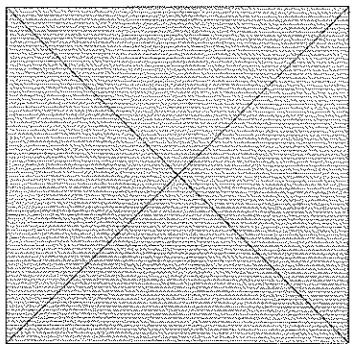
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS



OFFICE OF THE
MEDICAL INSPECTOR

Final Report
2008-D-1069

Quality of Care Review

Veterans Affairs Medical Center
Spokane, Washington

Veterans Integrated Service Network 20

Report Date: February 4, 2009

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Executive Summary

At the request of the Under Secretary for Health (USH), Department of Veterans Affairs (VA), the Office of the Medical Inspector (OMI) investigated the care provided to patients who died as a result of suicide while under the care of the Veterans Affairs

Medical Center in Spokane, Washington (hereafter, the Medical Center) from September 29, 2007, to the present. The facility had come under increasing media scrutiny following a newspaper article discussing the suicide of a Veteran on July 7, 2008, within 3 hours of having been evaluated at the Medical Center.[1] The article also discussed the suicide of another Veteran in March of this year. An OMI team conducted a 2-day site visit to the Medical Center on July 23-24, 2008. After the site visit, the OMI reviewed death certificates that were acquired by the Medical Center from the State of Washington on additional Veterans who had committed suicide.

Based on its findings the OMI makes the following conclusions and recommendations.

Conclusions

1. The Medical Center could improve its patient care by:

    a. Better utilization of the option of inpatient psychiatric admission. Emergency Department (ED) staff stated that it is sometimes difficult to admit patients on weekends and off-tours.

    b. Many Behavioral Health Service (BHS) policies are not formally written; processes and procedures are verbally communicated among staff thereby increasing the probability of inaccurate interpretation or lack of awareness.

    c. Better understanding of the limitation of the patient contract for safety. In several cases, the Veteran denied suicidal ideation and entered into safety contracts only to subsequently commit suicide.

    d. Understanding that the Question-Persuade-Refer-Treat (QPRT) suicide risk-assessment tool alone is not effective in identifying patients at risk for suicide. The OMI is concerned that staff is relying on the score obtained from the QRPT and less on clinical assessment and judgment.

    e. Improving awareness among treatment providers as to what services are available to help Veterans with chronic pain issues. The Pain Management Committee is under utilized as evidenced by approximately four consults each month.

2. The Medical Center could improve its use of the high-risk suicide list in the following areas:

    a. Many treatment providers are not aware of the list, thus limiting its use. Of the approximately 40 patients on the list at the time of the OMI site visit, almost all of them had been discharged from the inpatient unit. Outpatient providers rarely place patients that are at high risk for suicide on the list.

[1] "Lives Lost at Home," *The Spokesman-Review*, July 20, 2008.

b. Providers who see patients in the BHS clinic or ED need to be well acquainted with the purpose and availability of the high risk suicide list. Patients who present with past suicide attempts, current suicidal ideation or other high risk factors should be considered for inclusion on the list. Sixteen of 18 suicides reviewed by OMI were not on the list.

c. The high-risk suicide list is not available to clerks or others who often get the telephone calls from patients cancelling their appointments; thus, they are not able to identify patients who may need increased attention or follow up.

3. A current employee holds the copyright on the QPRT suicide risk-assessment screening tool used by the Medical Center.

4. Despite the fact that several staff members in key positions in Quality Management and BHS have been in their positions for less than 1 year, the Medical Center has complied with:

   a. VHA Directive 2008-004, *Peer Review for Quality Management*, in initiating protected peer reviews for the FY 2008 cases of completed suicides and suicide attempts within 30 days of an encounter.

   b. VHA Handbook 1050.01, *National Patient Safety Improvement Handbook* in initiating RCA investigations for the suicide cases involving Veterans receiving care at the Medical Center.

   c. VA-designated Patient Health Questionaire-2 (PHQ-2) and PHQ-9 depression screening tools.

   d. Conducting traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD) screenings of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans as required by VA policy. However, there is not a comprehensive OEF/OIF outreach program in place at this time which could make patients more aware of care that is available.

5. The Medical Center has taken positive initial steps to establish a partnership with the Spokane legal and behavioral health community to improve mental health services to Veterans. These efforts have the involvement and support of the State of Washington's Congressional and Senate staffs.

6. The number of suicides coupled with negative media attention has taken a toll on some of the BHS staff at the Medical Center.
7. The OMI notes the following about the cases examined during the site visit:

   a. Veteran #1 – The (b) (6)-year-old (b) (6) Veteran was seen by BHS professionals who conducted joint interviews with the Veteran and (b) (6). Staff should have

attempted to interview the Veteran alone as a supplement to the joint interview. In addition, inpatient hospitalization should have been offered to the Veteran.

b. Veteran #2 – This (b) (6)-year-old (b) (6) Veteran did not have a well-coordinated pain management plan to assist (b) (6) with (b) (6) intractable pain until a few days before (b) (6) death. Death by (b) (6) was possibly due to the Veteran's attempt to attain (b) (6).

c. Veteran #3 – The Medical Center did not have an opportunity to develop a BHS treatment plan for this (b) (6)-year-old (b) (6) Veteran of OEF/OIF. The Veteran only participated in (b) (6) initial primary care and (b) (6) examination.

d. Veteran #4 – The treatment plan developed by the Medical Center to assist this (b) (6)-year-old Vietnam era Veteran in management of (b) (6) (b)(6) & (b)(3) was appropriate.

e. Veteran #5 – Although this (b) (6)-year-old OEF/OIF Veteran had been diagnosed with (b) (6)

f. Veteran #6 – This (b) (6)-year-old Persian Gulf War Veteran had minimal contact with the Medical Center and suicide assessments were completed. The referral to the (b) (6) program was appropriate. The completed suicide appears to be the result of an impulsive act.

g. Veteran #7 – This (b) (6) year-old (b) (6) Persian Gulf War Veteran was given a (b) (6)

h. Veteran #8 – This (b) (6)-year-old Persian Gulf War Veteran had limited and sporadic contact with the Medical Center. (b) (6) last contact with the Medical Center was 14 months prior to (b) (6) suicide.

i. Veteran #9 – This (b) (6)-year-old (b) (6) Veteran was seen and treated on a regular basis for (b) (6). The Veteran had a history of (b) (6) l.

j. Veteran #10 – This (b) (6)-year-old Vietnam era Veteran had a history of (b)(6) & (b)(3)

8. The OMI notes the following about the additional cases submitted for review. These cases were generated from a request to the Spokane County Medical Examiner, after the site visit, for a listing of all suicides during Fiscal Year 2008:

   a. Veteran #11 – Appropriate screenings were given for (b) (6) [redacted]. Death certificate issued by the State of Washington lists the cause of death as (b) (6) [redacted] and the manner of death as suicide.

   b. Veteran #12 – This (b) (6)-year-old Veteran did not receive medical care at the Spokane VAMC. Death certificate issued by the State of Washington lists the cause of death as (b) (6) [redacted] and the manner of death as suicide.

   c. Veteran #13 – This (b) (6)-year-old Veteran expressed (b) (6) [redacted] The death certificate issued by the State of Washington lists the cause of death as (b) (6) [redacted] and the manner of death as suicide.

   d. Veteran #14 – This (b) (6)-year-old Veteran did not receive medical care at the Spokane VAMC. Death certificate issued by the State of Washington lists the cause of death as (b) (6) [redacted] and the manner of death as suicide.

   e. Veteran #15 – This (b) (6)-year-old (b) (6) Veteran received (b) (6) [redacted] on an intermittent basis following (b) (6) discharge from the military in (b) (6) [redacted], until (b) (6) death. (b) (6) was determined to be a low risk for suicide. On (b) (6) [redacted]. Referral was made to (b)(6) & (b)(3) [redacted]. Patient denied suicidal and homicidal ideation. Death certificate issued by the State of Washington following (b) (6) death in (b) (6) [redacted], lists the cause of death as (b) (6) [redacted] and the manner of death as suicide.

