United States Senate

WASHINGTON, DC 20510

October 3, 2024

The Honorable Denis McDonough
Secretary of Veterans Affairs
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Secretary McDonough,

Due to the tragic death of a veteran from suicide, we write to express our concern regarding recent revelations of the inadequate suicide prevention policies and practices at the Overton Brooks Veterans Affairs (VA) Medical Center in Shreveport, Louisiana.

A recent VA Office of Inspector General (OIG) report[1] details systemic noncompliance by the Overton Brooks VA Medical Center staff to adhere to suicide prevention policies under the Veterans Health Administration (VHA) Suicide Prevention Program. Veterans are significantly more vulnerable to the risk of suicide compared to the general population, and these lapses underscore the urgent need for immediate reforms within the facility to protect our veterans.

The OIG report details several alarming deficiencies at the Overton Brooks VA Medical Center, including:

1. **Failures in Suicide Risk Screening and Assessment**: The report substantiates that clinical staff did not adequately screen or assess patients for suicide risk, as evidenced by the case of a patient who was not assessed for suicide risk during a Veterans Crisis Line (VCL) request response call. This oversight led to missed information that could have informed a timely and potentially life-saving intervention.

2. **Inadequate Documentation**: The report highlights a consistent failure to document suicide prevention activities in both Medora and the electronic health record (EHR). This lack of dual documentation impedes transparent communication among healthcare providers and undermines clinicians' ability to make informed veteran patient-care decisions.

3. **Insufficient Performance Oversight**: The OIG found that the suicide prevention program manager neither took the necessary corrective actions to address identified performance deficiencies nor required clinical case reviews to be completed. This failure

[1] "Noncompliance with Suicide Prevention Policies at the Overton Brooks VA Medical Center in Shreveport, Louisiana" (VA OIG 23-02898-195).

in oversight significantly increased the risk that patient needs were not adequately addressed. Further, by not holding the corresponding staff accountable, the program manager allowed such failures to persist at the facility.

4. **Inadequate Follow-up and Staffing**: In the case of another patient, the facility did not ensure that such patient received the mandated mental health follow-up after a high-risk suicide patient record flag (PRF) was placed. Additionally, the report identified insufficient staffing levels within the suicide prevention team, further compromising the ability to provide necessary care.

It is possible that the tragic loss of a Louisiana veteran could have been prevented if the appropriate suicide prevention policies had been followed. Furtherly, we are concerned that more instances may occur if prompt action is not taken to address these deficiencies. It is imperative that the Overton Brooks VA Medical Center take decisive action and implement the OIG's recommendations without delay.

We request that the leadership at this facility immediately implement the following actions:

1. **Proper Documentation:** Promptly ensure that the suicide prevention team is utilizing Medora and other VHA tools when assessing suicide risk in response to VCL call requests. The suicide prevention program manager must document clinical case reviews of VCL call requests and address deficits or deficiencies when needed.

2. **Timely Completion of Documentation:** Evaluation and screening must be documented in the EHR in a timely manner according to national guidelines, including each contact attempt with the patient made by staff members. Behavioral health autopsy program chart reviews must be completed in a timely manner. Outlining these guidelines provides accountability and increased safety measures for staff.

3. **Adequate Staffing:** Implement these recommendations promptly and hire more staff in vacant areas like Suicide Prevention as is strongly suggested by the OIG. Having an adequate number of staff available ensures that policies like one-to-one observation are being carried out per facility policy. Provide additional mental health appointments to those with flags on their records for high suicide risk to increase prevention and maintain a therapeutic milieu.

4. **Interdisciplinary Communication and Training:** It is essential that all members of a patient's team are trained on screening, assessment, and documentation protocols. Communication between the patient's treatment teams is vital, especially when removing or inactivating high risk flags in a patient's EHR.

5. **Continuous Monitoring of Staff:** It is imperative that we give our veterans and their families the highest quality of care possible. The OIG advises continuous monitoring of staff to ensure comprehension and compliance of the outlined protocols.

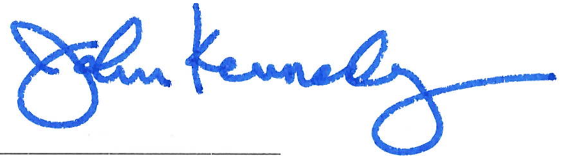
6. **Accountability:** It is essential that the responsible staff is held accountable under the furthest extent of both the law and of departmental policy, including termination and revoking physician licenses. It is unacceptable that noncompliance with existing practice on suicide prevention take place in a VA medical center.

The well-being of our veterans is a national priority, and it is our responsibility to ensure they receive the care and support they deserve through a medical system that was designed to help them. We urge you to take immediate and decisive action to rectify these failures and prevent further tragedies.

Thank you for your attention to this critical matter. We look forward to your prompt response and to working together to improve the care and safety of our veterans.

Sincerely,

Bill Cassidy, M.D.
United States Senator



John Kennedy
United States Senator