Island. He joined the Navy as a line officer, serving as a nuclear engineer and surface warfare officer aboard USS Carl Vinson (CVN-70), deploying twice to the Arabian Sea and completing a Pacific Rim Exercise. He then commanded a littoral patrol boat as an afloat officer-in-charge. Transitioning to Medical Corps service, he earned an M.D. from the Uniformed Services University of the Health Sciences, trained as a resident in psychiatry at Walter Reed Army Medical Center, and completed a fellowship in child and adolescent psychiatry at Northwestern University. He practices inpatient child and adolescent psychiatry at Fort Belvoir Community Hospital. His military decorations include the Defense

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Superior Service Medal and Defense Meritorious Service Medal, Surface Warfare and Officer-in-Charge Afloat devices, and campaign ribbons stemming from four overseas movements.

David Covington, LPC, M.B.A., is CEO and President of Recovery Innovations, Inc. (d/b/a RI International). He is also a partner in Behavioral Health Link, cofounder of CrisisTech 360 and leads the international initiatives "Zero Suicide," "Crisis Now," and "Peer 2.0." A licensed professional counselor, Mr. Covington received an M.B.A. from Kennesaw State and an M.S. from the University of Memphis. He previously served as Vice President at Magellan Health responsible for the executive and clinical operations of the $750 million Arizona contract. He is a member of the HHS Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) established in 2017 in accordance with the 21st Century Cures Act to report to Congress on advances in behavioral health. A recognized health care innovations entrepreneur, global speaker, and blogger, Mr. Covington is a two-time national winner of the Council of State Governments Innovations Award. He also competed as a finalist in Harvard's Innovations in American Government in 2009 for the Georgia Crisis & Access Line, and the program was featured in *Business Week* magazine. Mr. Covington is the President-Elect of the American Association of Suicidology and has served on the National Action Alliance for Suicide Prevention Executive Committee since 2010. He is also the Chair of the National Suicide Prevention Lifeline SAMHSA Steering Committee. He has served on numerous committees and task forces on clinical care and crisis services, including the National Council for Behavioral Health Board of Directors.

Arthur C. Evans, Jr., Ph.D., policy maker, clinical/community psychologist, and health care innovator, is the CEO of the American Psychological Association (APA). Dr. Evans has held faculty appointments at the University of Pennsylvania Perelman School of Medicine and the Yale University School of Medicine. Prior to coming to APA, he served for 12 years as Commissioner of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services where he led a groundbreaking transformation of the Philadelphia service system that significantly improved health care outcomes and saved millions of dollars that the city used to expand services. Dr. Evans has also served in leadership positions in clinical administration and state government in the state of Connecticut where he developed a multidisciplinary private practice.

Keita Franklin, L.C.S.W., Ph.D., a member of the Senior Executive Service, is the National Director of Suicide Prevention for the Department of Veterans Affairs (VA) Office of Mental Health and Suicide Prevention. Dr. Franklin serves as the principal advisor to VA leadership for all matters pertaining to suicide prevention. She leads a team of experts engaged in research, program evaluation, innovation, program development, data and surveillance, and partnerships. Before joining the VA, Dr. Franklin served as the Director of the Defense Suicide Prevention Office where she was responsible for policy and oversight of the Department of Defense suicide prevention programs. She is a licensed social worker with a specialization in children and families, and has a Ph.D. in social work with specialized training and certifications from the Center for Advancement of Research Methods and Analysis. Dr. Franklin received a leadership award from Virginia Commonwealth University for leading efforts to help train and advise the social work profession on working with military families.

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Julie Goldstein Grumet, Ph.D., is the Director of Health and Behavioral Health Initiatives at the Suicide Prevention Resource Center (SPRC). Dr. Goldstein Grumet provides strategic direction to health care providers to recognize and respond to suicide emergencies. She is also the Director of the Zero Suicide Institute, where she oversees the dissemination, resource development, and application of the Zero Suicide initiative nationally by providing consultation and training to health care systems. Dr. Goldstein Grumet received her Ph.D. from the George Washington University.

Taryn Hiatt is a dedicated advocate and shares her story and passion to give hope and educate our communities about suicide. She is a survivor of her own attempts as well as a survivor of suicide loss, losing her father Terry Aiken on October 5, 2002. Taryn is a founding member of the Utah Chapter of the American Foundation for Suicide Prevention and currently serves as the Area Director for Utah and Nevada. Taryn is a certified safeTALK, CONNECT Postvention and Mental Health First Aid Trainer, facilitating hundreds of seminars to many different groups. Taryn is a passionate advocate for change and has been featured in both *U.S. News & World Report* and *The Huffington Post*. She has testified before congressional members in Washington, DC, to increase awareness and support for better access to mental health services and to promote healthy discussions about suicide. She is widely respected throughout Utah for her hard work and dedication to saving lives. Taryn is a recent graduate of Utah Valley University with her Bachelor's Degree in Psychology.

Michael Hogan, Ph.D., served as New York State Commissioner of Mental Health from 2007 to 2012, and now operates a consulting practice in health and behavioral health care focusing on health care issues with significant public health impact, especially suicide prevention. The New York State Office of Mental Health operated 23 accredited psychiatric hospitals, and oversaw New York's $5 billion public mental health system serving 650,000 individuals annually. Previously Dr. Hogan served as Director of the Ohio Department of Mental Health (1991–2007) and Commissioner of the Connecticut DMH from 1987 to 1991. He chaired the President's New Freedom Commission on Mental Health in 2002–2003. He served as the first behavioral health representative on the board of The Joint Commission (2007–2015) and chaired its Standards and Survey Procedures Committee. He has served as a member of the National Action Alliance for Suicide Prevention since it was created in 2010, cochairing task forces on clinical care and interventions and crisis care. He is a member of the National Institute of Mental Health (NIMH) National Mental Health Advisory Council. Previously, he served on the NIMH Council (1994–1998), as President of the National Association of State Mental Health Program Directors (2003–2005) and as Board President of National Association of State Mental Health Program Directors' Research Institute (1989–2000). His awards for national leadership include recognition by the National Governor's Association, the National Alliance on Mental Illness, the Campaign for Mental Health Reform, the American College of Mental Health Administration, and the American Psychiatric Association. He is a graduate of Cornell University, and earned a M.S. degree from the State University College in Brockport, New York, and a Ph.D. from Syracuse University.

