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County of Los Angeles
CHIEF EXECUTIVE OFFICE
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(213) 974-1101
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FESIA A. DAVENPORT
Chief Executive Officer

August 3, 2021

To: Supervisor Hilda L. Solis, Chair
Supervisor Holly J. Mitchell
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

From: Fesia A. Davenport
Chief Executive Officer

REPORT BACK ON IMPLEMENTING THE LOS ANGELES COUNTY VETERAN SUICIDE REVIEW TEAM (ITEM NO. 3, AGENDA OF MAY 4, 2021)

On May 4, 2021, the Board of Supervisors (Board) adopted a motion to:

1. Adopt the Veteran Suicide Review Team (VSRT) Guiding Document, which includes recommendations on a "veteran" definition, VSRT purpose, objectives, goals, team composition, and case review criteria and process.

2. Designate the Department of Mental Health (DMH) as the administrative lead agency, to work in close partnership with the Department of Public Health's Office of Violence Prevention, Departments of Health Services, Medical Examiner-Coroner, Military and Veterans Affairs, and the United States Department of Veterans Affairs (VA) Desert Pacific Healthcare Network (VISN22), and other County of Los Angeles (County) and community partners, responsible for implementing the VSRT. This designation will begin as a pilot period of one year, with the option to extend based on the plans and timelines to reach implementation.

3. Direct DMH, in close coordination with the VSRT Working Group (WG) and other identified County departments and community stakeholders, to develop a VSRT implementation plan with timelines and report back to the Board at the end of calendar year 2021. The implementation plan should include:

a. Clear descriptions of roles and responsibilities of County departments and the VA VISN22, the development of VSRT protocols and guidelines, including confidentiality and data sharing protocols, and a data collection guide for reviewed and non-reviewed cases; and

b. Process for annual reporting to the Board and public with a comprehensive data set of County veterans who died by suicide, in order to better identify behaviors and trends. The annual report should include specific findings and recommendations.

4. Direct the Director of DMH to execute a Memorandum of Agreement between DMH and VISN22 to increase interagency collaboration and coordination in an effort to advance and improve the mental health and well-being of veterans in the County.

5. Given the delay in VSRT implementation, direct the CEO OCIO, in coordination with the VSRT WG, to explore conducting a data analysis of the identified veteran suicides from 2015-2019, using the County's Enterprise Information Hub and report back in 90 days with plans.

The attached report addresses the fifth directive to date and summarizes the actions undertaken by OCIO, as well as plans to conduct the requested data analysis.

OCIO has conferred with the VSRT WG to gather requirements for this analysis and plans to complete the initial analysis and present it to the WG in early November 2021. OCIO intends to incorporate the VSRT WG's feedback and report back its findings to the Board by December 10, 2021.

Should you have any questions concerning this matter, please contact me or Peter Loo, Acting Chief Information Officer, at (213) 253-5627 or ploo@cio.lacounty.gov.

FAD:JMN:TJM
PL:AP:pa

Attachment

c: Executive Office, Board of Supervisors
County Counsel

Attachment

Report Back on Implementing the Los Angeles County Veteran Suicide Review Team

Andrew Perry
Program Specialist III

July 2021

Chief Executive Office
COUNTY OF LOS ANGELES

On May 4, 2021, the Board of Supervisors (Board) adopted a motion to:

1. Adopt the Veteran Suicide Review Team (VSRT) Guiding Document, which includes recommendations on a "veteran" definition, VSRT purpose, objectives, goals, team composition, and case review criteria and process.

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    a. Clear descriptions of roles and responsibilities of County departments and the VA VISN22, the development of VSRT protocols and guidelines, including confidentiality and data sharing protocols, and a data collection guide for reviewed and non-reviewed cases; and

    b. Process for annual reporting to the Board and public with a comprehensive data set of County veterans who died by suicide, in order to better identify behaviors and trends. The annual report should include specific findings and recommendations.

4. Direct the Director of DMH to execute a Memorandum of Agreement between DMH and VISN22 to increase interagency collaboration and coordination in an effort to advance and improve the mental health and well-being of veterans in the County.

5. Given the delay in VSRT implementation, direct the CEO OCIO, in coordination with the VSRT WG, to explore conducting a data analysis of the identified veteran suicides from 2015-2019, using the County's Enterprise Information Hub (InfoHub) and report back in 90 days with plans.

