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Good morning, Chairman Connolly, Ranking Member Meadows, and Members of the Committee. Thank you for the opportunity to discuss the recent events at the Washington, DC VA Medical Center (DC VAMC). I am accompanied today by Mr. Michael Heimall, Director of the DC VAMC.

Introduction

The DC VAMC, and the extended VA hospital network, take great pride in providing world-class health care to all Veterans in an environment that fosters compassion, commitment, and service. However, hospitals by their very nature carry an intrinsic risk to patients as personnel contend with unpredictable situations, infection control, large numbers of vulnerable individuals with significant care needs, and changing demands on a daily basis. This facility and VA leadership recognize the upsetting recent events addressed in the media and by this Committee. Our health care facilities are designed to be safe havens for the women and men who defended our Nation, and we are deeply heartbroken and saddened by the circumstances that led to the assault of an innocent person.

The local Washington, DC media have recently reported on three unfortunate and concerning incidents that occurred at the DC VAMC. The Medical Center, Veterans Integrated Services Network 5, and the Department share the Committee's concern about these incidents and have conducted thorough reviews in each case and, where appropriate, have changed policies and procedures and retrained or disciplined staff to ensure these incidents do not occur in the future. Director Heimall can speak to the details of each incident during today's hearing.

Ensuring physical security of VHA's nearly 170 VAMCs can be complicated because VA must balance safety and security with providing an open and welcoming health care environment. Additionally, VA serves a vulnerable population with high rates of posttraumatic stress disorder (PTSD) and substance use disorder.

VHA has implemented panic alarms, badge access to certain areas, limited guest hours, police presence, security cameras, de-escalation training, emergency preparedness, and more. Physical Security Assessments and Vulnerability Assessments are performed at the local level every two years identify risk at each VAMC, as requirements may differ. What works in a rural hospital may not make sense in an urban setting. Collaboration between law enforcement and health professionals is essential in shared responses to violent incidents or police calls for service in the

field. VA recognizes the need to improve its VA police services. To help bridge the gap between community resources and VA services, and increase the opportunity to treat Veterans in crisis, the VA Law Enforcement Training Center (LETC) has developed a training program specifically designed for community first responders. Our goal is to change the culture of the Enterprise and ensure health care providers and VA police personnel work collaboratively to ensure the safety of our unique Veteran population.

Our promise to Veterans remains the same: to promote, preserve, and restore Veterans' health and well-being; to empower and equip them to achieve their life goals; and to provide state-of-the-art treatments. Veterans possess unique characteristics and experiences related to their military service that may increase their risk of substance use disorder, mental health issues, and suicide. They also tend to possess skills and protective factors, such as resilience or a strong sense of belonging to a group. Our Nation's Veterans are strong, capable, valuable members of society, and it is imperative that we connect with them early as they transition into civilian life, facilitate that transition, and support them over their lifetime.

The health and well-being of the Nation's men and women who have served in uniform is the highest priority for VA. VA is committed to providing timely access to high-quality, recovery-oriented, evidence-based health care that anticipates and responds to Veterans' needs and supports the reintegration of returning Servicemembers wherever they live, work, and thrive.

Mental Health and Suicide Prevention

We know that an average of approximately 20 Veterans die by suicide each day; this number has remained relatively stable over the last several years. Of those 20, only 6 have used VA health care in the 2 years prior to their deaths, while the majority — 14 — have not. In addition, we know from national data that more than half of Americans who died by suicide in 2016 had no mental health diagnosis at the time of their deaths.

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

When we look at our data from the years 2015 to 2016, we see a small decrease in the number of suicides; there were 365 fewer deaths by suicide in 2016 compared to 2015. This means we are moving in the right direction, but if there is still one suicide, we know there is significantly more work to be done. We are also concerned about the fact that we are seeing a rise in the rates of Veteran suicides among those aged 18-34 in the past two years. Efforts are already underway to better understand this population and other groups that are at elevated risk, such as women Veterans, never federally-activated Guardsmen and Reservists, recently separated Veterans, and former Servicemembers with Other Than Honorable discharges.