Ashleigh Husbands, M.A., is a Prevention Specialist for the Suicide Prevention Resource Center within the Education Development Center. Ashleigh provides technical assistance to state and campus youth suicide prevention Substance Abuse and Mental Health Services

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Administration (SAMHSA) grantees as well as unfunded state suicide prevention coordinators. Ashleigh has previously worked as a Regional Suicide Prevention Specialist for the Florida state youth suicide prevention SAMHSA-funded grant, where she provided technical assistance to behavioral health providers on Zero Suicide implementation as well as provided suicide prevention, intervention, and postvention trainings to community members. She also has prior experience as a crisis counselor, answering for the National Suicide Prevention Lifeline. Ashleigh earned a master's in clinical psychology from Towson University in 2013.

Nikole S. Jones, L.C.S.W., completed her undergraduate studies in Psychology (Minor in Criminal Justice) at James Madison University in 1993 and Master's Degree in Social Work at Howard University in Washington, DC She completed her internship at the Department of Veteran Affairs at the Washington, DC VA Medical Center. She really enjoyed working with veterans and wanted to commit her career to helping America's warriors. Ms. Jones' experience in the VA includes work in the Substance Abuse Rehabilitation Program (SARP), and as an Inpatient Psych Social Worker. However, after the death of her family member in 2006 to suicide, Nikole became passionate about suicide prevention. During that time suicide prevention became a major initiative in the VA, Ms. Jones accepted a job as the Suicide Prevention Coordinator at the VA Maryland Health Care System. Ms. Jones and the Suicide Prevention Team are committed to providing education to veterans and their families, VA employees, and the local community of the risk, warning signs, and protective factors suicide in an effort to reduce the incidence of suicide and increase access to appropriate care in the VA. Nikole was instrumental in establishment of the Maryland State Chapter of the American Foundation for Suicide Prevention and served as the chapter's first President of the Board of Directors. The Maryland chapter has grown to provide prevention efforts to every county in the state. Nikole is currently working on her first self-help book, *The Compulsion to Die*, that will be available in early 2019. Nikole also has a private practice (Therapy 4 Life) that provides Christian counseling and consultation services.

Maia Laing, M.B.A., is the Senior Business Consultant within the Office of the Chief Technology Officer (CTO) at the Department of Health and Human Services (HHS). In her role, Maia identifies innovative solutions to complex challenges within HHS. Prior to joining the Office of the CTO, Maia worked for the Center for Medicare and Medicaid Services on an enterprise effort to implement a process improvement mindset across the center. Ms. Laing holds a deep passion for improving delivery of care and has worked on projects in both federal government and nonprofit settings; including *U.S. News & World Report* top 10 ranked Brigham and Women's Hospital in Boston.

Marcus Lilly is a University of Baltimore college student and an Outreach Worker with Concerted Care Group. As a former incarcerated citizen, he also advocates for prison reform, substance abuse treatment, and mental health services. He is the author of *The Marshall Project's* article, "Finding College by Way of Prison." He has been a guest speaker at the University of Baltimore and Georgetown University. He is the cocreator of "37th and Jessup: Classmates Divided by Bars, United for Justice," which is one of Georgetown University Justice Initiative projects. His goal is to become a mentor and share his story of transformation with high-risk youth.

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Richard McKeon, Ph.D., M.P.H., received his Ph.D. in Clinical Psychology from the University of Arizona, and a Master's of Public Health in Health Administration from Columbia University. He has spent most of his career working in community mental health, including 11 years as director of a psychiatric emergency service and 4 years as Associate Administrator/Clinical Director of a hospital-based community mental health center in Newton, New Jersey. In 2001, he was awarded an American Psychological Association Congressional Fellowship and worked for United States Senator Paul Wellstone, covering health and mental health policy issues. He spent 5 years on the Board of the American Association of Suicidology as Clinical Division Director and has also served on the Board of the Division of Clinical Psychology of the American Psychological Association. He is currently Chief for the Suicide Prevention Branch in the Center for Mental Health Services, of the Substance Abuse and Mental Health Services Administration, where he oversees all branch suicide prevention activities, including the Garrett Lee Smith State/Tribal Youth Suicide Prevention, Campus Suicide Prevention grant programs, the National Suicide Prevention Lifeline, the Suicide Prevention Resource Center, and the Native Aspirations program. In 2008, he was appointed by the Secretary of Veterans Affairs to the Secretary's Blue Ribbon Work Group on Suicide Prevention. In 2009, he was appointed by the Secretary of Defense to the Department of Defense Task Force on Suicide Prevention in the Military. He served on the National Action Alliance for Suicide Prevention Task Force that revised the National Strategy for Suicide Prevention and participated in the development of World Health Organization's World Suicide Prevention Report. He is also the cochair of the Federal Working Group on Suicide Prevention.

Christine Moutier, M.D., Chief Medical Officer of the American Foundation for Suicide Prevention, knows the impact of suicide firsthand. After losing colleagues to suicide, she dedicated herself to fighting this leading cause of death. Since earning her medical degree and training in psychiatry at the University of California, San Diego, Dr. Moutier has been a practicing psychiatrist, professor of psychiatry, dean in the medical school, medical director of the Inpatient Psychiatric Unit at the VA Medical Center in La Jolla, and has been clinically active with diverse patient populations, such as veterans, Asian refugee populations, as well as physicians and academic leaders with mental health conditions. She has presented at the White House, testified before the U.S. Congress on suicide prevention, and has appeared as an expert on *Anderson Cooper 360*, the BBC, *CBS This Morning*, *The Atlantic*, *The New York Times*, *Time*, *The Washington Post*, *The Economist*, and *NBC Nightly News*, among others.