In response to the fifth directive, OCIO has conferred with the VSRT WG to gather requirements for the specified data analysis and has performed simple exploratory analysis to determine points of intersection between the identified veteran suicides and the InfoHub. Key takeaways of this process are as follows:

- Only a subset of the identified veteran suicides have records of service receipt in the InfoHub:
    - 30 percent have available service records in at least one InfoHub department other than the DMEC;
    - 15 percent have Sheriff's Department records;
    - 11 percent have DMH records; and
    - 10 percent have Department of Public Social Services records;
- Another 16 percent have InfoHub client records, but lack service records, meaning that they received County services at a time prior to the period covered by the InfoHub's data;
- The two factors of greatest interest to the VSRT WG are the methods and geographic locations of the suicides to be analyzed:
    - Understanding suicide methods can help VA staff and other service providers reduce access to lethal means and better plan intervention;
    - Geographic patterns can help target supportive services to the right area, as well as increase the cultural competence of outreach (if, for example, the decedents are, on average, younger in a particular service planning area [SPA] and older in another SPA, service and outreach planning can take that information into account); and
    - Geographic analysis could also reveal patterns over time if suicide locations have changed from year to year;
- Other demographic analyses are also desirable, again, to support culturally competent outreach and intervention, and to surface systemic inequities;
- In order for this analysis to be meaningful, it will be important to have something to compare it to; therefore, OCIO will conduct a similar analysis of nonveteran suicides from the same period; and
- Service data should be analyzed for the purpose of identifying opportunities for intervention:
    - What systems did the decedents touch most often?
    - What is the average time between last date of service and suicide?

- Relevant data resides both in the InfoHub and in VA data included in the matched file of identified suicides provided to OCIO.

Given the research questions of greatest interest to the VSRT WG, as well as the limited availability of relevant service data in the InfoHub, OCIO plans to conduct the following analysis:

1. Using the DMEC's data present in the InfoHub, OCIO will analyze suicide methods prevalent among three groups:

    a. Decedents in the matched VA data file who have been confirmed to be veterans;

    b. Decedents in the matched VA data file whose veteran status could not be confirmed; and

    c. Decedents from the same time period (2015 - 2019) who died by suicide and did not match available VA records.

2. OCIO will further analyze method of suicide by age, race, ethnicity, gender, and other available demographic categories, within and across the groups listed in 1), to see if useful patterns emerge.

3. OCIO will geocode the locations of suicide event and/or death within the DMEC's file and produce Geographic Information System maps and analysis to identify and visualize patterns, especially patterns that represent intersections between geographic data and the categories of analysis specified in 1) and 2).

4. Finally, OCIO will analyze County service history data for the groups listed in 1) and 2), as well as VA service information available for veteran suicides, to identify patterns that could inform intervention strategies to reduce veteran suicides in the future.

OCIO will begin this analysis in late August 2021, with the goal of presenting findings to the VSRT WG by early November 2021. OCIO will report these findings to the Board by December 10, 2021.

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

JONATHAN E. SHERIN, M.D., Ph.D.
Director

Gregory C. Polk, M.P.A.
Chief Deputy Director

Curley L. Bonds, M.D.
Chief Medical Officer

Lisa H. Wong, Psy.D.
Senior Deputy Director

February 7, 2022

TO: Supervisor Holly J. Mitchell, Chair
Supervisor Hilda L. Solis
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

FROM: Jonathan E. Sherin, M.D., Ph.D.
Director

SUBJECT: **REPORT RESPONSE - IMPLEMENTING THE LOS ANGELES COUNTY VETERAN SUICIDE REVIEW TEAM (ITEM 3, AGENDA OF MAY 4, 2021)**

On May 4, 2021, your Board approved a motion that adopted the Veteran Suicide Review Team (VSRT) Guiding Document, which includes recommendations on a "veteran" definition, VSRT purpose, objective, goals, team composition, and case review criteria and process, and designated the Department of Mental Health (DMH) as the administrative lead agency, to work in close partnership and collaboration with Department of Public Health Office of Violence Prevention (DPH-OVP), Department of Health Services (DHS), Department of the Medical Examiner-Coroner (DMEC), Los Angeles County Department of Military and Veteran Affairs (MVA), the Suicide Prevention Office at the United States Department of Veterans Affairs (VA) Veteran Integrated Services Networks (VISN 22), and other County and community partners responsible for implementing the VSRT. The motion also included the following Directives:

Directive 3: Direct DMH, working in close coordination with the VSRT workgroup and other identified County departments and community stakeholders, to develop a VSRT implementation plan with timelines that includes:

a. Clear descriptions of roles and responsibilities of County departments and the VA VISN 22, the development of VSRT protocols and guidelines, including confidentiality and data sharing protocols and a data collection guide for reviewed and non-reviewed cases.

b. The plan should also include a process for annual reporting to the Board and public with a comprehensive data set of County Veterans who died by suicide in order to better identify behaviors and trends. The annual report should include specific findings and recommendations.