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, women Veterans are still more likely to die by suicide than non-Veteran women. In 2016, the suicide rate of women Veterans, with 257 women Veterans dying by suicide, was nearly twice the suicide rate of non-Veteran women after accounting for age differences.

These data underscore the importance of our programs for this population. VA is working to tailor services to meet their unique needs and have put a national network of Women's Mental Health Champions in place to disseminate information, facilitate consultations, and develop local resources in support of gender-sensitive mental health care.

DC VAMC Suicide Prevention Policy

The DC VAMC uses the VA suicide prevention standard, which is meant to establish policy and procedures to ensure the evaluation of patients at potential risk for suicide and ensure that the evaluation is documented, easily identifiable, accessible to all clinical staff and compliant with both VHA Central Office (VHACO) and The Joint Commission (TJC) guidelines. Currently, TJC requires all patients in an organization such as a psychiatric hospital and a general hospital with a primary diagnosis or primary complaint of an emotional or behavioral disorder be surveyed under the Behavioral Health Comprehensive standards.

It is the policy of the DC VAMC to ensure that all patients at risk for suicide are thoroughly evaluated and appropriately treated. We will make a special effort to identify, assess, treat, and provide maximum suicide prevention efforts for all patients who present with a high risk of suicide. The DC VAMC will implement modifications to the current suicide prevention policy as further guidance comes from VHACO regarding suicide prevention assessment and treatment.

Patients who have attempted suicide are to be admitted to the appropriate medical/surgical unit if the suicide attempt has resulted in significant physical illness or injury and kept on at least 1:1 nursing observation status there; at times even 2:1 observation might be necessary in patients who have a high elopement potential. The Mental Health consult team assigned to medical/surgical inpatient services evaluate the patient daily until the patient is transferred to the inpatient psychiatry unit. When the patient is medically or surgically cleared, and appropriate documentation to this effect in the chart has been provided (including arrangements for medical and surgical follow up when required), the Staff Psychiatrist will arrange for transfer to the psychiatric service.

DC VAMC Mental Health and Suicide Prevention Training

Every DC VAMC employee is required to take Suicide Prevention Training, (Operation S.A.V.E.: Signs, Ask, Validate, Encourage, and Expedite). At this training, the epidemiology of Veteran death by suicide is discussed along with related contributing factors. The training elaborates on the signs of suicidal thinking, asking the most important question (i.e., are you thinking of killing yourself), validating the Veteran's experiences, and encouraging treatment. Factors of increased risk are also discussed. Finally, programs and resources including the Recovery Engagement and

Coordination for Health—Veterans Enhanced Treatment, gun lock programs, and crisis call management are explained during this training.

Moreover, all clinicians are required to take a knowledge-based program that provides an overview of information regarding suicide and suicide prevention. Topical discussions include:

- Suicide as a social and medical issue;
- Suicide assessment;
- Systemic and environmental issues; and
- Safety planning.

The primary intent of this training is to provide information so both clinicians and non-clinicians are able to recognize and bring into treatment Veterans who are struggling with suicidal thoughts. All clinicians should know the suicide risk factors, the safety nets needed to manage the prevention of suicide, support systems, and referral resources.

All staff, including clinicians and nurses, are required to take annual refresher courses. There is a training that is offered using face-to-face modality for facility staff that routinely do not use or have access to a computer for their official duties. This session is hosted by the local Suicide Prevention Coordinator and includes viewing the refresher training video and a question and answer session for staff. There is a mandatory Web course that ensures registered nurses are capable of assessing risk factors for suicide as they are highly skilled in establishing a therapeutic rapport with distressed patients and possess clinical aptitude for evaluating potential suicide risk. The purpose of this webinar is to prepare nurses to complete suicide assessments and formally document their interventions. Lastly, clinicians and registered nurses are required to take refreshers of the initial course every 3 years.

The DC VAMC Suicide Prevention program does not refer patients to community providers for outpatient treatment. We do partner with local police and emergency medical services to perform what is known in the field of mental health as a “welfare check” when a Veteran is potentially in crisis. When appropriate, first responders can transport the Veteran to the DC VAMC Emergency Department or the nearest local hospital for emergency mental health evaluations and treatment.