Laurelle Myhra, Ph.D., LMFT, is Ojibwe and a enrolled member of Red Lake Nation and is the Director of Behavioral Health at the Native American Community Clinic (NACC) and sits on the Health Equity Advisory & Leadership (HEAL) Council for the state of Minnesota and previously on the community board for Hennepin County Healthcare for the Homeless Clinic. Dr. Myhra completed her doctorate at the University of Minnesota in Family Social Science and Marriage and Family Therapy program, where she was an American Association for Marriage and Family Therapy Substance Abuse and Mental Health Services Administration Fellow. She has dedicated her career, as a researcher, supervisor, clinician, and educator, to addressing historical trauma, traumatic stress, and substance use disorders among Native Americans. She has published numerous peer-reviewed articles on these subjects. She has received training on the top evidence-based trauma treatment modalities including Eye Movement Desensitization Reprocessing (EMDR), Trauma Focused Cognitive Behavioral Therapy (TF-CBT), and

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Honoring Children, Mending the Circle (culturally adapted TF-CBT) and has adapted these to be culturally appropriate in practice. She was also trained on White Bison's Wellbriety-Medicine Wheel and 12-Step, culturally adapted model, and Mending Broken Hearts on healing from grief and loss. Dr. Myhra is a licensed marriage and family therapist and has provided therapeutic service to the Native American community in the Twin Cities metro area since 2005.

Alfreda Patterson has worked in the counseling field since 1997 in positions ranging from Counselor Tech, Case Manager, and Substance Abuse Counselor. She was educated at Baltimore City Community College with a degree in Allied Human Services in Addiction Counseling. She joined Concerted Care Group on September 14, 2015. Her work as a Substance Use Counselor and a Housing Coordinator is very dear to her heart. Her childhood and most of her adult life was in East Baltimore. She come from a background of Human Services: her mother was a teacher for 45 years, and her brother is a professor at Morgan State University. She owned several transitional houses for over 7 years that housed clients with substance use disorders and mental health. Her goal is to always help anyone in need with services and adequate care. Housing is an important part of stabilization. When she is not working, she is working. She has been married for 27 years and is raising an 8-year-old with autism. Her message is always dedication, honesty, and commitment.

Joshua Prasad, M.P.H., is currently the Director of the Concerted Care Group (CCG) integrated behavioral health and wellness center focused on addiction in Frederick, Maryland. At CCG, he is designing and implementing new programs to expand access to primary care and mental health in addition to traditional addiction and medication-assisted treatment. He is also currently a board member, and has been nominated as next-chair for a tobacco control and prevention nonprofit—Counter Tools. Josh is also the cofounder of a social justice innovation consulting firm, IIF Health and is currently advising several disruptive companies domestically and internationally. He was formerly a Senior Advisor in the Office of the Assistant Secretary for Health within the Department of Health and Human Services (HHS) in Washington, DC. There he focused on increasing the incorporation of the social determinants of health through national initiatives, the development of health systems and workforce concerns for rural communities, and designed solutions to improve government efficiencies. While at HHS, he also assumed the role as Director for the National Tobacco-Free College Campus Initiative, which designed policy and community-based solutions and provide technical assistance to increase tobacco-free environments. Prior to this time in the federal government, Mr. Prasad worked as an advocacy outreach worker at a community health center in Philadelphia, and performs epidemiological analyses at the State Department of Health in Pennsylvania. In 2015, he completed an Innovation Fellowship at the Harvard Medical School Center for Primary Care where he cofounded a startup focused on improving preventive health. Prior to this, he received his Master's in Public Health from Drexel University, and his Bachelors from Rutgers University, where he double majored in English and Psychology. When he's not working, Josh enjoys hiking, playing several instruments, and writing his novel.

Jerry Reed, MSW, Ph.D, serves as Senior Vice President for Practice Leadership at Education Development Center. In this capacity, he directs the Suicide, Violence and Injury Prevention Portfolio leading a staff of 53. He oversees the work on multiple projects such as the Suicide Prevention Resource Center, the Zero Suicide Institute, the Action Alliance for Suicide

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Prevention, the Children's Safety Network, several violence prevention initiatives and serves as codirector of the Injury Control Research Center for Suicide Prevention with partners at the University of Rochester Medical Center. His interests include geriatrics, mental health, suicide prevention, global violence prevention, and public policy. Dr. Reed recently co-led the committee that updated the U.S. National Strategy for Suicide Prevention and he serves as an Executive Committee member of the National Action Alliance for Suicide Prevention. Dr. Reed received a Ph.D. in Health Related Sciences with an emphasis in Gerontology from the Virginia Commonwealth University in Richmond in 2007 and his M.S.W. degree from University of Maryland at Baltimore in 1982 with an emphasis in Aging Administration. He served in the United States Navy during the period 1974–1978.

Jennifer Shaw, Ph.D., is a medical anthropologist and senior researcher at Southcentral Foundation (SCF), an Alaska Native-owned and operated health care system serving 65,000 people in the greater Anchorage area and 55 rural villages. At SCF, Dr. Shaw's research has focused heavily on suicide prevention in the Alaska Native community, including Methamphetamine and Suicide Prevention Initiative projects to identify protective factors for suicide, explore lived experience of recovery from suicidal thoughts and behavior, and identify factors in the electronic health record associated with suicide risk. She is currently funded as primary investigator on an Idea Networks of Biomedical Research Excellence-funded study to apply a predictive algorithm to electronic health records to stratify suicide risk. She is also the Alaska primary investigator of a National Institute of Mental Health-funded four-site trial to culturally tailor and test Caring Contacts for suicide prevention.