   f. Veteran #16 – This (b) (6)-year-old Veteran first presented at the Medical Center in (b) (6) [redacted]; however, the Veteran did not give any indication of being suicidal or homicidal prior to his death in (b) (6) [redacted]

(b) (6); however, the death certificate issued by the State of Washington lists the cause of death as (b) (6) and the manner of death as suicide.

g. Veteran #17 – This (b) (6)-year-old Veteran was followed at the Medical Center for several years due to various medical problems. (b) (6) Death certificate issued by the State of Washington lists the cause of death as (b) (6). The manner of death was listed as suicide.

h. Veteran #18 – The Veteran, who was (b) (6) years old, was followed at the Medical Center between (b) (6). He reported that he was receiving (b) (6) at that time. The Veteran was made aware of available VA services for management of suicidal ideation. Death certificate issued by the State of Washington lists the cause of death as (b) (6) and the manner of death as suicide.

i. Veterans #19, 20, 21, and 22 were on the list of individuals who had committed suicide provided to the Medical Center by the Spokane County Medical Examiner. They were identified as Veterans but did not receive care at the Medical Center. The OMI did not review their death certificates.

9. The Medical Center reported to the National Center for Patient Safety that there were nine completed suicides for the 12-month period from July 2007 through June 2008 (4th quarter FY 2007 through the 3rd quarter FY 2008). Using information from the Medical Center and the review of death certificates provided by Spokane County, the OMI found 14 completed suicides for this same 12-month period of Veterans who received at least some of their care at the Medical Center. The methods and sources routinely being utilized by the Medical Center to identify Veterans who have committed suicide may be inadequate.

10. An unexpected incidental finding was that 8 of the 22 Veterans committing suicide were between the ages of 70 and 90; several of these were not being treated at the Medical Center.

Recommendations

1. The Medical Center should peer review the care provided to Veteran #1 and appropriate actions should be taken based on the findings.

2. The Medical Center should further develop the OEF/OIF program in order to provide greater outreach to this high-risk group.

3. The Medical Center should formalize its BHS policies and procedures (e.g., follow up on missed BHS appointments, age-specific mental health care, suicide assessment, use of the high-risk list, coordination of care among the Medical Center, Community Based Outpatient Clinics, and Veterans Outreach Center, management of chronic pain etc.). This should be followed by educating all BHS staff on the more formal program.

4. The Medical Center should ensure that BHS is in compliance with "Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version," which can be found at http://vaww.mentalhealth.va.gov.

5. The Medical Center should conduct competency assessments to determine whether there are deficiencies in their staff's ability to use clinical skills to assess a patient's risk of suicide rather than total reliance on a suicide risk-assessment tool.

6. The Medical Center should complete recruitment and assignment of vacant positions identified on the BHS organizational chart.

7. The Medical Center should continue to meet on a routine basis with the mental health community focus group; develop a plan to implement relevant short and long-term initiatives identified in the community focus meeting.

8. The Medical Center should ensure that staff support systems are in place to assist staff in handling the negative publicity as well as any concerns they have associated with the suicide of Veterans assigned to their care.

9. The Medical Center should ensure that providers attempt to meet with mental health patients privately even when they are accompanied by a family member or significant other.

10. The Medical Center should assess the admission process, the availability of beds on the inpatient psychiatric unit, staffing, and communication systems with outpatient services to ensure patients have adequate access to inpatient care.

11. The Medical Center should ensure compliance with VHA Directive 2008-036, July 18, 2008, requiring that Patient Record Flags (PRF) be used to identify patients that are at high risk for suicide. The high-risk suicide list should be available to clerks and other staff who receive phone calls from patients cancelling their appointments so that the names can then be checked against the high-risk list and special efforts made to

contact and reschedule these patients as soon as possible.

12. The Medical Center should educate all providers treating chronic pain as to the resources available, such as the Pain Management Committee and the Pain Education Classes and the ability to refer to another facility.

13. The Medical Center should adopt a suicide assessment screening tool that allows staff to complete a more comprehensive assessment of their observations. This tool should be consistently used by BHS staff.

14. The Medical Center should evaluate the appropriateness of using the QPRT suicide risk-assessment tool and obtain a legal opinion to ensure that there is not conflict of interest with the use of the tool.

15. VHA should consider, in order for its facilities to better identify all suicides, whether or not facilities should query state/county health departments for death certificates of those Veterans who committed suicide.

16. VHA should ensure that the elderly are regularly assessed for suicide potential. In addition, VHA may what to have the Geriatric Research Education Clinical Centers (GRECCs) address this issue on a national level.

17. VHA should examine the issue of suicide to determine the most effective way to assess patients for suicidal potential, e.g., clinical observation/judgment, assessment tools, etc.

18. VA and Department of Defense should determine under what circumstances or clinical situations patient safety should take priority over patient privacy, e.g., reservist being treated by VA who is in no physical/mental condition to deploy.

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I. Introduction

At the request of the Under Secretary for Health (USH), Department of Veterans Affairs (VA), the Office of the Medical Inspector (OMI) investigated the care provided to patients who died as a result of suicide while under the care of the Veterans Affairs Medical Center (VAMC) in Spokane, Washington (hereafter, the Medical Center) from September 29, 2007, to the present. The facility had come under increasing media scrutiny following a newspaper article discussing the suicide of a Veteran on July 7, 2008, within 3 hours of having been evaluated at the Medical Center.[2] The article also discussed the suicide of another Veteran in March of this year. An OMI team conducted a 2-day site visit to the Medical Center on July 23-24, 2008. Following the site visit, the OMI was asked to evaluate additional deaths of Veterans from the Spokane area some of which may have been suicides.

II. Facility Profile

The Medical Center, located in Spokane, Washington, operates 32 acute beds and 38 rehabilitation-oriented nursing home beds. The facility also operates two Community Based Outpatient Clinics (CBOCs) in Coeur D'Alene, Idaho and Wenatchee, Washington. A mobile clinic, outfitted with two examination rooms, provides selected primary care services to Veterans living in remote areas outside the metropolitan Spokane area. The Medical Center provides primary and secondary care for approximately 215,000 outpatient visits and 1,700 inpatient hospitalizations annually. Tertiary care is coordinated through referrals to the VA Puget Sound Health Care System and the Portland VA Medical Center. Sharing agreements exist with the 92nd Medical Group at Fairchild Air Force Base, Indian Health Services for Native Americans, and the Idaho and Washington State Departments of Veterans Affairs for the care of state home residents in Lewiston, Idaho and Spokane.

The Behavioral Health Service (BHS) consists of inpatient and outpatient programs provided by a staff of 50. The inpatient program consists of an 8-bed inpatient unit capable of expansion to 12 beds. The inpatient unit currently has an average daily census of five beds with a 7-day average length of stay. Outpatient behavioral health services consist of Mental Health Clinics, Case Management Services, Recovery and Integrated Care, Substance Abuse Treatment Program (SATP), Veterans Trauma Recovery Program, and an Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Program.

The Medical Center is part of Veterans Integrated Service Network (VISN) 20, VA Northwest Health Network, which also includes facilities in Anchorage, Alaska; Boise, Idaho; Portland, Roseburg, and White City, Oregon; Puget Sound (Seattle/American Lake), and Walla Walla, Washington.

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[2] "Lives Lost at Home," *The Spokesman-Review*, July 20, 2008.

III. Background

On July 20, 2008, an article in the *Spokesman-Review*, the major newspaper in Spokane, discussed a marked increase in Veteran suicides. The article stated that the July 7, 2008, death of a 26-year-old Navy Veteran, 3 hours after seeking help at the Medical Center, was the sixth suicide this year of a Veteran who had contact with the facility. The article also discussed the suicide of another Veteran in March. The parents of both Veterans were interviewed for the article.