Involuntary Commitment of Patients at the DC VAMC

Mentally ill patients who present to the DC VAMC, who are likely to injure themselves or others because of their mental illness, and who refuse treatment shall not be discharged from the VAMC. The VAMC will initiate Involuntary commitment procedures when a staff physician or qualified staff psychologist has reason to believe that a mentally ill patient is likely to injure himself/herself or others because of his/her mental illness and the patient refuses voluntary admission (a guardian or surrogate cannot consent to admission to the VAMC’s psychiatric unit on behalf of the patient).

In the District of Columbia, a person is mentally ill if he/she has a psychosis or other disease that substantially impairs his/her mental health. The term "injure" is not to be interpreted narrowly. There need not have been any recent overt violent act, nor does there need to be physical danger or violence, as the act or acts may be violent or non-violent, intentional or unintentional. It includes the likelihood of committing a criminal act, which will expose him/her to arrest, trial, and conviction, or that is likely to

expose him/her to violent retaliating acts by the victim of the crime. Further, a person is likely to injure himself/herself if he/she is likely to place himself/herself inadvertently in a position of danger because of his/her mental illness or if he/she is unable to take care of himself/herself as a result of his/her mental illness.

On the other hand, it must be noted that psychiatric commitments are purely a matter of state law (subject to the requirements of the U.S. Constitution for due process before depriving a patient of his or her liberty). So, each state has its own process for determining what behavior can subject an individual to loss of liberty on a psychiatric basis, how to initiate a hold/how to oppose a hold, etc. These matters are adjudicated in state court, and there is to my knowledge no compact or any other basis for allowing one state to honor another state's action or request (unlike, detainers for prisoners or processing of adoptions, both of which have interstate compacts addressing the relationships between a sending and a receiving entity). In circumstances of an elopement where a patient is found in another state, the DC VAMC would not have the ability to retrieve the patient outside of the District.

Under DC law, there are two distinct phases for involuntary commitments: (1) detention for emergency observation and diagnosis; and (2) judicial hospitalization. Patients who are involuntarily committed shall receive medical care and treatment at the medical facility where they are an inpatient while those proceedings are pending.

All VA personnel who may become involved in involuntary commitment proceedings are responsible for familiarizing themselves with standard procedures. The Staff Psychiatrist is primarily responsible for ensuring that proper procedures are followed in processing a patient for involuntary commitment in the District of Columbia. Emergency Room (ER) Medical staff are responsible for evaluating patients and providing medical clearances, in accordance with VA regulations, prior to admitting said patients to the receiving units in the VAMC. When appropriate, the treating ER Physician may also serve as the staff physician completing the Application for Emergency Hospitalization confirming that a mentally ill patient is imminently dangerous to self or others and requires involuntary hospitalization.

When a patient has attempted suicide and is either medically or surgically unstable and has been admitted to the appropriate medical/surgical unit (e.g., if a suicide attempt has resulted in significant physical damage, or an underlying unstable medical condition has caused the mental condition requiring involuntary commitment), the patient's treating physician and nursing staff, in consultation with the Mental Health Nurse Executive (Lead Nurse of the Mental Health Service or designee) and the Psychiatric Consultant, are responsible for following the procedures outlined herein. When it has been determined that an involuntarily committed patient on medical/surgical inpatient services needs at least 1:1 nursing or 2:1 observation status, it is the responsibility of the appropriate VAMC nursing authority on duty to arrange for the necessary additional nursing staff.

The Mental Health consult team to the medical/surgical inpatient services will daily evaluate patients who have attempted suicide and have been admitted to the appropriate medical/surgical unit until the patient is ready for transfer to the inpatient psychiatry unit, which is arranged by the Psychiatrist Chief of the Mental Health consult team. It is the responsibility of the Staff Psychiatrist to arrange for transfer to the

inpatient psychiatric service (3DE) in consultation with the 3DE ward attending and Head Nurse.

Finally, the Chief of Police of the VAMC is responsible for assuring the proper involvement of the Police Service to ensure patient and staff safety whenever a patient is hospitalized while pending involuntary commitment proceedings or has been judicially hospitalized at the VAMC. Police assistance in the management of a difficult patient must always be a last resort and only after less restrictive therapeutic interventions have been tried and failed.