Directive 4: Direct the Director of DMH to execute a Memorandum of Agreement between DMH and VISN 22 to increase interagency collaboration and coordination in an effort to advance and improve the mental health and wellbeing of veterans in Los Angeles County.

Directive 5: Given the delay in VSRT implementation, direct the Chief Executive Office-Chief Information Office's (CEO-CIO), in coordinate on with the VSRT Work Group (WG) to explore conducting a data analysis of the identified veteran suicides from 2015-2019, using the County's Enterprise Information Hub and report back in 90 days with plans.

The attached reports address Directives 3 and 4 (Attachment A), including the draft VSRT Charter (Attachment I), and a follow-up to (CEO-CIO) August 3, 2021, report, submitted in response to Directive 5, to explore conducting a data analysis of the identified veteran suicides from 2015-2019, using the County's Enterprise Information Hub (Attachment II), which provides an extensive analysis on all identified Veteran suicide decedents from 2015-2019 in Los Angeles County.

If you have any questions or require additional information, please contact me or staff can contact LaTina Jackson, Deputy Director Countywide Resources, at email ljackson@dmh.lacounty.gov.

JES:GCP:LJ:jv

Attachments

c: Executive Office, Board of Supervisors
Chief Executive Office
Chief Information Office
County Counsel
Department of Public Health
Department of Health Services
Department of the Medical Examiner-Coroner
Department of Military and Veteran Affairs
U.S. Department of Veterans Affairs

Attachment A

County of Los Angeles

Department of Mental Health

Report Response on Implementing the Los Angeles County Veteran Suicide Review Team

Jonathan E. Sherin, M.D., Ph.D.
Director
Department of Mental Health

Report Response on Implementing the Los Angeles County Veteran Suicide Review Team

On May 4, 2021, the Board of Supervisors (Board) adopted the Veteran Suicide Review Team (VSRT) guiding document that enabled a coordinated response to reducing veteran suicides (Directive 1). Furthermore, the Board designated the Department of Mental Health (DMH) as the lead agency, to work in close partnership and collaboration with Department of Public Health Office of Violence Prevention (DPH-OVP), Department of Health Services (DHS), Department of the Medical Examiner-Coroner (DMEC), LA County Department of Military and Veteran Affairs (MVA), the Suicide Prevention Office at the U.S. Department of Veterans Affairs (VA) Veteran Integrated Services Networks (VISN 22) and other County and community partners (Directive 2), including Special Advisors who have extensive knowledge of areas of interest related to understanding circumstances behind Veteran suicide to implement the VSRT. The motion also directed the Director of DMH to:

- Work in collaboration with the VSRT workgroup and other identified County departments and community stakeholders to develop a VSRT implementation plan with timelines that includes:
    - Clear descriptions of roles and responsibilities of County departments and the VA VISN 22, the development of VSRT protocols and guidelines, including confidentiality and data sharing protocols and a data collection guide for reviewed and non-reviewed cases;
    - The plan should also include a process for annual reporting to the Board and Public with a comprehensive data set of County Veterans who died by suicide in order to better identify behaviors and trends. The annual report should include specific findings and recommendations (Directive 3);
- Execute a Memorandum of Agreement (MOU) between DMH and VISN 22 to increase interagency collaboration and coordination in an effort to advance and improve the mental health and wellbeing of veterans in Los Angeles County (Directive 4); and
- Direct the CEO-CIO, in coordination with the VSRT WG, to explore conducting a data analysis of the identified veteran suicides from 2015-2019, using the County's Enterprise Information Hub and report back in 90 days with plans (Directive 5).

Directive 1: Adopt the VSRT Guiding Document

The Los Angeles County VSRT will identify, report, and make recommendations to minimize risk for suicidal behavior for veterans and increase protective supports including help-seeking behaviors for veterans and their families at the systems, policy and practice change level. The VSRT working group adopted the VSRT Guiding Document, as

instructed by the Board, that included the definition of a "veteran," VSRT purpose, objectives, goals, team composition, and case review criteria and process to create a charter (Attachment 1).