The USH charged the OMI to investigate the BHS care provided to Veterans at the Medical Center. The OMI team expanded the review of BHS to include all deaths by suicide for the current fiscal year (FY 2008). During the review, it was discovered that a suicide had occurred on (b) (6) and the team elected to include that case as part of this investigative review. Following the site visit, the OMI became aware of additional deaths that occurred in the Medical Center's catchment area that may have been suicides. They have also been included this review.

None of the deaths occurred in the inpatient setting. Two of the Veterans were known to be OEF/OIF Veterans and three were identified as Persian Gulf War Veterans. It should be noted that through the efforts of the Medical Center, in conjunction with local agencies, a number of other Veteran suicides in the Spokane area have recently been identified, including some of Veterans not enrolled or treated at the Medical Center. Thus, from September 29, 2007, to July 24, 2008, a total of 22 deaths were provided to the OMI for review.

As a result of the suicides, the Medical Center is actively working with the Spokane mental health community to address the problems in the Veteran population. On July 22, 2008, a local congresswoman hosted a roundtable discussion to address partnerships between the VA, law enforcement, and various county mental health program leaders. In addition to executive management and BHS leadership, attendees included the U.S. Attorney (Spokane Region), County Commissioner, County Sheriff, and the Director, Spokane County Mental Health. Several short-term and potential long-term initiatives were discussed at the meeting. Proposals included establishing a community presence for the Suicide Prevention Coordinator (SPC) and BHS staff, as well as including Medical Center staff in the community Crisis Intervention Team training scheduled for later this year.

A follow-up meeting was held at the Spokane VAMC on October 6, 2008, and was attended by Medical Center Administration, BHS chief and staff, local law enforcement, Spokane Mental Health and Regional Support Network. The purpose of the meeting was to share further details of Medical Center BHS Policies and Procedures pertaining to the Medical Center's suicide risk reduction program. There was a question and answer

period and the next meeting is currently being planned although no date has been set at this time. It should be noted that this community effort has the support of the state's senior United States senator.

IV. Methods

The OMI conducted a site visit at the Medical Center from July 23-24, 2008. The team consisted of the Director, Clinical Investigations, a Psychologist, and a Clinical Program Manager (a registered nurse), all from the OMI. Numerous documents, including the root cause analysis reports, peer reviews, hospital policies, issue briefs, autopsies, and behavioral health performance measure scorecard results were reviewed.

On arrival at the Medical Center, the OMI team had an entrance conference with the senior leadership. The Medical Center Director (via teleconference) provided an overview of the Medical Center issues that triggered the site visit. Interviews were conducted with the Chief of Staff, the Chief, BHS, the SPC, the Patient Safety Manager, the OEF/OIF Coordinator, the parents (separate interviews) of Case #1, the mother of Case #5, and non-supervisory medical, nursing, and social work staff from the BHS who had worked with the cases under review.

After the site visit, the OMI reviewed death certificates acquired by the Medical Center from the State of Washington on additional Veterans who had died of suicide.

The OMI's draft report was circulated to VISN 20 and the Medical Center, as well as to selected VA and VHA offices for review and comment. The comments received were incorporated into the final report as appropriate.

V. Findings

a. Description of the Behavior Health Services (BHS)

The Medical Center has one inpatient mental health unit with an average daily census of five patients. The inpatient unit has 8 operating beds and is capable of expanding to 12 beds; however, management reported that they are not currently staffed to support this expansion. The bulk of mental health services are provided in the outpatient setting. Staff could not recall having had an inpatient suicide in recent memory, but among the outpatients, 22 Veterans with potential deaths by suicide with varying levels of involvement with the Medical Center since September 29, 2007, have been identified.

At the time of the site visit, the Medical Center had had 207 patients discharged from the inpatient psychiatric ward during Fiscal Year (FY) 2008. Two-thirds had been admitted through the Emergency Department (ED) and one-third through the mental health clinics. Ten percent of the admitted patients were seen in both departments at the time of

admission.

During mental health clinic hours, inpatient admissions are handled by one of the BHS psychiatrists. During non-clinic hours, admissions to inpatient psychiatry are processed through the ED. Psychiatrists are on-call for telephone consultation after business hours. They are also required to come into the ED to see patients if needed; however, most consultations are done by phone. The majority of the patients admitted to the inpatient BHS ward are in a voluntary status. If it is determined that an acute involuntary hospitalization may be indicated, the Medical Center policy is that staff members are to adhere to all appropriate Washington state laws by contacting the on-call mental health professional employed by Spokane County as a County Designated Mental Health Professional (CDMHP), to determine whether an involuntary hold can be invoked. The CDMHP has 6 hours to respond to the evaluation request. Several staff interviewed expressed the belief that the psychiatric inpatient admission process was not well organized or customer friendly when the patient had to be processed through the ED when the mental health clinics were closed. The Medical Center policy titled "Suicides, Attempts, and Suicidal/Homicidal Behavior" dated August 15, 2006, which discussed the patient admission process, was revised on October 1, 2008 and addresses concerns regarding admissions.

The 50 full-time equivalent (FTE) staff assigned to the BHS includes 8 psychiatrists and 4 psychologists. Several social workers, addiction therapists, and case managers are assigned to the program, as well as a full-time SPC and a full-time OEF/OIF Program Manager. The incumbents of these last two positions have been in them for less than a year.

The Chief, BHS met with the OMI team to discuss the policies related to management of high-risk patients with suicide ideation. He stated that the BHS department was in the process of revising its policies in the wake of the recent increase in suicide activity and described some of the practices and policies, noting that the process needed to be more formalized for consistency in follow-up. He discussed the plan to hold an off-station retreat for the BHS staff in which the staff would discuss ways to improve the delivery of mental health services to Veterans.

Suicide Prevention Program

The SPC is a social worker assigned to the BHS who has two case managers assigned to work with him. He is responsible for identifying Veterans at risk for suicide or self-injurious behavior, tracking appointments, and coordinating provision of services. He maintains a list of high-risk patients whom he closely monitors. At-risk Veterans are placed on a safety plan for a minimum 90-day follow-up. During the first 30 days, the Veteran is contacted weekly. If the SPC is unable to verify the safety of the Veteran, local police are contacted to go to the Veteran's home to conduct a "welfare check." Patients are primarily placed on the list by the SPC; however, any BHS employee can recommend inclusion of a patient. The majority of patients on the list are added

according to risk- assessment reviews prior to discharge from inpatient hospitalizations. The OMI team received inconsistent responses from staff as to their awareness and utilization of this list. Two of the 10 Veteran cases under review, (b) (6), were placed on the high-risk patient list at the time of discharge from the inpatient unit. The SPC was following 42 patients on the high-risk list at the time of the OMI site visit. The OMI is concerned that although a number of the other patients included in this report had attempted suicide previously, and were being monitored for suicidal behavior, they were not on the high-risk patient list.

Suicide Assessment Screening Program

Patients seen in BHS are routinely screened for suicidal/homicidal ideation as part of the Mental Health Risk Assessment Screening Note. The tool currently being used is the QPRT Suicide Risk Management Inventory (QPRT).[3] The Chief, BHS spoke very favorably of the tool and said that it was used by other facilities within the VA. One of the two copyright holders for the QPRT is an employee at the Medical Center, but it is not known whether the other copyright holder ever worked at the facility. At least one provider stated being uncomfortable using the tool due to ethical considerations regarding copyright status. VHA does not have a single suicide risk-assessment tool mandated for use in VA facilities.

Although the QPRT is the designated suicide risk-assessment tool for the Medical Center, only four of the cases under review had their assessments completed using it. The QPRT design does not allow for a comprehensive assessment of the mental health status of the Veteran. The QPRT assessments completed on (b) (6) and (b) (6) provided a brief description of the suicidal behavior being assessed. The staff members provided short answers to the QPRT prompts such as "What is wrong?" and "Why now?" but did not elaborate with a more objective assessment of the patient's mental health status based on the non-verbal behaviors and actions being observed.

