VA | U.S. Department of Veterans Affairs

Inspector General
Washington DC 20420

NOV 29 2016

The Honorable Joni Ernst
United States Senate
Washington, DC 20510

Dear Senator Ernst:

This is in response to your November 16, 2016 letter requesting that the VA Office of Inspector General (OIG) review the health care provided to Mr. Curtis Gearhart by the Veterans Health Administration (VHA) prior to his suicide in November 2016. We have been gathering information on this matter and have requested additional information from VA. We will assess all the information and determine our next steps based on our analysis of the matter. We expect this initial process could take up to two months. Upon completion of our review, we will make every effort to share whatever information we can in accordance with applicable law.

I would like to address other points made in your letter. Your letter references our June 2015 Healthcare Inspection, "Alleged Poor Mental Health Care Resulting in a Patient Death at VA Central Iowa Health Care System – Des Moines, Iowa." I would like to clarify that we did not conclude that the patient did not receive adequate mental health care from VHA. Our inspection did not substantiate that the "patient received poor access to care through the [Emergency Department]" or "that the patient received poor quality of care from [Emergency Department] staff who provided care to the patient in winter 2015..." However, we did substantiate that the facility's case management services were not in compliance with VHA policy. Our inspection made two recommendations, and VA provided information sufficient for the recommendations to be closed in late 2015. A copy of our report is enclosed for your consideration, and it can also be found at: https://www.va.gov/oig/pubs/VAOIG-15-02627-386.pdf.

Your letter also expresses concerns about VA's release of Mr. Gearhart's individually identifiable health information. We believe that VA's Office of General Counsel would be in a better position to explain VA's ability to release Mr. Gearhart's information to members of Congress. However, we note that individually identifiable health information created in the course of treatment at VHA is protected from disclosure not authorized by the privacy provisions enacted in the Health Insurance Portability and Accountability Act. We do not believe that Mr. Gearhart's alleged posting to social media would be considered authorization to release his protected health information or allow VHA to comment upon the information he allegedly posted.

Our mission is to serve veterans by conducting effective oversight over VA programs and operations. We do this, in part, by being independent of VA and making meaningful recommendations that drive economy, efficiency, and effectiveness through VA's programs and operations. However, as a consequence of our statutorily mandated independence, we cannot direct VA operations or mandate their specific policies.

I am also enclosing a copy of our recently released Semi Annual Report that details some of our work on this topic over the last six months. It can also be found at: https://www.va.gov/oig/pubs/sars/vaoig-sar-2016-2.pdf. Our work made numerous recommendations to help improve VA's health care system. We are firmly committed to working with all stakeholders to help improve VA's mental health care operations and to help in the treatment of mental illness nationally.

I would welcome the opportunity to meet with you and discuss this and other work being conducted by the OIG. Thank you for your interest in the OIG.

Sincerely,

MICHAEL J. MISSAL

Enclosures