Directives 2 and 3: Designate DMH as the Administrative Lead Agency and Develop the VSRT Implementation Plan and Timeline

DMH, working in close coordination with the VSRT planning co-chairs (DPH-OVP and VA), identified and convened County departments including DHS, DMVA, and DMEC along with community stakeholders to participate in three focused workgroups – (Roles and Responsibilities; Structures and Protocols; and Data and Confidentiality), to develop a VSRT implementation plan. The VSRT working group met bi-weekly to review progress, review existing best practices, and develop the charter (Attachment I).

As directed by the Board, the Department of Medical Examiner-Coroner (DMEC) is formalizing a process to match DMEC case information to Veteran Health Administration (VHA) and Department of Defense (DoD) electronic medical records to verify veteran deaths by suicide. Through newly established data sharing agreements with the Suicide Prevention Office at the Greater Los Angeles VA and the VA VISN 22, the VA will identify veteran status for all suicide decedents in Los Angeles County. Data will be shared between partners using a secure MFT site managed by DPH's IT program. VA VISN 22 will provide the final list of veteran suicide decedents on the data sharing site. LA County Chief Information Office (CIO) will use this information to cross-reference with County data. This will allow all partners (MEC, CIO, VA, and DPH-OVP) to access the data files when needed. This data will be compiled into annual reports highlighting trends, findings and recommendations for ongoing surveillance of veteran suicide rates, prevention and intervention activities. VA and LA County can explore data sharing agreements with CalVet if additional veteran status verification is required.

Additionally, the Board requested that all data sharing agreements include a connection with the LA County Violent Death Reporting System (LAC-VDRS). DMEC is working with the Department of Public Health (DPH) and County Counsel to amend an existing MOU to ensure veteran status data is included. To ensure consistency with State data collection practices and reporting, and in response to the Board directive, veteran status is defined as any individual who has known service in the United States Armed Forces, regardless of their active/reserve duty status, the duration of their service, or the nature of separation or discharge.

In order to implement the VSRT, DMEC will also be incorporated as a co-chair. DMH, DPH-OVP, VISN 22, and DMEC will convene VSRT members monthly to begin the mortality review process for all veteran suicide decedents starting June 2022.

The attached VSRT Charter draft (Attachment I) outlines the VSRT Pilot Implementation Plan, including clear descriptions of roles and responsibilities of County departments and the three VA Medical Facilities in VISN 22: West LA, Long Beach, and Loma Linda (VA),

the development of VSRT protocols and guidelines, including confidentiality and data sharing protocols. The plan also includes a data collection guide for reviewed and non-reviewed cases, and a process for annual reporting to the Board and the public with a comprehensive data set on County veterans who died by suicide, in order to better identify behaviors and trends.

Directive 4: Execute a Memorandum of Agreement (MOU) between DMH and VISN 22

DMH executed an MOU (Attachment III) with the VISN 22 of the Veterans Administration on July 20, 2021, as instructed by the Board.

Next Steps

Following review by County Counsel, VSRT co-chairs will finalize the charter. Once approved, DMH and other VSRT co-chairs will hold the first review meeting in March 2022, commencing the one-year pilot. DMH will work with the other co-chairs to produce an interim report for the Board 6 months post pilot implementation, and final report at the conclusion of pilot period.

Attachment I

Veteran Suicide Review Team (VSRT) Charter

PURPOSE

The Veterans Suicide Review Team (VSRT) evaluates the circumstances leading to and surrounding the suicide deaths of veterans who died in Los Angeles County in order to develop and enhance system-level intervention and prevention measures to prevent suicide among veterans.

Suicide is a public health crisis that affects every Los Angeles County resident, especially the veteran community. Los Angeles has one of the highest number of veterans of any county in the country. Reducing suicide rates is possible and most effectively done when informed by data that is analyzed to inform practices and policy.

The veteran suicide review process will assist us in better understanding veteran suicide deaths in Los Angeles County and therefore help us in our prevention, intervention, and postvention strategies. Los Angeles County intends to build from this model developed for veterans to eventually scale to all residents of Los Angeles County.

MISSION

The mission of the VSRT is to utilize data and information gathered in the review process, and to identify themes or patterns, which can impact and inform policy change and programming throughout the Los Angeles County to reduce suicide rates of veterans.

VSRT VETERAN DEFINITION

The U.S. Department of Veterans Affairs (VA) considers a person who served in the active military service and who was discharged or released under conditions other than dishonorable as a veteran. Current and former members of the Reserves and/or National Guard who were called to active duty by a federal order and have completed the full period of duty may be eligible for VA health benefits. If their active duty was only for training purposes, they do not meet the basic eligibility for VA benefits.