Potential for suicide is also being assessed through the use of the depression screening tool. Depression screening is being accomplished with the VA's standardized Patient Health Questionnaire (PHQ-2).[4] When the PHQ-2 score is positive for depression, the patient is given additional screening with the PHQ-9 tool on the same calendar day.[5]

[3] The QPRT (Question-Persuade-Refer-Treat) is described as a tactical, structured interview protocol designed to obtain critical dynamic suicide risk and protective factor information. It is a strategic intervention designed to help reduce immediate risk of suicide through empathic inquiry and the marshalling of suicide protective factors. The facility has been using the tool for at least 5 or 6 years.

[4] The Patient Health Questionnaire (PHQ-2) is a 6-question tool that has been selected as the standardized depression screening instrument for the general VA population. The questions help to identify which patients are exhibiting signs and symptoms of depression based on a positive score of three or more out of six questions.

[5] The PHQ-9 Assessment of Depression Severity is a 10 question depression screening tool that must be completed when a positive result is found on the PHQ-2 in order to: lead to the effective treatment of patients who might otherwise go untreated, help practitioners differentiate between normal situational stressors and clinical depression that requires treatment, help practitioners determine the extent of functional impairment and patient distress level, and help practitioners detect functional changes in patient

OEF/OIF Program

The Medical Center has an OEF/OIF Coordinator and a patient advocate who contact and assist military personnel returning from Iraq and Afghanistan to facilitate a seamless transition to VA health care. The BHS organization chart reflected that two additional FTE, a psychologist and a registered nurse (RN), are slated to be added to the program. The Coordinator divides her time between the Medical Center and the assigned CBOCs. She conducts traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD) screening assessments of OEF/OIF Veterans and follows-up on the OEF/OIF Veterans on the high-risk list maintained by the SPC. The Coordinator has only been in the position since December 2007, but had been in contact with (b) (6) and (b) (6) She is still in the process of developing the program, but says the development is limited because there are still vacant case manager positions under recruitment.

Translating Initiatives for Depression into Effective Solutions (TIDES) Program

The Medical Center's TIDES program has been operational since October 2007; it is a VACO-funded program designed to reduce the stigma associated with mental health problems. The TIDES program is designed to integrate mental health and primary care services for Veterans with mild-to-moderate depression based on PHQ-2 and PHQ-9 scores. The target population is Veterans who have been identified with mental health concerns but may have a self-stigma about being treated in the mental health setting. The program staff is closely located to the primary care area and referrals are initiated by a "warm handoff" in which the primary care provider (PCP) introduces the Veteran to the mental health professional rather than making a referral. The program is staffed by a social worker, RN, and a 0.5 FTE psychiatrist. The mental health worker advises the PCPs on the treatment of symptoms and mental health concerns while the patient remains under the direct care of the PCP. As of August 2008, 371 patients had been evaluated and assisted.

The program duration is approximately 8 months long. Veterans are initially followed weekly for 4 to 6 weeks; the frequency of follow-up then gradually decreases to monthly. If the Veteran has a relapse while being followed, the frequency of visits increases. Veterans with severe depression are assigned to a mental health provider. Of the cases reviewed by OMI, Veteran (b) (6) was the only patient who had been referred to this program, but he committed suicide within a few days of his initial program assessment.

Veterans Outreach Center

The Medical Center has a close relationship with the Veterans Outreach Center (VOC)

conditions, identify changes in the severity of illness, track progress, and detect setbacks when the PHQ-9 is administered intermittently and during the course of treatment. Questions are scored 0 (not at all) – 3 (Nearly every day); numbers are added to determine a total cumulative score ranging from 0-27. Scores begin at 1-4 which is considered as minimal depression going up to scores of 20-27 which is considered severe depression.

located in Spokane; the VOC (also known as a Vet Center) is under the VA Readjustment Counseling Service. Veterans are able to receive readjustment counseling and limited mental health service at the VOC. If it is determined that the Veteran has a suicidal or homicidal ideation, the Veteran is immediately referred to the Medical Center for follow-up. It should be noted that the VOC maintains its own patient care records which are not linked to the Medical Center.
Of the cases reviewed by OMI, Veterans (b) (6) and (b) (6) received services from the VOC. Veteran (b) (6) had contact with the VOC (b) (6) weeks before he committed suicide. He stopped by the VOC office and told the staff that everything was going well. Veteran (b) (6) last had contact with the VOC staff on (b) (6), 2 months before committing suicide. An employee at the VOC transported Veteran (b) (6) to the ED at the Medical Center for treatment of suicidal ideation on (b) (6).

Staff Support Systems

Based on the OMI interviews with staff at the Medical Center, it was obvious that some of the staff were clearly troubled by the number of Veteran suicides and in some instances took personal responsibility for failing to meet the psychological needs of their Veteran population. The staff members who were personally attacked in the local newspaper were very upset at what they perceived as professional character assassination. The issue of staff support was discussed in interviews with the Chief, BHS, and the Chief of Staff. Both of them indicated that they were acutely aware of the stress the negative press reports have had on the staff assigned to the BHS and are trying to ensure that there are support systems in place for staff to discuss their concerns. The Chief, BHS stated that one of the purposes of the BHS retreat that is being planned is to relieve some of the stress that the staff is experiencing.

Pain Management

Our review of medical records indicated that several of the Veterans who committed suicide had (b) (6) problems. Some were getting medications to help treat their (b) (6). It is difficult to assess how much their (b) (6) may have contributed to their suicides, but they might have benefitted from a referral to the Medical Center's (b) (6)

The (b) (6) consists of an interdisciplinary group of six members, one each from the disciplines of (b) (6) monthly meeting.

Considerations are given to the (b) (6) experienced by the Veteran, past treatment methods utilized, and the outcomes of these methods. The (b) (6) then answers the consult and makes recommendations as to what methods of treatment or medications to initiate for the (b) (6). The (b) (6) does not meet with the Veteran nor does it take over the management of (b) (6) care. Staff also indicated that patients who have complex (b) (6) issues can be referred to the VA Medical Center, Seattle, Washington; however, no patients have been referred from the Medical Center.

In addition to the (b) (6), the Medical Center provides a (b) (6) education class that conducts weekly 90-minute sessions for 6 weeks. Veterans are referred to this class by their treatment providers and are assessed for their suitability. The groups generally average six Veterans, but as they are educational and didactic in nature additional Veterans could be accommodated. The co-leaders are a psychologist and a substance abuse counselor, but various professionals also provide information about the treatment and effects of (b) (6). A different topic is presented each week such as (b) (6)

Medical Center and CBOC staff had various descriptions of the (b) (6) program and how it functions. There was varied understanding and knowledge of what was available to treatment providers in dealing with (b) (6) within the Veteran population.

Performance Improvement Activities

The Medical Center received full accreditation from their triennial Joint Commission survey in December 2007. Survey findings included a Recommendation for Improvement (RFI) identified during a patient tracer related to the management of a Veteran determined to have suicide ideation who was placed in seclusion in the ED. The surveyor cited several violations of restraint and seclusion guidelines related to behavioral health. The surveyor also noted that the psychiatrist did not consult with the ED staff about the physical and psychological status of the patient, nor did the psychiatrist provide the ED staff with guidance on ways to regain control of the situation so that the seclusion order could be discontinued. The facility has not had a Combined Assessment Program (CAP) review by the Office of the Inspector General since November 2005.