Holly C. Wilcox, Ph.D., has a joint faculty appointment as an Associate Professor in the Bloomberg School of Public Health Department of Mental Health and the Johns Hopkins University School of Medicine Department of Psychiatry. Dr. Wilcox received her Ph.D. in psychiatric epidemiology from Johns Hopkins Bloomberg School of Public Health. She just completed a national project to summarize the state of the science and research needs for data linkage, which served as the foundation for a National Institutes of Health Pathway to Prevention workshop on youth suicide prevention. She teaches a course in the Bloomberg School of Public Health entitled "Suicide as a Public Health Problem" and leads a multidisciplinary, interdepartmental suicide prevention work group at Johns Hopkins.

T. J. Wocasek's first professional job was a substance use counselor at the Salvation Army Clitheroe Center (SACC) in Anchorage, Alaska, in 1998. In 2000, he was promoted to the Dual Diagnosis Supervisor at SACC where he served for 2 and a half years. The clientele in this program had issues with mental illness, substance abuse, and homelessness. He has worked at Southcentral Foundation since 2002. Wocasek has worked as a clinician at the Southcentral Foundation Pathway Home for 4 years where he addressed behavioral health and substance abuse issues with adolescents in a residential treatment setting. He transferred to the Behavioral Urgent Response Team (BURT) as a clinician working with people who were in behavioral health crisis. He conducted risk assessments, assessed for depression and anxiety symptoms, completed substance use screenings, and consulted on capacity cases. In 2006, Wocasek started as a BURT clinician and was promoted to BURT clinical supervisor in 2007. He developed the BURT team into a 24/7 team. From 2006 to 2010, he had a private practice where he addressed behavioral health and substance abuse issues on an outpatient basis. From 2009 to 2010,

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Wocasek was the Project Director for two of Southcentral Foundation suicide prevention grants, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Indian Health Services (IHS) Methamphetamine and Suicide Prevention Initiative (MSPI). These grants are providing more resources for suicide prevention. From 2010 to 2015, he was the Pathway Home Clinical Supervisor. Since 2015, Wocasek has been the BURT Clinical Supervisor.

Keith Wood, Ph.D., ABPP, has a 40-year history of providing services to, creating and implementing programs for, and researching intervention effectiveness with individuals diagnosed with severe mental illness behavioral disorders. He developed and directed successful service programs in psychiatric inpatient and crisis stabilization units, psychiatric emergency rooms, hospital-affiliated outpatient behavioral health clinics, community mental health centers and on-the-street settings. Currently he is the clinical director of an intensive outpatient service focused on reducing psychotic symptoms through the teaching and enhancement of normalization and positive life functioning skills.

NATIONAL ACADEMIES STAFF AND CONSULTANTS

Natacha Blain, J.D., Ph.D., serves as the Director of the Board on Children, Youth, and Families at the National Academies. Dr. Blain has more than 15 years of experience working with policy makers and senior legislative officials on a variety of social justice issues and campaigns including serving as a Supreme Court Fellow, Chief Counsel to Senator Dick Durbin (D-IL) on the Senate Judiciary Committee, and Lead Strategic Advisor for the Children's Defense Fund's Cradle to Prison Pipeline Campaign. Most recently, she served as Associate Director/Acting Executive Director at Grantmakers for Children, Youth and Families (GCYF). Dr. Blain joined GCYF in January 2010 as GCYF's first Director of Public Policy. Her talents were quickly recognized and a year later, she was elevated to Associate Director. For approximately 2 years at the end of her tenure with GCYF, she also served as the Acting Executive Director. In her various capacities, Dr. Blain has played a critical role in helping convene and engage diverse constituencies, fostering leadership, collaboration, and innovation-sharing through a network of funders committed to the enduring well-being of children, youth, and families.

Joseph Goodman is a senior program assistant and has been at the National Academies for 11 years. He has worked on a variety of activities related to military and veterans, Social Security, traumatic brain injury, and more.

Bridget B. Kelly, M.D., Ph.D., is a consultant specializing in strategy development, learning and evaluation, and meeting design and facilitation. She worked previously at the National Academies of Sciences, Engineering, and Medicine for 8 years leading a portfolio of projects that included mental health, early childhood, chronic diseases, HIV, and evaluation science, culminating in a term as the interim director of the Board on Children, Youth, and Families. More recently she cofounded the nonprofit Bridging Health & Community, with the mission of helping the health sector work more effectively with communities. She is also an experienced dancer, choreographer, and arts administrator. She received an M.D. and Ph.D. from Duke University, and a B.A. from Williams College.

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Natalie Perou Lubin is a Senior Program Assistant with the Board on Health Care Services and the National Cancer Policy Forum (NCPF) of the National Academies of Sciences, Engineering, and Medicine. Natalie has helped plan and disseminate NCPF workshops, including Long-Term Survivorship Care after Cancer Treatment, Establishing Effective Patient Navigation Programs in Oncology, and more. Prior to the National Academies, Natalie worked as a Program Assistant at the Duke-Margolis Center for Health Policy. In collaboration with the Duke-Margolis Center and the Duke Global Health Institute, she helped edit a policy report evaluating the funding mechanisms in global development. In Ms. Lubin's academic and professional career, she is passionate in the areas of child and maternal health, women empowerment, and education and its intersection with health. Supporting these interests, in the summer of 2016, Natalie was a data analyst intern at the Global Development Lab at USAID, in which she worked on the monitoring, evaluation and learning strategy for the Innovations and Design Advisory team. Additionally, in the summer of 2015, Ms. Lubin carried out water sanitation research in rural Kenya through DukeEngage and the Women's Institute for Secondary Education and Research (WISER). Ms. Lubin is a graduate of Duke University with bachelor's degrees in global health and cultural anthropology.