Los Angeles County agencies serve veterans who are eligible or ineligible for VA benefits. In many cases, the veteran status of County service recipients is only self-reported. For the purposes of the VSRT, to ensure consistency with State data collection practices and reporting, and to be as inclusive as possible, Veteran status is identified broadly based on the answer to the following question, "Was the decedent ever in the United States Armed Forces?" This definition does not distinguish between a Veteran's active/reserve duty status, the duration of their service, nor the nature of their separation or discharge

VSRT GOALS AND OBJECTIVES

Goals	Objectives
• Reduce the number of suicides among veterans in Los Angeles County. • Increase efficiency in targeted outreach to drive effective use of resources. • Create and demonstrate collaboration across government, non-profit, and philanthropic sectors. • Enhance suicide prevention, intervention, and postvention efforts in Los Angeles County • Develop a coordinated response to veteran suicide that addresses systemic concerns • Provide recommendations for intervention and prevention efforts to minimize risk suicidal behavior among veterans • Explore opportunities to expand resources allocated to prevent suicide through data driven recommendations.	• Identify specific barriers, gaps and opportunities for systems engaging veterans at risk for suicide • Identify risk factors and trends in suicide deaths for future prevention/intervention efforts • Increase the enhancement of potential protective factors against suicide, at the individual, family, community and societal levels • Develop strategies for increased communication and coordination of delivery of services to survivors of suicide loss

VSRT MEMBER ROLES AND RESPONSIBILITIES

The VSRT Co-Chair Team will be comprised of representatives from the following departments and organizations:

- LAC Department of Mental Health
- LAC Department of Public Health - Office of Violence Prevention
- Veterans Administration VISN 22
- LAC Department of the Medical Examiner and Coroner Office

Co-Chair Responsibilities

- VA and DPH-OVP will coordinate directly with DMEC to receive data on suicide decedents in LA County.
- VA will coordinate with CalVets to identify which suicide decedents were veterans.
- The VA will contact the legal next of kin of veteran suicide decedents to obtain releases of information to review the deaths.
- From the pool of cases with a release of information, the Co-Chairs will then identify the cases to be reviewed and reach out to Team members for additional information.
- Calendar of cases will be determined based on data and reports obtained.
- Representative from the DMEC's Office will provide the medical information and designated co-chairs will facilitate the discussion.

- Special Advisors provide additional case information, as needed/if available and invited by the co-chairs.
- DPH-OVP will collect the case review data from each meeting.
- Co-chairs will retain all appropriate records in accordance with HIPAA.
- VA will send a thank you note to the next of kin after the review is complete.
- DMH will assist in keeping all paperwork for the VSRT up to date and will take lead with annual report.
- VA and DPH-OVP will provide data and analysis to DMH in support of the annual report.
- DMH will provide agendas to the team, schedule team meetings, take minutes, and distribute.
- DMH, with assistance from the VSRT Co-Chairs, will submit an annual report to the Los Angeles County Board of Supervisors with VSRT findings and recommendations.

The VSRT Core Team will be comprised of representatives from the following departments and organizations:

- Didi Hirsch
- U.S. Vets
- Los Angeles Suicide Prevention Network
- Los Angeles City Area Agency of Aging
- California Department of Veterans Affairs (CalVet)
- Long Beach Veterans Affairs Medical Center
- Loma Linda Veterans Affairs Medical Center
- Greater Los Angeles Veterans Affairs Medical Center
- Los Angeles County Department of Health Services
- Los Angeles County Department of Military and Veterans Affairs
- Los Angeles County Sheriff's Department
- Los Angeles County Department of Human Resources
- Los Angeles County Department of Children and Family Services
- Los Angeles County Fire Department
- Los Angeles County Chief Executive Office- Chief Information Office
- Los Angeles County Public Defender's Office
- Los Angeles Police Department
- Los Angeles County Department of Probation
- Los Angeles Homeless Services Authority
- Los Angeles County District Attorney (DA)

The VSRT Special Advisors will consist of individuals invited to VSRT case reviews based on their relevance/knowledge to a particular case.

Core Team and Special Advisor responsibilities

Participation:

- Core team members and special advisors will be required to read and sign LA Veterans Suicide Review Charter.
- Core team members and special advisors are expected to come to meetings prepared to share any relevant information regarding the fatalities to be reviewed.

