Federal Health Matters

OIG Finds VA Suicide Prevention Efforts Adequate

The VA's Office of the Inspector General (OIG) reported on September 22 that the suicide prevention efforts of 24 VHA facilities "generally met the VHA requirements" issued in 2008—but that there was room for improvement at half of these facilities. It came to these conclusions after inspecting the facilities between January 1 and June 30, 2009, as part of Combined Assessment Program reviews. The OIG interviewed clinical staff at the facilities and looked at the medical records of 239 patients identified as being at high risk for suicide.

The OIG found that all of the facilities reviewed met VHA requirements to hire a full-time suicide prevention coordinator (SPC), identify and track patients at high risk for suicide, follow up on these patients when they missed mental health appointments, train staff members in suicide prevention, and provide monthly reports to the national SPC on attempted and completed suicides. It found that 96% of the facilities complied with VHA requirements to designate staff to manage programs in the absence of SPCs, follow up on patients referred by the National Suicide Hotline, provide suicide prevention training in the community, and report regularly to mental health leaders. In interviews with the OIG, 92% of the facilities' SPCs reported that they had adequate resources to do their jobs. Only two of the four large community-based outpatient clinics (CBOCs) affiliated with the reviewed facilities, however, fulfilled the VHA requirement to hire full-time SPCs.

In reviewing the patients' medical records, the OIG found that 95% contained the required patient record flags, which alert staff to a patient's high suicide risk. It found that 86% of the records included the required documentation of collaboration between mental health providers and the facility's SPC. And it found that 74% of the records included the required evidence that patients had safety plans to use during suicidal crises.

OIG inspectors made improvement recommendations, most of which involved medical record documentation, to half of the reviewed facilities. The report also included three recommendations for the VA acting under secretary for health, Gerald M. Cross, MD, to carry out in collaboration with VISN and facility senior managers: to ensure that (1) SPCs and mental health providers engage in documented collaborations, (2) mental health providers "develop comprehensive and timely safety plans," and (3) large CBOCs appoint full-time SPCs. Cross responded that a new patient flag template would document SPCs' collaborations with mental health providers and that SPCs' monthly reports to the national SPC would begin to include information on safety plan completion rates. He added that the VHA's Patient Care Services Office of Mental Health would ensure the hiring of SPCs at large CBOCs.

VHA Facilities Improve Colonoscope Reprocessing Compliance

VHA facilities made great strides between May and August in complying with the department's February 2009 directive on colonoscope reprocessing, according to a September 17 report by the VA's Office of the Inspector General (OIG). After inspecting 129 facilities in August, the OIG found that all had posted instructions on colonoscope reprocessing and all but one had documented staff competence with such reprocessing.

These findings came in contrast to those of a June OIG report, which estimated, based on May inspections at 42 VHA facilities, that fewer than half of all VHA facilities were in compliance with the directive. The September report included every VHA facility that was found to be noncompliant or was not included in the June report.

The September report said that only the White River Junction VA Medical Center in White River Junction, VT had failed to document staff competence in colonoscope reprocessing. Gerald M. Cross, MD, VA acting under secretary for health, responded that the facility's apparent noncompliance resulted from a typographical error that substituted the word "cystoscope" for "colonoscope." He added that the VHA's Office of Medical Surgical Services visited the facility on August 18 and confirmed that the staff was competent in colonoscope reprocessing. The OIG maintained, however, that the facility's documentation would have been incomplete regardless of the typo, as it lacked necessary details about the facility's colonoscopes.

The February directive on endoscope reprocessing and both OIG reports were prompted by findings in December 2008 and January 2009 that three VHA facilities had processed endoscopes improperly. Use of these endoscopes is believed to have exposed 10,617 patients to a minimal chance of infection.