Marc Meisnere, M.S.P.H., is an Associate Program Officer at the National Academies of Sciences, Engineering, and Medicine's Board on Health Care Services. He currently works on activities related to clinician well-being, mental health, and primary care. Since 2010, Mr. Meisnere has worked on a variety National Academies' consensus studies, primarily focusing on mental health among service members and veterans. Before joining the National Academies, Mr. Meisnere worked on a family planning media project in northern Nigeria with the Johns Hopkins Center for Communication Programs and on a variety of international health policy issues at the Population Reference Bureau. He is a graduate of Colorado College and the Johns Hopkins Bloomberg School of Public Health.

Sharyl Nass, Ph.D., serves as Director of the Board on Health Care Services and Director of the National Cancer Policy Forum at the National Academies of Sciences, Engineering, and Medicine. The National Academies provide independent, objective analysis and advice to the nation to solve complex problems and inform public policy decisions related to science, technology, and medicine. To enable the best possible care for all patients, the Board undertakes scholarly analysis of the organization, financing, effectiveness, workforce, and delivery of health care, with emphasis on quality, cost, and accessibility. The Cancer Forum examines policy issues pertaining to the entire continuum of cancer research and care. For nearly two decades, Dr. Nass has worked on a broad range of health and science policy topics that includes the quality and safety of health care and clinical trials, developing technologies for precision medicine, and strategies for large-scale biomedical science. She has a Ph.D. in cell biology from Georgetown University and undertook postdoctoral training at the Johns Hopkins University School of Medicine, as well as a research fellowship at the Max Planck Institute in Germany. She also holds a B.S. and an M.S. from the University of Wisconsin–Madison. She has been the recipient of the Cecil Medal for Excellence in Health Policy Research, a Distinguished Service Award from the National Academies, and the Institute of Medicine staff team achievement award (as team leader).

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Anne N. Styka, M.P.H., is a program officer in the Health and Medicine Division at the National Academies. Over her tenure she has worked on more than 10 studies on a broad range of topics related to the health of military and veteran populations. Studies have included mental health treatment offered in the Department of Defense and the Department of Veterans Affairs (VA), designing and evaluating epidemiological research studies using VA data for health outcomes related to deployment-related exposures including burn pits and chemicals, and directing a research program of fostering new research studies using data and biospecimens collected as part of the 20-year Air Force Health Study. Before coming to the National Academies, Ms. Styka spent several years working as an epidemiologist for the New Mexico Department of Health and the Albuquerque Area Southwest Tribal Epidemiology Center, and she spent several months in Zambia as the epidemiologist on a study of silicosis and other nonmalignant respiratory diseases among copper miners. She has several peer-reviewed publications and has contributed to numerous state and national reports. She received her B.S. in cell and tissue bioengineering from the University of Illinois at Chicago and has an M.P.H. in epidemiology from the University of Michigan. Ms. Styka was the 2017 recipient of the Division of Earth and Life Sciences Mt. Everest Award, the 2015 recipient of the Institute of Medicine and National Academy of Medicine Multitasker Award, and a member of the 2011 National Academies' Distinguished Group Award.

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NEJM Catalyst

How We Dramatically Reduced Suicide

Case Study · April 20, 2016

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In 2001, the Behavioral Health Services division of Henry Ford Health System set out to radically transform its mental health care delivery system by participating in the Robert Wood Johnson Foundation's "Pursuing Perfection National Collaborative." Our "Perfect Depression Care" (PDC) initiative leveraged the power of an audacious goal — eliminating suicide — to achieve dramatic and sustained reductions in patient suicide, as well as improved performance of our entire delivery system. The goal of zero suicides has since become an international movement.

KEY TAKEAWAYS

1. Pursuing perfection is a viable model for health care system transformation.
2. Pursuing perfection is most successful within a just culture.
3. Zero suicides is a social transformation, not a bundle of specific interventions.
4. Suicide is preventable.

The Challenge: Suicide rates over the last several decades have remained unchanged. Despite tremendous advances in clinical neuroscience, physicians and mental health care workers can't reliably predict whether or when a patient will commit suicide. Preventive strategies have the potential to lower the risk of these tragedies, but widespread implementation requires traditional mental health care systems to undergo radical redesign. The Institute of Medicine's *Crossing the Quality Chasm* report (2001) called for sweeping reform of the American health care system, and the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement responded with a $26 million national demonstration project — Pursuing Perfection — that challenged health care systems to dramatically improve patient outcomes by redesigning all major care processes in order to deliver perfect care. Our participation in the first phase of Pursuing Perfection (we were not ultimately awarded an implementation grant) challenged us to create a workplace culture in which the performance goal was *perfection*, not just incremental improvement.

> *In spite of its radicalism — indeed because of it — the goal of zero suicides became the galvanizing force behind an effort that achieved one of the most dramatic and sustained reductions in suicide in the clinical literature."*

The Goal: We selected depression care as the target for transformation for our department, but struggled initially to articulate a vision of what "perfect care" would look like. Finally one of our staff suggested that if depression care was truly perfect, no patient would die from suicide. That stunning idea set in motion a debate that continues even today.

The notion of eliminating suicide is radical and antithetical to traditional teaching in psychiatry, where suicide has historically been understood as the unfortunate but inevitable outcome in some patients with mental illness. Our team challenged this assumption and asked, If zero is not the right goal for suicide occurrence, then what number is? Two? Twelve? Which twelve? In spite of its radicalism — indeed because of it — the goal of *zero suicides* became the galvanizing force behind an effort that achieved one of the most dramatic and sustained reductions in suicide in the clinical literature.

The Execution: The audacious goal of zero suicides was part of the Behavioral Health Services division's larger goal to develop a system of perfect care for depression. Our roadmap for transformation was the *Quality Chasm* report, which defined six dimensions of perfect care: safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness. We set perfection goals and metrics for each dimension, with zero suicides being the perfection goal for effectiveness. Very quickly, however, our team seized on zero suicides as the overarching goal for our entire transformation.