- If the core team does not have any information to share, they are expected to participate in the discussion regarding risk factors, protective factors, and system recommendations from their various expert perspectives and given the information presented by others.

Meeting Frequency & Attendance:
Meetings will be re-occurring monthly, determined by the co-chairs. If a Core Team member is unable to attend a meeting, a substitute will be sent in their place. If a substitute is unable to attend, prior to the meeting, the member should forward all available information about each fatality to be reviewed to the co-chairs. If no information is available, the member should inform the co-chairs.

VSRT STRUCTURE AND PROTOCOLS

Confidentiality/Next of Kin:
Out of respect for the deceased, their families, friends, and colleagues from the workplace, the VSRT will conduct its work to increase understanding that can be channeled into improved education and prevention programs while maintaining the highest degree of professionalism which includes the application of strict standards of confidentiality while still encouraging important collaboration that is necessary to meet the objectives of the VSRT.

At the beginning of their service on the VSRT and each year thereafter, all members will sign and submit to the co-chairs, a confidentiality agreement, which will be kept on file by DMH. Special Advisors will sign and submit to the co-chairs a confidentiality agreement, which will provide consent to verbally share information during the review.

In order to assure a coordinated response that fully addresses systemic concerns surrounding deaths due to suicide, all relevant data should be shared and reviewed by the committee, as permitted by law, including historical information concerning the deceased individual, his/her/their family, medical records, and the circumstances surrounding the death. Much of this information is protected from public disclosure by law.

Releases of Information:
Release of Information will be obtained from the authorized representative of the deceased prior to any review to allow for members of the committee to share information. The Veterans Administration will request the legal next of kin sign a release of information so HIPAA protected information may be shared with and within the group. Information regarding the process will be provided to the legal next of kin. The team will only review those cases in which a release of information has been signed by the legal next of kin.

Use of the information covered in the Release of Information is limited to the fatality review process. This process is confidential. In no case will any team member disclose any information regarding team discussion outside of the meeting other than pursuant to the mandated agency responsibilities of the individual. Requests for any information outside of the designated team meetings will be referred to the co-chairs.

Members will receive basic information regarding the deceased prior to the meetings for information gathering purposes. If any physical documents are shared during the case review , they will be returned by attendees , at the end of the meeting along with any notes or other materials produced as a result of the death review to be shredded.

Records:
Core team and special advisors are expected to bring reports they have received from the co-chairs to the meeting or mail the reports back to co-chairs in a timely manner if they are unable to attend. Core team and special advisors are expected to keep these records confidential while they are in their possession in accordance with the confidentiality agreement.

Co-chairs will request additional information on particular cases from the core team and special advisors; each chair will be responsible for contacting the identified systems. The co-chair with the most appropriate connection will contact the Special Advisor and other ancillary partners.

MEETING STRUCTURE

Co-Chairs will establish both in-person and virtual/hybrid protocols for the VSRT meetings. Confidentiality Agreements will be created for in-person and virtual meetings. Trauma informed processes will be in place during in person, virtual or hybrid meetings.

County Counsel, Privacy Officers, and Chief Information Officers will inform how data and information is collected, shared, and handled after review. Specific instructions will be provided to each VSRT member. An appropriate HIPAA approved platform for virtual and hybrid meeting will be identified. Meetings will be held and hosted by the Coroner's Office.

Structure Requirements:

In Person

- All attendees must sign the annual confidentiality form prior to participation
- Folders with confidential information will be made available to all participants and must be returned prior to leaving
- No photographs or recordings are allowed at any time
- Documents will be shredded after each meeting
- Official procedural note taking procedures to capture information from the review process will be established by the co-chairs. Participants are permitted to take notes, but all notes shall be destroyed or turned over to the co-chairs at the end of the meeting
- Disclaimer will be provided: *Materials/case information may be upsetting

Virtual/Hybrid

- All virtual attendees must e-sign confidentiality form prior to participation
- Confidential case-related materials will only be released to each participant after e-signing and via a secure unique link; none of the materials shall be downloaded or saved
- No photographs or recordings are allowed at any time
- Virtual participants (other than the official note taker) are not permitted to take notes
- Virtual participants will only access the meeting from a non-public location and network; all participants should work in a quiet, private location, free from distractions and without easy access to the computer screen by third parties
- Virtual participants must be able to ensure confidentiality and privacy; headsets are mandated if the virtual meeting location can be accessed by third parties at any time during the meeting
- Provide a Disclaimer *Materials/cases information may be upsetting

Meeting Format

Case Review Flow (figure 1):