Office of Inspector General (OIG) Critical Deficiencies Report

In March 2018, OIG issued its final report on critical deficiencies found at the DC VAMC in April 2017. The report included 40 recommendations for the VAMC, VISN 5, and VHA. Collectively, they have been working hard to address the deficiencies and improve the administrative processes and environment of care at the VAMC. It must be noted that although these deficiencies increased the risk of harm to Veterans cared for at the facility, OIG could find no evidence of actual harm to Veterans as a result of the identified deficiencies. This speaks to the dedication and commitment to zero harm by the entire staff of the DC VAMC.

To date, 28 of the 40 recommendations have been fully addressed and closed by OIG. Five additional recommendations are currently being reviewed and may be recommended for closure this month. The remaining recommendations involve longer-term monitoring of processes to ensure the corrective actions have become routine processes at the VAMC. These involve monitoring the availability of supply stockage levels, monitoring of periodic equipment inventories, and auditing of financial records for supply and equipment purchases. We expect all outstanding recommendations to be closed by October 31, 2019.

Despite the process failures outlined in the report and the events reported in the media, the DC VAMC is on par with the medical facilities in the Washington, DC metropolitan area. Using the Center for Medicare and Medicaid Services' Hospital Compare data, the DC VAMC recorded the lowest hospital mortality rates in the market for patients with chronic obstructive pulmonary disease (COPD), heart attack, heart failure, and pneumonia. The DC VAMC has also focused on reducing the risk of hospital acquired infections like catheter-associated urinary tract infections, central line-associated blood stream infections, intestinal infections, and methicillin-resistant staphylococcus aureus infections. As a result of these focused efforts, DC VAMC-hospital acquired infection rates (also known as nosocomial infection rates) are comparable to civilian hospitals in the DC market. As the leadership continues to build a culture of high-reliability care centered on employee engagement, we expect to see hospital-acquired infection rates continue to decrease, with a goal of zero preventable harm to patients.

The OIG report also raised concerns about equipment sterilization processes at the hospital and the resulting unnecessary delays and risk to surgical patients. Tremendous progress has been made rebuilding the staff of the Sterile Processing Service. During the period of April 2017 to May 2018, the DC VAMC cancelled 20 surgical cases due to the unavailability of reusable medical equipment. Over the same

period ending May 1, 2019, the DC VAMC reported 5 case cancellations due to the unavailability of medical equipment, the last occurring in December 2018. And at no time in the period of 2018-2019 was a patient placed under anesthesia before the care team recognized the appropriate equipment was not available.

Human Resources and Employee Engagement

The DC VAMC is also in the process of recovering from poor morale, high turnover, and a lack of employee engagement. In 2018, the DC VAMC ranked 130th out of 147 VAMCs in the Partnership for Public Service Best Places to Work survey with a composite score of 44 compared to 66 for the entire VA. Additionally, the survey response rate for the DC VAMC was 33 percent, approximately half the rate of other facilities. Certainly, the lack of stable, consistent leadership, the persistent negative media attention, and outside scrutiny contributed to this response rate and ranking. Staffing shortages are a major contributing factor to the low morale and lack of engagement. In 2018, the DC VAMC leadership determined approximately 425 additional staff were needed to meet their mission requirements. Some of this requirement were new hires to implement action plans to address the OIG critical deficiencies or to implement Care in the Community programs. But more than two-thirds of this requirement was to replace staff who had left the VAMC between 2015 and 2017. These included police officers, supply chain staff, and sterile processing staff. Turnover of the workforce is approximately 10 percent, although the DC VAMC has seen significant improvement in nursing turnover during the last two quarters. Recruiting police officers continues to be a challenge, and the DC VAMC has requested salary adjustments and the use of recruitment incentives to meet these challenges.

Conclusion

We look forward to the opportunity to discuss efforts to restore the trust of our Veterans and continue to improve access to care inside and outside VA. Our objective is to give our Nation's Veterans the top-quality care they have earned and deserve while keeping them safe within our walls. Chairman Connolly, we appreciate this Subcommittee's continued support and encouragement in identifying and resolving challenges as we continue our journey to provide high reliable care to our Veterans. This concludes my testimony. My colleague and I are prepared to respond to any questions you may have.