TAMMY BALDWIN
WISCONSIN

COMMITTEES:
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LABOR, AND PENSIONS

# United States Senate

WASHINGTON, DC 20510

August 10, 2018

John J. Rohrer
Director
William S. Middleton Memorial Veterans Hospital
2500 Overlook Terrace
Madison, WI 53705

Dear Director Rohrer:

I have reviewed the healthcare inspection report I requested from the VA Office of Inspector General regarding the care of Wisconsin Marine Veteran, Robert Franks-Mess. The deficiencies highlighted by the Inspector General report regarding the discharge process and coordination of care for this Veteran are extremely concerning.

The Inspector General's report includes a series of recommendations and I am requesting an update from you each time one of these recommendations is completed. Further, I have a series of questions that I would like answered:

1. What changes were made to the facility's policies and procedures to coordinate with county monitoring agencies when court Settlement Agreement violations occur? Please share the updated policy and procedure.
2. What changes were made to the facility's policies and procedures to ensure Facility staff speaks directly with and notifies county monitoring agency staff prior to the discharge of an inpatient with a court Settlement Agreement? Please share the updated policy and procedure.
3. What changes were made to the facility's policies and procedures to include family notification with patient consent in mental health inpatient discharge? Please share the updated policy and procedure.
4. Outside of the mental health inpatient unit, what is the rest of the facility's policy concerning family notification with patient consent in discharge? Are the rest of the facility's policies consistent with VHA policy?
5. Please share the results of the ethics review regarding Mr. Franks-Mess' participation in the research study. Has the facility allowed any other Veterans under a Settlement Agreement to enter into a research study? If so, how many and does the facility intend to allow this practice to continue in the future?
6. Please list Mr. Franks-Mess' interactions with the facility, including what member of the mental health team interacted with the Patient at the time of that visit.
7. Explain what changes were made in the Behavioral Health Interdisciplinary Program Team to track collaboration and consultation regarding patient care and changes to their treatment plans. Please give examples of what this tracking or documentation now looks like in a Veteran's medical record.

8. Lastly, in conversations with the Veteran's family, they raised a very important question regarding the mental health services that the VA provides to help families supporting loved ones. For many families, this is the first time they are dealing with someone experiencing a mental health emergency and beginning their recovery process. When a veteran consents, what education does the VA provide to families about mental illness and treatment options available to help them assist their Veteran? Specifically, if a Veteran receives inpatient mental health treatment at the Madison VAMC and they consent to family involvement, what information and counseling does the family receive from the mental health team?

I appreciate your timely response to these questions and please keep me informed regarding the progress of the Inspector General recommendations. We must do more to address veteran suicides and I remain committed to working with you on solutions to what is a disturbing mental health crisis in America.

Sincerely,

Tammy Baldwin
United States Senator