- The inclusion criteria for cases to be reviewed include:
  - All veteran suicide deaths occurring in Los Angeles County
  - All veteran suicide deaths of Los Angeles County residents (where records are available)
  - Those deaths of veterans in Los Angeles County which are undetermined and containing questionable characteristics that would lead someone to consider the death a possible suicide
  - All veteran suicide deaths where next of kin has signed a form providing consent for the review

The review process is not intended to seek errors on the part of specific individuals or agencies. Rather, it is used to determine if all the pertinent questions the team has about the circumstances of the death have been answered. Service provision questions similarly are intended to identify areas of gaps, barriers, challenges, opportunities and improvement and to ensure those who may be affected by a suicide receive needed support services. VSRT will establish clear expectation of use of time, identify and review as much information as possible. We will create an environment that promotes healing and awareness of impact on members.

a) Share, question and clarify all case information
   - A representative of the DMEC office will be the primary presenter of cases for deaths that occurred in LA County.
   - Team members and relevant agencies will share any information they have in summary form for individual case reviews
   - Meetings will provide a forum for question, discussions and clarification of information presented. If more information is needed, case review will be continued at next meeting.

b) Discuss the cases identified
   - The key findings identified by each partner agency or participant

c) Discuss the delivery of services
   - Were there any social services that the Veteran or family member(s) was accessing prior to the death?
   - Were services provided to the family member(s) as a result of the Veteran's death?
   - Were services provided to responders, witnesses, or community members?
   - Are there additional services that should be provided to anyone?
   - Who will take the lead in following up on these service provisions?
   - Does the team have suggestions to improve service delivery systems?

d) Identify risk factors and protective factors
   - What risk factors were involved in this deceased individual's death?
   - What protective factors might have been enhanced or accessed prior to the individual's death?

e) Recommend system improvements
   - What changes in behaviors, technologies, agency systems and/or laws could minimize the risk factors or increase protective factors and prevent another suicide?

- Where there any potential "touch points" for additional system/agency support, intervention, etc.
- Are there recommendations generated by the review of cases?

f) Identify action needed to implement prevention/intervention recommendations
   - What are our best recommendations for helping implement change?
   - Who should take the lead in implementing the change?
   - Identify next steps and strategies.

g) Determine final steps for concluding the current case review
   - Does the case need to be reviewed at a future meeting?
   - What information is needed between now and a future review?
   - Close case and finalize team review.

Data Sharing Protocols (see figure 1)

- Data will be gathered from DMEC, VA, West LA, Long Beach, and Loma Linda (VISN 22), DPH-OVP, CalVet, and CIO.
- Cases will be reviewed for all veterans that die by suicide in LA County
- Data sharing agreement will set precedent for data sharing from DMEC to VA VISN 22 for verification of veteran status.
- A second level verification will be completed by CalVet and returned to VA VISN 22.
- VA VISN 22 will send final list of veteran suicide decedents to DPH-OVP.
- DPH-OVP will coordinate with LA County CIO to cross reference data with county data.
- Data will be shared between partners using a secure MFT site managed by DPH's IT program. This will allow all partners (MEC, CIO, VA, DPH-OVP) to access the data files when needed.
- DMEC recommends a one (1) quarter delay in processing data to ensure records are mostly complete. Data from Q1 will be available in July of a particular year. Data from Q2 will be available in October, etc.
- New data use agreements that may be needed:
  a) CIO and the VA
  b) DPH-OVP and the VA
  c) CIO and DPH-OVP (may already be covered by an existing DPH-CIO agreement)

Confidentiality and Document Storage

- The LA County DMEC will provide the Veterans Administration VISN 22 with the next of kin information. VA VISN 22 will request the legal next of kin to sign a release of information so HIPAA protected information may be shared within the group. Information regarding the process will be provided to the legal next of kin.
- Storage of data and any documents relevant to the review process will be kept by the Department of Public Health Office of Violence Prevention. Notes generated during the review not kept as relevant for data collection will be collected at the end of the meeting and destroyed.
- The team will only review those cases in which a release of information has been signed by the legal next of kin.
- Team members will sign a confidentiality agreement before sharing information in a review meeting.

- Storage of data and any documents relevant to the review process will be kept by DPH-OVP.
- Notes generated during the review not kept as relevant for data collection will be collected at the end of the meeting and destroyed by DPH-OVP.