We used three key strategies to achieve this goal. The first two — improving access to care and restricting access to lethal means of suicide — are evidence-based interventions to reduce suicide risk. While we had pursued these strategies in the past, setting the target at zero suicides injected our team with gumption. To improve access to care, we developed, implemented, and tested new models of care, such as drop in group visits, same-day evaluations by a psychiatrist, and department-wide certification in cognitive behavior therapy. This work, once messy and arduous for the PDC team, became creative, fun, and focused. To reduce access to lethal means of suicide, we partnered with patients and families to develop new protocols for weapons removal. We also redesigned the structure and content of patient encounters to reflect the assumption that every patient with a mental illness, even if that illness is in remission, is at increased risk of suicide. Therefore, we eliminated suicide screens and risk stratification tools that yielded non-actionable results, freeing up valuable time. Eventually, each of these approaches was incorporated into the electronic health record as decision support.

> *When we achieved the goal of "zero suicides," the success was self-evident. In turn, the initiative gained even more traction as a transformational force"*

Notwithstanding this system redesign, the pursuit of perfection was not possible without a *just culture* for our internal team. Ultimately, we found this the most important strategy in achieving zero suicides. Since our goal was to achieve radical transformation, not just to tweak the margins, PDC staff couldn't justly be punished if they came up short on these lofty goals. We adopted a root cause analysis process that treated suicide events equally as tragedies and learning opportunities. Participating in this process left staff feeling not only supported but also empowered to be agents of improvement. The key to establishing a just culture was to hold people accountable for learning and improving.

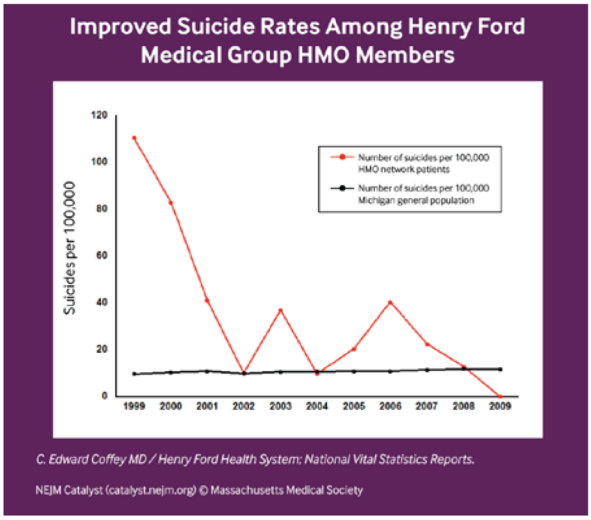
The early success of PDC created momentum that facilitated its spread. The U.S. Surgeon General and the Substance Abuse and Mental Health Services Administration endorsed the goal of zero suicides and invited one of the authors (CEC) to help develop the 2012 National Strategy for Suicide Prevention. In addition, the clinical leaders of Henry Ford Health System charged one of the authors (MJC) to spread PDC into primary care and the general hospital setting.

The Team

Dubbed the "Blues Busters," the PDC team was led by the Department of Psychiatry Chair (CEC) and included all clinical and administrative leaders within the department.

The Metrics

The overall result of this transformation was a dramatic and statistically significant 80% reduction in suicide that has been maintained for over a decade, including one year (2009) when we actually achieved the perfection goal of zero suicides (see the figure below). During the PDC initiative, the annual HMO network membership ranged from 182,183 to 293,228, of which approximately 60% received care through Behavioral Health Services. From 1999 to 2010, there were 160 suicides among HMO members. In 1999, as we launched PDC, the mean annual suicide rate for these mental health patients was 110.3 per 100,000. During the 11 years of the initiative, the mean annual suicide rate dropped to 36.21 per 100,000. This decrease is statistically significant and, moreover, took place while the suicide rate actually increased among non–mental health patients and among the general population of the state of Michigan.



Care teams don't often know the suicide rate in their patient population, and initially we were no different. We learned very quickly that official government mortality records were of little use in managing real-time improvement, because there was a delay of two years before they became available. So we implemented a real-time suicide surveillance system and, retrospectively, reconciled data obtained from it with government data once they became available.

Communicating effectively about the metrics was crucial. Statistically speaking, suicide is a rare event. But while metrics like "rate per 100,000 population" or "time between events" were informative, they did not stir people to action. On the other hand, when we achieved the goal of "zero suicides," the success was self-evident. In turn, the initiative gained even more traction as a transformational force.

Of note, Perfect Depression Care had no negative impact on our division's financial health, which remained strong throughout the Initiative.

Hurdles

The most unexpected hurdles were skepticism that perfection goals like zero suicides were reasonable or feasible (some objected that it was "setting us up for failure"), and disbelief in the dramatic improvements obtained (we heard comments like "results from quality improvement projects aren't scientifically rigorous"). We addressed these concerns by ensuring the transparency of our results and lessons, by collaborating with others to continually improve our methodological issues, and by supporting teams across the world who wish to pursue similar initiatives.

Where to Start

Begin by making a commitment to radical quality. Commit to the goal of zero suicides — or whatever perfection goal most inspires your team. Determine the baseline rate of defects, then engage all team members in devising creative ways to drive that rate to zero. Leaders must ensure a just culture that nurtures this pursuit of perfection.

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STATEMENTS FOR THE RECORD

Prepared Statement of American Legion

Chairman Takano, Ranking Member Roe, and distinguished members of the Committee, on behalf of National Commander James Oxford and the nearly two million members of The American Legion, we thank you for the opportunity to address the important issue of caring for veterans in crisis. As the largest veterans service organization in the United States, we stand ready to assist this committee and the Department of Veterans Affairs to ensure that America's veterans are provided with the highest level of support and healthcare.