The Medical Center has a Patient Safety and Risk Management Program. The Risk Manager has only been in his position since October 2007, and has also been assigned to Infection Control Nurse duties. The facility has had 7 tort claims filed during FY 2008, none related to mental health services. In accordance with VHA Directive 2008-004, *Peer Review for Quality Management*, protected peer reviews are initiated on all completed suicides and suicide attempts within 30 days of an encounter. Peer reviews have been completed on the following cases under review: Veterans (b) (6) Peer reviews were not completed on Veterans (b) (6) because the patients had not had sufficient contacts with the facility to evaluate their care. Although Veteran (b) (6)

had been receiving care at the facility in the weeks prior to (b) (6) death, the Risk Manager did not have a record of a protected peer review being initiated following (b) (6) death in September 2007. A protected peer review has been initiated on Veteran (b) (6)

The Patient Safety Manager has been in his position since November 2007. He has completed the annual review of suicides and suicide attempts for the period of the 4th quarter/FY 2007 through the 3rd quarter/FY 2008, as required by the National Center for Patient Safety. There were 34 attempts and 9 completed suicides for the period under review. The suicide of Veteran (b) (6) is not included in the FY 2008 summary because it occurred in the 4th quarter of FY 2008. He stated that there had been seven attempts and one outpatient suicide reported during the previous FY 2007 review. He attributes the increase as being due, in part, to improvements in reporting as a result of the significant attention and oversight brought about by the recent VA suicide prevention initiatives. The Patient Safety Manager has initiated or completed root cause analyses (RCAs) on Veterans (b) (6). The Patient Safety Manager indicated the Medical Center did not conduct an RCA investigation on Veteran (b) (6) because the coroner attributed the death was due to (b) (6). RCAs were not initiated on the remaining cases because the Veterans had little or no contact with clinical staff at the Medical Center.

The most recent performance measure results for mental health quality indicators were reviewed. National performance guidelines were met during the most recent External Peer Review Program (EPRP) data extraction records review in July 2008. The results were as follows –

- MC6b Post-Traumatic Stress Disorder (PTSD) Screening with Primary Care- Post-Traumatic Stress Disorder (PC–PTSD) – Eligible patients are required to be screened annually using the standard four-question PC-PTSD Screen. Facility compliance score was 16/18 records or 89 percent
- MC6c Depression Screening with Patient Health Questionnaire (PHQ)-2 or PHQ-9 – Eligible patients are screened annually for depression using the standardized PHQ-2 depression screening instrument. The PHQ-9 depression screening instrument must be completed on the same day if the patient has a positive result on the PHQ-2. Facility compliance score was 24/27 records or 89 percent
- MC6a Screening for Alcohol Misuse with AUDIT-C – Eligible patients are screened annually with the three question AUDIT-C alcohol usage instrument. Facility compliance score was 33/35 records or 94 percent.

b. Summary of Suicide Cases

At the time of the site visit, the OMI knew of nine Veteran suicides that had taken place in FY 2008 (Veterans (b) (6) and one that had taken place in the last few days of FY 2007 (Veteran (b) (6)). Following the site visit, the OMI was asked to evaluate additional deaths of Veterans from Spokane County identified by death certificates issued by the State of Washington.

Veteran (b) (6)
Date of death – (b) (6)
Cause of death - (b) (6)

Veteran #1 was (b) (6) years old at the time of (b) (6) death. Born in (b) (6) joined (b) (6)

(b) (6) served (b) (6) and was honorably discharged with (b) (6) He is not listed as an OEF/OIF Veteran. He did not (b) (6) first contact with the BHS at the Medical Center was through (b) (6)

Veteran (b) (6) returned to the Spokane area in (b) (6) and resumed attendance at the (b) (6)

During (b) (6) Veteran (b) (6) reported that he would (b) (6)

Veteran (b) (6) resumed (b) (6) contact with the Medical Center in (b) (6). At that time,

(b)(6) & (b)(3)

Veteran (b)(6) & (b)(3) was next seen on (b)(6) & (b)(3)

Six months elapsed before Veteran (b)(6) & (b)(3) resumed contact with BHS in (b)(6) & (b)(3)

Veteran (b) (6) next and final contacts with staff at the Medical Center occurred on (b) (6). He came to the (b) (6) area in BHS accompanied by (b) (6). There is not a record of the (b) (6) having accompanied the Veteran to any of (b) (6) appointments previously. The clinic clerks noted that (b) (6) had to physically keep the Veteran in the area to complete the (b) (6) appointment.

Veteran (b) (6) was initially evaluated by a social worker assigned to the (b) (6). With (b) (6) permission, Veteran (b) (6) sat in during the interview and at times spoke for (b) (6) (b) (6) was (b) (6)

(b) (6) having to (b)(6) & (b)(3) she provided the Veteran with a business card with her name and telephone number as well as the contact information for the VA National Suicide Hotline.

Shortly after completing the interview with (b) (6). The psychiatrist entered "None" on the progress note template prompt for suicidal and/or homicidal. He was given a follow-up appointment for 2 weeks later on (b) (6).

Upon leaving the clinic, the Veteran (b) (6) stopped by the (b) (6) Clinic and left a note for (b) (6) PCP, a nurse practitioner, to contact (b) (6). Since (b) (6) provider was not on duty, a nurse in the clinic contacted the Veteran to make sure (b) (6) was okay. (b) (6) progress note was entered into the medical record at 4:15 pm. The PCP was interviewed by the OMI team and basically recalled the events as entered in the medical record. This was the last contact that Veteran (b) (6) had with Medical Center staff.

The psychiatrist was interviewed by the OMI staff regarding his contact with Veteran (b) (6)

The psychiatrist was clearly troubled by the fact that (b) (6) committed suicide shortly after being seen in clinic. He said that upon reconsidering his intervention with Veteran (b) (6) he (b) (6) to the session. He explained his decision to (b) (6) [redacted].

Shortly after (b) (6) conversation with (b) (6) PCP, Veteran (b) (6) [redacted]. The time of death is projected as being between (b) (6) [redacted]. (b) (6) body was discovered by (b) (6) [redacted]

The OMI team met with the (b) (6) of Veteran (b) (6) [redacted]. The OMI team first expressed condolences on behalf of the agency for (b) (6) loss. The team explained the purpose of our investigation and indicated that they wanted to give (b) (6) an opportunity to raise any patient care concerns that (b) (6) felt should be considered as part of this review. Veteran (b) (6) [redacted] and spoke to the OMI by telephone. The (b) (6) stated that her (b) (6) [redacted]

Veteran (b) (6) was accompanied by (b) (6) [redacted] The OMI team explained the investigation was ongoing and that patient privacy laws prevented disclosure of that information to (b) (6) [redacted] also expressed frustration with the difficulties they encountered in obtaining a copy of (b) (6) medical records; they eventually obtained an unredacted copy (b) (6) [redacted]

Veteran (b) (6)
Date of Death - (b) (6)

Cause of death - (b) (6)

Veteran (b) (6) was a (b) (6) -year-old (b) (6) Veteran who had enlisted in (b) (6)

Veteran (b) (6) lived in (b) (6) . (b) (6)

Veteran (b) (6) began treatment at the Medical Center in (b) (6)

Veteran (b) (6) was regularly followed in the (b) (6)

Veteran (b) (6) was hospitalized on the (b) (6)

Veteran (b) (6) had subsequent contacts in the (b) (6)

On (b) (6), the day of Veteran (b) (6) s death, (b) (6)

Veteran # (b) (6)
Date of Death: (b) (6)
Cause of death - (b) (6)

Veteran (b) (6) was a (b) (6) year-old who had served in (b) (6)
An OEF/OIF Veteran, (b) (6) had been placed in (b) (6)

(6)

(b) (6)

Veteran (b) (6) was last evaluated at the Medical Center on (b) (6)

The results of the (b) (6) assessment conducted during this visit diagnosed Veteran (b) (6) as having (b) (6)

Although Veteran (b) (6) had stated he was receiving (b) (6) services in the community, (b) (6) was given a follow-up appointment for (b) (6) Clinic on (b) (6)

Veteran (b) (6) did not return to the VA, but he had some limited contact with the (b) (6)

(b) (6)

On (b) (6), the OEF/OIF Transition Coordinator received a call from the (b) (6), reporting that Veteran(b) (6) had committed suicide on (b) (6). They were requesting counseling assistance for (b) (6) and were referred to the VOC in Spokane. The OEF/OIF Transition Patient Advocate then notified the Medical Center's SPC and Patient Safety Manager of this event.

The OMI team met with the physician assistant who had evaluated Veteran(b) (6) on the(b) (6) visit. (b) (6).