The Comprehensive Approach

Veteran suicide is a national issue and far exceeds the ability of any one organization to handle alone. The American Legion stands behind the Department of Veterans Affairs (VA) in its efforts to collaborate with partners and communities nationwide to assist veterans in crisis. The public health approach looks beyond the individual to involve peers, family members, and the community in preventing suicide. Preventing veteran suicide is a top priority for VA, but they need help from dedicated partners to reach veterans who are in crisis.

On April 24, 2019, National Commander Brett Reistad teamed up with Dr. Keita Franklin, VA's previous Executive Director of Suicide Prevention, and penned a letter emailed to nearly 850,000 American Legion members, family, and friends, to let them know that we are working together to adopt a public health approach to suicide prevention.[1] It is imperative that the entire extended veteran network is involved in assisting veterans in crisis. Equally as essential is the need to centrally coordinate all efforts to ensure valuable resources are not squandered in duplicative efforts, as well meaning as they may be.

In an effort to increase collaboration with partners and communities nationwide, The American Legion's TBI/PTSD Committee developed a Mental Health Survey. The target audience was veterans and caregivers, of which 13,648 responded. The data collected indicated 82.47 percent of survey participants never received any form of suicide prevention training, and 67.39 percent of survey participants were somewhat likely, likely, or very likely to take suicide prevention training if offered. Survey participants identified training as a critical area and are ready to participate if the opportunity is made available.

VHA Staffing Issues

The American Legion remains deeply concerned by the trend of suicides reported at VA facilities. One contributing factor to the increase in suicide on VA campuses may be traced to staffing shortages experienced by VA hospitals and clinics. Data released in September 30, 2019, as mandated by the VA Choice and Quality Employment Act of 2017, reported 2,500 occupational staffing shortages across the VHA system. Of note, 60 percent of the facilities noted severe occupational shortages for Psychiatry, making it the most cited clinical occupational shortage.[2] The high rate of employee turnover, insufficient recruitment, non-competitive salary, geographical recruitment challenges, private sector competition, and drawn-out hiring processes attribute to shortages in VA personnel. These factors inherently lend themselves to overworked staff, poor patient experiences, and lower quality of care.

In keeping with The American Legion Resolution No. 115, *Department of Veterans Affairs Recruitment and Retention*, we urge Congress to pass legislation to improve VA's tedious hiring process and increase VA's recruitment, retention and relocation

[1] https://www.legion.org/commander/245458/legion-va-team-approach-suicide-prevention
[2] OIG report 19–00346–241

budget.[3] It will allow VA to retain quality mental health providers, incentivize exemplary performance, and increase employee morale. Improvements in these areas will lead to increased customer satisfaction and overall quality of care for veterans.

Access to Care for Rural Veterans

Connecting those who served to the medical resources they deserve is a top priority for The American Legion.[4] Many veterans live in remote areas and are unable to access care in a timely manner which can create major issues in a time of crisis. The VA has taken action to address this issue by expanding its Telehealth capabilities, and has teamed up with The American Legion and Philips to bring VA healthcare to veterans in a familiar setting – their local posts. Through Project ATLAS (Accessing Telehealth through Local Area Stations), Philips will install video communication technologies and medical devices in selected American Legion and VFW posts to enable remote examinations through a secure, high-speed internet line. Veterans will be examined and advised in real time through face-to-face video sessions with VA medical professionals, who may be located hundreds or thousands of miles away. Project ATLAS aims to increase the convenience and accessibility of care which will prove to be essential to veterans in crisis.

Conclusion

Chairman Takano, Ranking Member Roe, and distinguished members of this committee, The American Legion thanks you for holding this important hearing and for the opportunity to explain the views of the nearly 2 million members of this organization. The American Legion is committed to working with the Department of Veterans Affairs and this committee to ensure that America's veterans are provided with the highest level of support. For additional information regarding this testimony, please contact Mr. Jeffrey Steele, Senior Legislative Associate of The American Legion's Legislative Division at (202) 263–2993 or JSteele@legion.org

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Prepared Statement of American Federation of Goverment Employees, AFL-CIO

Chairman Takano, Ranking Member Roe, and Members of the Committee, The American Federation of Government Employees, AFL–CIO and its National Veterans Affairs Council (AFGE) appreciate the opportunity to submit a statement for the record on caring for veterans in crisis, and the essential role that Department of Veterans Affairs (VA) police play in deescalating crises and ensuring that every veteran receives timely, comprehensive care. AFGE represents more than 700,000 Federal and District of Columbia government employees, 260,000 of who are proud VA employees. The workforce we represent includes police officers working at the vast majority of VA medical facilities across the Nation, and many of these officers are veterans themselves.

Short staffing of police officers and clinical staff, reduced emergency and urgent care services within the VA, and lack of permanent medical center leadership all threaten the ability of VA police officers to adequately respond to veterans in crisis. These are all symptoms of a health care system under great strain from the ever-increasing privatization of veterans' health care.

Overview

VA police officers are very often the first point of contact for a veteran in crisis at a VA medical center. Their mission is to provide a compassionate, safe response that ensures that the veteran is quickly connected to the treatment he or she needs. The veteran's mental health is the priority of the officers. In many instances, the police officer is the one who deals directly with a homicidal or suicidal individual who tries to leave the facility and is refusing to be admitted for inpatient care. As one officer stated

These officers are an integral part of both the Behavioral Emergency Response Teams (BERT) that handle crisis situations inside inpatient and outpatient facilities and the external response teams that cover the rest of the campuses. Officers may identify veterans in crisis when they seek help at a VA emergency department (ED), VA urgent care center or through outreach by VA mental health professionals or Crisis Line of call center employees. The officer then attempts to engage the veteran, deescalate and connect to clinical care by phone or in person. If needed, the

[3] https://archive.legion.org/bitstream/handle/20.500.12203/5772/2016N115.pdf
[4] https://archive.legion.org/bitstream/handle/20.500.12203/6926/2017N075.pdf

VA police officer will reach out to local law enforcement to go to the veteran's home and convince him or her to come into the VA for treatment. Depending on the State and individual facility policy, the officer may also be able to impose a temporary detention order on the veteran to secure an initial mental health assessment.