Veteran(b) (6)
Date of Death: (b) (6)
Cause of death - (b) (6)

Veteran(b) (6) was a 54-year-old Vietnam-era Veteran who served in (b) (6) (b)(6) & (b)(3) There was no other contact documented in the medical records until(b)(6) & (b)(3).

Veteran(b)(6) & (b)(3) presented to the Medical Center on (b)(6) & (b)(3).

Veteran(b)(6) & (b)(3) attended the (b)(6) & (b)(3)

A follow-up call on (b)(6) & (b)(3), as a result of (b)(6) & (b)(3), revealed that the

Veteran (b)(6) & (b)(3) committed suicide by (b) (6) Medical Center staff verified with the Spokane County Sheriff's Department that Veteran (b) (6) had (b) (6) .

OMI staff spoke with the (b)(6) & (b)(3)

Veteran (b) (6)
Date of death: (b) (6)
Cause of death - (b) (6)

An OEF/OIF Veteran who committed suicide shortly after (b) (6) , Veteran (b) (6) was on active duty (b) (6)

Veteran (b) (6) was first seen at the Medical Center on (b) (6)

Veteran (b) (6) s next contact with the Medical Center was when (b) (6)

(b) (6)

Veteran (b) (6) was given an (b) (6)

The psychiatrist who treated Veteran (b) (6)

Veteran (b) (6) obtained follow-up care at the Medical Center throughout (b) (6)

Veteran (b) (6) s last contact with the Medical Center was for a (b) (6)

(b) (6)

Veteran (b) (6) called to (b) (6)

The OMI team conducted a telephone interview with the (b) (6)

(b) (6)

The Medical Center has conducted an individual RCA on the case.

Veteran (b) (6)
Date of death – (b) (6)
Cause of death - (b) (6)

Veteran (b) (6) was a (b) (6) year-old Persian Gulf War Veteran. (b) (6)

(b) (6)

(b) (6) initial contacts with the Medical Center were for (b) (6)

On (b) (6), Veteran (b) (6) was seen for the (b) (6)

Veteran (b) (6) returned (b) (6)

(b) (6)

On (b) (6) staff received a phone call from Veteran (b) (6)

(b) (6)

The OMI team interviewed the (b) (6) as part of the investigation. (b) (6)

Veteran (b) (6)
Date of Death – (b) (6)
Cause of death - (b) (6)

Veteran (b) (6) was a (b) (6) year-old (b) (6), Persian Gulf War Veteran who lived (b) (6)

Her initial appointment with (b) (6) at the Medical Center was on (b) (6). (b) (6)

Veteran (b) (6) was (b) (6) percent service connection for these conditions with (b) (6) percent being for (b) (6)

(b) (6)

Veteran (b) (6)

Veteran (b) (6) last visit to the Medical Center was (b) (6)

Medical records indicate that Veteran (b) (6)

On (b) (6), Veteran (b) (6) was admitted to (b) (6)

When Veteran (b) (6) was discharged by (b) (6)

Veteran (b) (6)
Date of suicide – (b) (6)
Cause of death - (b) (6)

Veteran (b) (6) a (b) (6)-year-old (b) (6) Persian Gulf War Veteran who had minimal contact with the Medical Center. (b) (6)

The next medical record entry is on (b) (6)

Veteran (b) (6)
Date of suicide: (b) (6)
Cause of death - (b) (6)

Veteran (b) (6) was a (b) (6) year-old (b) (6)

Veteran (b) (6) initiated (b) (6) care at the Medical Center on (b) (6)

(b) (6).

There was a break in treatment at the Medical Center from (b) (6) (b) (6).

On (b) (6), Veteran (b) (6) presented to the (b) (6).

Veteran (b) (6) continued treatment in the clinic 1 to 3 times monthly until (b) (6)

From (b) (6), Veteran (b) (6) was treated by a (b) (6)

In (b) (6), Veteran (b) (6) had (b) (6)

(b) (6).

In (b) (6), Veteran (b) (6)

On (b) (6), Veteran (b) (6)s case manager received a telephone call from (b) (6)

(b) (6).

Medical Center staff attempted to obtain records from the city's Crisis Line of Veteran (b) (6)

Veteran (b) (6)
Date of death – (b) (6)
Cause of death - (b) (6)

Veteran (b) (6) was a (b) (6) -year old, Vietnam-era Army Veteran, (b) (6)

Veteran (b) (6) was first seen in the (b) (6)

On (b) (6), Veteran (b) (6)

Three days later on (b) (6), Veteran (b) (6) was brought into the (b) (6) After evaluation, he was admitted to the (b)(6) & (b)(3).

Veteran (b)(6) & (b)(3) was a no-show for (b)(6) & (b)(3)

(b)(6) & (b)(3)

On (b)(6) & (b)(3), during a routine quarterly review on the continuity of participation for Veterans who had entered the (b)(6) & (b)(3)

The death of Veteran (b) (6) was not known to staff at the facility when the OMI team was conducting the on-site investigation. For this reason, none of the staff involved in the care of Veteran (b) (6) were interviewed by the OMI team.

In (b) (6) VA officials contacted the Spokane County Medical Examiner's office to obtain a list of individuals who had committed suicide since October 1, 2007. The list was cross-referenced to VA files and the following Veterans were found to be on the list. Veterans (b) (6) where known to the Medical Center; Veterans (b) (6) were in the VA data base but had not been seen at the Medical Center; Veterans 19-22 were not in the VA data base.

Following the site visit, the OMI was asked to evaluate additional deaths of Veterans from Spokane County identified by death certificates issued by the State of Washington. From the list of all suicides in Spokane County in FY 2008 to date, the Medical Center identified the following eight patients as Veterans.

Veteran (b) (6)
Date of Death: (b) (6)
Cause of death - (b) (6)

Veteran (b) (6) was (b) (6) years old at the time of (b) (6) death. (b) (6) had served during the (b) (6) and was a (b) (6).

Veteran (b) (6) began receiving health care at the Medical Center in (b) (6); it is unknown where he received medical care prior to that time. After enrolling at the Spokane VAMC, he was regularly followed as an outpatient in the primary care (medicine) clinic. In (b) (6)

(b) (6)

(b) (6)

Veteran(b) (6) may have had (b) (6)

(b) (6) last visit at the Medical Center was (b) (6)

The Veteran's date of death is reported as (b) (6), at (b) (6) The death certificate issued by the State of Washington lists the cause of death as (b) (6) and the manner of death as suicide.

Veteran(b) (6)
Date of Death: (b) (6)
Cause of death - (b) (6)

(b) (6) was a (b) (6) who was(b) (6) years old at the time of(b) (6) death. There is no record of(b) (6) receiving any medical care at the Spokane VAMC. The Veteran's date of death is reported as (b) (6), at (b) (6). The death certificate issued by the State of Washington lists the cause of death as (b) (6) and the manner of death as suicide.

Veteran(b) (6)
Date of Death: (b) (6)
Cause of death - (b) (6)

Veteran (b) (6) was an(b) (6)-year-old (b) (6) Veteran who had served (b) (6)

(b) (6)

(b) (6)

(b) (6)

(b) (6)

(b) (6)

(b) (6)

Veteran (b) (6) last outpatient visit to the Medical Center was on (b) (6)

Medical Center staff became aware of Veteran (b) (6) death when a call was placed to (b) (6) The death certificate issued by the State of Washington lists the cause of death as (b) (6) and the manner of death as suicide. The Veteran's date of death is reported as (b) (6).

Veteran (b) (6)
Date of Death: (b) (6)
Method of Death: (b) (6)

Veteran (b) (6) was a (b) (6) Veteran who was (b) (6) years old at the time of his death. There is no record that he received any health care services from the Spokane VAMC. The Veteran's date of death is reported as (b) (6) The death certificate issued by the State of Washington lists the cause of death as (b) (6) and the manner of death as suicide.

Veteran (b) (6)
Date of Death: (b) (6)
Cause of death - (b) (6)

Veteran (b) (6) was a (b) (6) year old who had served in the (b) (6)

(b) (6)

(b) (6)

Following (b) (6) discharge, (b) (6)

(b) (6)

Over the course of the next 3 years, (b) (6)

(b) (6)

(b) (6) last visit to the BHS was on (b) (6)

(b) (6) next scheduled appointment was (b) (6). The final entry in (b) (6) medical record is (b) (6)

The Veteran's date of death is reported as (b) (6), at a local address in Spokane County. The death certificate issued by the State of Washington lists the cause of death as (b) (6) and the manner of death as suicide.

Veteran (b) (6)
Date of death – (b) (6)
Cause of death - (b) (6)

Veteran (b) (6) was a (b) (6) year-old non-service connected Veteran, (b) (6)

(b) (6) initial contact with the medical center was (b) (6)

(b) (6)

(b) (6)

(b) (6)

(b) (6)

(b) (6)

(b) (6)

The death certificate issued by the State of Washington lists the cause of death as (b) (6) and the manner of death as suicide. The Veteran's date of death is reported as (b) (6) in Spokane County.

Veteran (b) (6)
Date of Death – (b) (6)
Cause of death – (b) (6)

Veteran (b) (6) was an (b) (6)-year–old non service connected, (b) (6) Veteran. (b) (6)

(b) (6)

(b) (6)

(b) (6)

(b) (6)

(b) (6)

(b) (6)

The Veteran's date of death is reported as (b) (6). The death certificate issued by the State of Washington lists the cause of death as (b) (6)

Veteran (b) (6)
Date of death – (b) (6)
Cause of death – (b) (6)

Veteran (b) (6) was a (b) (6) year-old (b) (6) Veteran, 0 percent service connected. He first initiated care with the Medical Center in (b) (6)

(b)(6) & (b)(3)

.

(b) (6)

.

(b) (6)

(b) (6)

(b) (6)

The last entry in Veteran (b) (6)'s medical record is a (b) (6)

The Veteran's date of death is reported as (b) (6), at (b) (6) in Spokane County. The death certificate issued by the State of Washington lists the cause of death as (b) (6) and the manner of death as suicide.

From the list of all suicides in Spokane County in FY 2008 to date, the following four individuals were identified as Veterans by the Seattle Regional Office and the National Cemetery Administration. There is no record that they were enrolled or had any contact with the Medical Center.

Veteran #19
Date of Death – January 18, 2008
Cause of death - unknown

There is no evidence the Veteran was ever enrolled at the Medical Center. There is no information available on the medical or psychiatric history. The OMI has no information as to how the Veteran died.

Veteran #20
Date of Death – July 4, 2008
Cause of death - unknown

There is no evidence the Veteran was ever enrolled at the Medical Center. There is no information available on the medical or psychiatric history. The OMI has no information as to how the Veteran died.

Veteran #21
Date of Death – June 14, 2008
Cause of death - unknown

There is no evidence the Veteran was ever enrolled at the Medical Center. There is no

information available on the medical or psychiatric history. The OMI has no information as to how the Veteran died.

Veteran #22
Date of Death – November 11, 2007
Cause of death - unknown

There is no evidence the Veteran was ever enrolled at the Medical Center. There is no information available on the medical or psychiatric history. The OMI has no information as to how the Veteran died.

c. Medical Center Suicide Rate

As mentioned on page 8 above, the Medical Center reported to the National Center for Patient Safety (NCPS) that there were 34 attempts and nine completed suicides for the 12-month period from July 2007 through June 2008 (4th quarter FY 2007 through the 3rd quarter FY 2008). Using information from the Medical Center and the review of death certificates provided by Spokane County, the OMI found 15 completed suicides for this same period of Veterans who received at least some of their care at the Medical Center. On review of the death certificates from the Spokane County Medical Examiner, the Patient Safety Manager stated that he later provided updated information on the additional suicides to NCPS.

The Medical Center has approximately 25,000 unique users. Suicides rates are generally reported per 100,000 per year; therefore the number of suicides would have to be multiplied by four to determine the rate per 100,000. Given the data above, the suicide rate for this 12 month period would be (15 x 4) 60 per 100,000.[6]

The additional suicides over those the Medical Center reported to the National Center for Patient Safety came from a review of the death certificates supplied by the Spokane County Medical Examiner. It is probable that even additional suicides would have been found if the query for death certificates had been expanded to all other counties in the Medical Center's catchment area.

VI. Conclusions

1. The Medical Center could improve its patient care by:

    a. Better utilization of the option of inpatient psychiatric admission. ED staff stated that it is sometimes difficult to admit patients on weekends and off-tours.

    b. Many BHS policies are not formally written; processes and procedures are verbally communicated among staff thereby increasing the probability of

[6] It was reported to the OMI by Patient Care Services that the suicide rate for users of the Medical Center for the years 2001 through 2005 was 52.5 per 100,000 per year.

inaccurate interpretation or lack of awareness.

c. Better understanding of the limitation of the patient contract for safety. In several cases, the Veteran denied suicidal ideation and entered into safety contracts only to subsequently commit suicide.

d. Understanding that the QPRT suicide risk-assessment tool alone is not effective in identifying patients at risk for suicide. The OMI is concerned that staff is relying on the score obtained from the QRPT and less on clinical assessment and judgment.

e. Improving awareness among treatment providers as to what services are available to help Veterans with chronic pain issues. The Pain Management Committee is under utilized as evidenced by approximately four consults each month.

2. The Medical Center could improve its use of the high-risk suicide list in the following areas:

   a. Many treatment providers are not aware of the list, thus limiting its use. Of the approximately 40 patients on the list at the time of the OMI site visit; almost all of them had been discharged from the inpatient unit. Outpatient providers rarely place patients on the high-risk list.

   b. Providers who see patients in the BHS clinic or ED need to be well acquainted with the purpose and availability of the high risk suicide list. Patients who present with past suicide attempts, current suicidal ideation or other high risk factors should be considered for inclusion on the list. Sixteen of 18 suicides reviewed by OMI were not on the list.

   c. The high-risk suicide list is not available to clerks or others who often get the telephone calls from patients cancelling their appointments, thus they are not able to identify patients that may need increased attention or follow up.

3. A current employee holds the copyright on the QPRT suicide risk-assessment screening tool used by the Medical Center.

4. Despite the fact that several staff members in key positions in Quality Management and BHS have been in their positions for less than 1 year, the Medical Center has complied with:

   a. VHA Directive 2008-004, *Peer Review for Quality Management*, in initiating protected peer reviews for the FY 2008 cases of completed suicides and suicide attempts within 30 days of an encounter.

b. VHA Handbook 1050.01, *National Patient Safety Improvement Handbook* in initiating RCA investigations for the suicide cases involving Veterans receiving care at the Medical Center.

c. VA-designated Patient Health Questionaire-2 (PHQ-2) and PHQ-9 depression screening tools.

d. Conducting TBI and PTSD screenings of OEF/OIF Veterans as required by VA policy. However, there is not a comprehensive OEF/OIF outreach program in place at this time which could make patients more aware of care that is available.

5. The Medical Center has taken positive initial steps to establish a partnership with the Spokane legal and behavioral health community to improve mental health services to Veterans. These efforts have the involvement and support of the State of Washington's Congressional and Senate staffs.

6. The number of suicides coupled with negative media attention has taken a toll on some of the BHS staff at the Medical Center.