Dangers of Short Staffing

VA officers have reported that their facilities have been at minimal staffing levels for years. The Department's outdated staffing policy risks the safety of the veteran in crisis, other veterans and family members and employees. If one of the officers must leave the ED to address an incident elsewhere on the campus, often there is simply not enough coverage to properly respond to another emergency involving a veteran. The larger the campus, the greater the gap in police coverage becomes. As an officer who works at one of the 39 medical centers with the greatest complexity (based on patient volume, patient risk, teaching and research, specialists and ICUs) reported, even though their staffing minimums are usually higher (4 officers per facility), they still lack sufficient coverage when they are responding to multiple calls or need to leave the campus to have a veteran detained.

The VA Office of Inspector General (OIG)'s June 2018 report found that VA police rank seventh highest in the Veterans Health Administration (VHA) regarding occupational shortages, with 52 facilities reporting police shortages, an 18 percent vacancy rate and numerous facilities staffed below authorized levels.[1] Turnover of VA police officers is also very high; an officer reported to us that nearly a third of the officers at his facility leave every year. Reports we received from the field confirm what the OIG found in its 2018 report—that noncompetitive wages are a top cause of the inability to recruit and retain officers at the VA.

The OIG also identified a serious structural problem in its June 14, 2018 report: a lack of standardized police officer staffing models that can be utilized by medical facilities to determine the appropriate number and composition of officers. The lack of a sound staffing model forces facilities to resort to extreme short-term measures such as contracting out critical police officer functions to companies without specialized experience or training, or "borrowing" VA officers from other nearby facilities.

A number of additional factors further strain already short-staffed police forces, including large campus sizes, facilities in urban areas and high crime areas, high usage levels, large rehabilitation and homeless veteran units and EDs at maximum capacity.

Severe short staffing of clinical staff on emergency response teams further endangers veterans in crisis. Officers express frustration over the inability to access front line medical staff, especially during transitions from the day to evening shifts, before night staff and on call staff come on duty.

Chronic short staffing and high turnover at the leadership level is also taking its toll on the VA police force. Officers find it increasing difficult to determine where to bring concerns given constant changes in leadership at their facilities. In addition, front line officers feel that their voices are not welcome. They no longer have the ability to express their views through labor-management groups that would be convened in the past. In contrast, VHA regularly receives input and recommendations from facility level chief of policy committees, that often include officers who come from outside the VA and lack the critical hands on experience that rank and file officers could bring to the table. These committees appear to communicate with VA Central Office but not with the rank and file officers at the facility.

Sadly, Secretary Wilkie continues to appear unwilling to fill the nearly 50,000 vacancies that the VA is required to report under the VA MISSION Act. The VA must be held accountable for this chronic and harmful short staffing, which continues to erode VA's capacity every year and provide the justification for further dismantling of the VA through privatization.

AFGE urges the Committee to insist on firm deadlines for filling the unfilled vacancies in the VHA police force and other VHA positions that have been identified by the OIG. We also recommend that the VA's current mandate to report vacancies under the VA MISSION ACT be expanded to include a breakdown by profession so that veterans and the public know which facilities have a shortage of police, clinical staff and other positions.

Training

Officers are generally satisfied with the Standardized Training they receive at the VA Law Enforcement Training Center (LETC). However, they express interest in re-

[1] OIG Determination of Veterans Health Administration's Occupational Staffing Shortage Fiscal Year 2018, June 14, 2018.

ceiving more skills training at their facilities to ensure that they are fully equipped to serve as the first point of contact for veterans with suicidal ideations and engage in successful de-escalation. For instance, while everyone gets standardized mental health training to assess immediate threats made by a veteran, the initial LETC training is only an acceptable baseline and VA leadership should consider providing more hands-on training with role playing using the Crisis Intervention Team (CIT) model that originated in Memphis and has been replicated in facilities across VA. AFGE also recommends updating the LETC training to include more training models that focus on treatment rather than arrests, consistent with VA policy that law enforcement should be the last resort.

The Danger of Closed VA Emergency Departments and Urgent Care Centers

Improvements in officer training and staffing will be of far less value if veterans in crisis do not have a designated place to go for help and comprehensive care within the VA. Sadly, that is exactly the direction that the VA is heading toward. AFGE has raised concerns with Congress for over a decade about the dismantling of VA health care through the closing of in-house EDs and urgent care centers. We know anecdotally that many VA medical centers across the country have lost EDs and urgent care centers over the years but are not aware of any comprehensive studies of this trend.

VA officers have reported that the absence of a designated place in medical centers for a veteran to go to when he or she is crying out for help greatly impedes their mission to make treatment, rather than arrest, the first priority. One officer at a facility that lost its ED expressed concern that veterans in his community no longer have an appropriate place to go where they can just get "something off their chest." As he explained, when a veteran becomes agitated, he now has to be sent across town for emergency care and then back again to the VA for continued treatment. This breakdown in continuity of care can cause a great deal of stress for the veteran. Additionally, the VA officers and clinicians risk ending up with less information because the emergency care was provided outside of the VA instead of within VA's integrated system. **Therefore, AFGE urges the Committee to conduct oversight into the status of EDs and urgent care centers across VHA facilities and how their closures are impacting veterans in need of crisis intervention.**

AFGE appreciates the Committee's attention to the important issue of caring for veterans in a crisis and the role of the VA police. We look forward to working with you to address needed improvements in order to provide VA police officers with more tools to assist veterans. Thank you.

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