7. The OMI notes the following about the cases examined during the site visit:

a. Veteran (b) (6) – The (b) (6) year old (b) (6) Veteran was seen by BHS professionals who conducted joint interviews with the Veteran and (b) (6). Staff should have attempted to interview the Veteran alone as a supplement to the joint interview. In addition, inpatient hospitalization should have been offered to the Veteran.

b. Veteran (b) (6) – This (b) (6) year old (b) (6) Veteran did not have a well-coordinated pain management plan to assist (b) (6) with (b) (6) intractable pain until a few days before (b) (6) death. Death by (b) (6) was possibly due to the Veteran's attempt to attain pain relief.

c. Veteran (b) (6) – The Medical Center did not have an opportunity to develop a BHS treatment plan for this (b) (6) year old (b) (6) Veteran of OEF/OIF. The Veteran only participated in (b) (6) initial primary care and (b) (6) examination.

d. Veteran (b) (6) – The treatment plan developed by the Medical Center to assist this (b) (6) year-old, (b) (6) Veteran in management of (b)(6) & (b)(3) was appropriate.

e. Veteran (b) (6) – Although this (b) (6) year-old OEF/OIF Veteran had been diagnosed with (b) (6) .

f. Veteran (b) (6) – This (b) (6)-year-old Persian Gulf War Veteran had minimal contact with the Medical Center and suicide assessments were completed. The referral to the (b) (6) program was appropriate. The completed suicide appears to be the result of an impulsive act.

g. Veteran (b) (6) – This (b) (6) year-old (b) (6) percent service connected Persian Gulf War Veteran was given a (b) (6)

h. Veteran (b) (6) – This (b) (6) year old Persian Gulf War Veteran had limited and sporadic contact with the Medical Center. His last contact with the Medical Center was 14 months prior to his suicide.

i. Veteran (b) (6) – This (b) (6) year-old (b) (6) Veteran was seen and treated on a regular basis for (b) (6). The Veteran had a history of (b) (6)

j. Veteran (b) (6) – This (b) (6)-year-old (b) (6) Veteran had a history of (b)(6) & (b)(3)

8. The OMI notes the following about the additional cases submitted for review. These cases were generated from a request to the Spokane County Medical Examiner, after the site visit, for a listing of all suicides during Fiscal Year 2008:

a. Veteran (b) (6) – (b) (6) Death certificate issued by the State of Washington lists the cause of death as (b) (6) and the manner of death as suicide.

b. Veteran (b) (6) – This (b) (6)-year-old Veteran did not receive medical care at the Spokane VAMC. Death certificate issued by the State of Washington lists the cause of death as (b) (6) and the manner of death as suicide.

c. Veteran (b) (6) – This (b) (6)-year-old Veteran expressed (b) (6). The death certificate issued by the State of Washington lists the cause of death as (b) (6)

(b) (6) and the manner of death as suicide.

d. Veteran (b) (6) – This (b) (6)-year-old Veteran did not receive medical care at the Spokane VAMC. Death certificate issued by the State of Washington lists the cause of death as (b) (6) and the manner of death as suicide.

e. Veteran (b) (6) – This (b) (6)-year-old (b) (6) Veteran received (b) (6) Death certificate issued by the State of Washington following his death in (b) (6), lists the cause of death as (b) (6) and the manner of death as suicide.

f. Veteran (b) (6) – This (b) (6)-year-old Veteran first presented at the Medical Center in (b) (6); however, the death certificate issued by the State of Washington lists the cause of death as (b) (6) and the manner of death as suicide.

g. Veteran (b) (6) – This (b) (6)-year-old Veteran was followed at the Medical Center for several years due to various medical problems. (b) (6) Death certificate issued by the State of Washington lists the cause of death as (b) (6). The manner of death was listed as suicide.

h. Veteran (b) (6) – The Veteran, who was (b) (6) years old, was followed at the Medical Center between (b) (6). (b) (6) Death certificate issued by the State of Washington lists the cause of death as (b) (6) and the manner of death as suicide.

i. Veterans #19, 20, 21, and 22 were on the list of individuals who had committed suicide provided to the Medical Center by the Spokane County Medical

Examiner. They were identified as Veterans but did not receive care at the Medical Center. The OMI did not review their death certificates.

9. The Medical Center reported to the NCPS that there were nine completed suicides for the 12-month period from July 2007 through June 2008 (4th quarter FY 2007 through the 3rd quarter FY 2008). Using information from the Medical Center and the review of death certificates provided by Spokane County, the OMI found 14 completed suicides for this same period of Veterans who received at least some of their care at the Medical Center. The methods and sources routinely being utilized by the Medical Center to identify Veterans who have committed suicide may be inadequate.

10. Eight of the 22 Veterans committing suicide were between the ages of 70 – 90, which was an unexpected incidental finding; several of them were not being treated at the Medical center.

VII. Recommendations

1. The Medical Center should peer review the care provided to Veteran #1 and appropriate actions should be taken based on the findings.

2. The Medical Center should further develop the OEF/OIF program in order to provide greater outreach to this high-risk group.

3. The Medical Center should formalize its BHS policies and procedures (e.g., follow up on missed BHS appointments, age specific mental health care, suicide assessment, use of the high-risk list, coordination of care among the Medical Center, CBOCs, and Veterans Outreach Center, management of chronic pain etc.). This should be followed by educating all BHS staff on the more formal program.

4. The Medical Center should ensure that BHS is in compliance with "Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version," which can be found at http://vaww.mentalhealth.va.gov

5. The Medical Center should conduct competency assessments to determine whether there are deficiencies in their staff's ability to use clinical skills to assess a patient's risk of suicide rather than total reliance on a suicide risk-assessment tool.

6. The Medical Center should complete recruitment and assignment of vacant positions identified on the BHS organizational chart.

7. The Medical Center should continue to meet on a routine basis with the mental health community focus group; develop a plan to implement relevant short- and long-term initiatives identified in the community focus meeting.

8. The Medical Center should ensure that staff support systems are in place to assist staff

in handling the negative publicity as well as any concerns they have associated with the suicide of Veterans assigned to their care.

9. The Medical Center should ensure that providers attempt to meet with mental health patients privately even when they are accompanied by a family member or significant other.

10. The Medical Center should assess the admission process, the availability of beds on the inpatient psychiatric unit, staffing, and communication systems with outpatient services to ensure patients have adequate access to inpatient care.

11. The Medical Center should ensure compliance with VHA Directive 2008-036, July 18, 2008, requiring that Patient Record Flags (PRF) be used to identify patients that are at high risk for suicide. The high-risk suicide list should be available to clerks and other staff who receive phone calls from patients cancelling their appointments so that the names can then be checked against the high-risk list and special efforts made to contact and reschedule these patients as soon as possible.

12. The Medical Center should educate all providers treating chronic pain as to the resources available, such as the Pain Management Committee and the Pain Education Classes and the ability to refer to another facility.

13. The Medical Center should adopt a suicide assessment screening tool that allows staff to complete a more comprehensive assessment of their observations. This tool should be consistently used by BHS staff.

14. The Medical Center should evaluate the appropriateness of using the QPRT suicide risk-assessment tool and obtain a legal opinion to ensure that there is not conflict of interest with the use of the tool.

15. VHA should consider, in order for its facilities to better identify all suicides, whether or not facilities should query state/county health departments for death certificates of those Veterans who committed suicide.

16. VHA should ensure that the elderly are regularly assessed for suicide potential. In addition, VHA may what to have the Geriatric Research Education Clinical Centers (GRECCs) address this issue on a national level.

17. VHA should examine the issue of suicide to determine the most effective way to assess patients for suicidal potential, e.g., clinical observation/judgment, assessment tools, etc.

18. VA and Department of Defense should determine under what circumstances or clinical situations patient safety should take priority over patient privacy, e.g. reservist being treated by VA who is in no physical/mental condition to deploy.

VIII. Acceptance Memorandum from the Under Secretary for Health

Department of Veterans Affairs

Memorandum

Date: FEB 04 2009

From: Under Secretary for Health (10)

Subj: Acceptance of Recommendations Contained in the Office of the Medical Inspector's Final Report: Quality of Care Review, Veterans Affairs Medical Center, Spokane, Washington (WebCIMS 420312)

To: Principal Deputy Under Secretary for Health (10A)
Deputy Under Secretary for Health for Operations and Management (10N)
Office of the Medical Inspector (10MI)

1. This memorandum is to advise your offices that the recommendations in the subject report are accepted as submitted.

2. My decision in this matter is based on the consideration of the observations and conclusions of the Office of the Medical Inspector.

3. Please work together to implement the recommendations found in the report.

Michael J. Kussman

Michael J. Kussman, MD, MS, MACP