Data Collection

Data collected will include:

- Demographics
- Location, Method of Death, Other Incident Information
- Military Service Details (CalVet, VA)
- Medical, Mental Health, Legal history
- Supports, including housing, family, others

Reporting, Communication and Sharing Information

Data/Annual Report

- The Los Angeles County DPH-OVP's Epidemiologist will assist the team in collating and analyzing the data collected during the review process for an annual report. This report will be submitted to the Los Angeles County Board of Supervisors by DMH and will be made public to inform prevention/intervention/postvention activities on a local and state level. The report will also include general aggregated information on veteran suicides that were not reviewed by VSRT.
- CEO/CIO's office will contribute to the annual report with information from their Data Hub.
- VSRT Members – DMH lead on report out, all VSRT members will contribute
- Communication – DMH and DPH-OVP will jointly coordinate with the Veteran Administration on all public facing, written communication.

Figure 1. Draft Flow of Cases

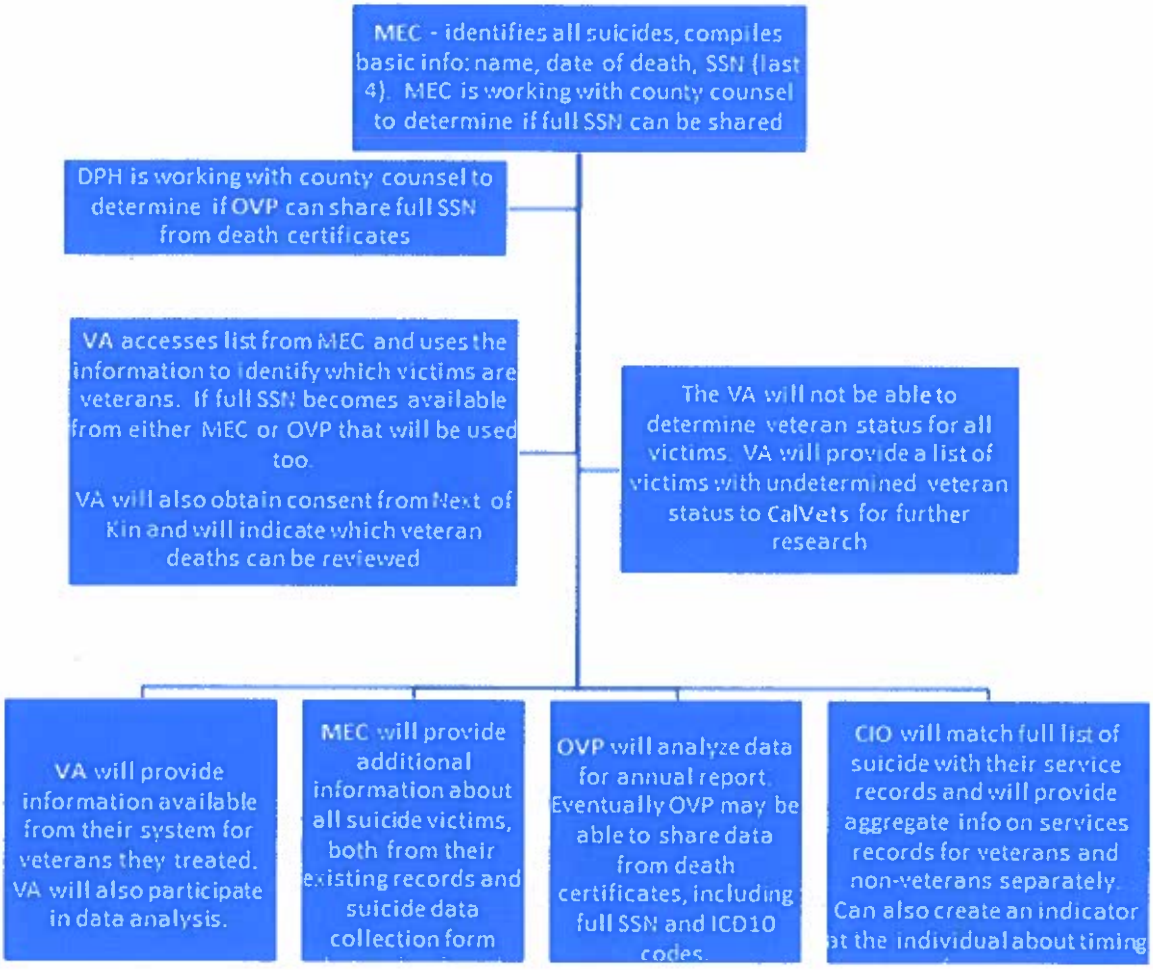
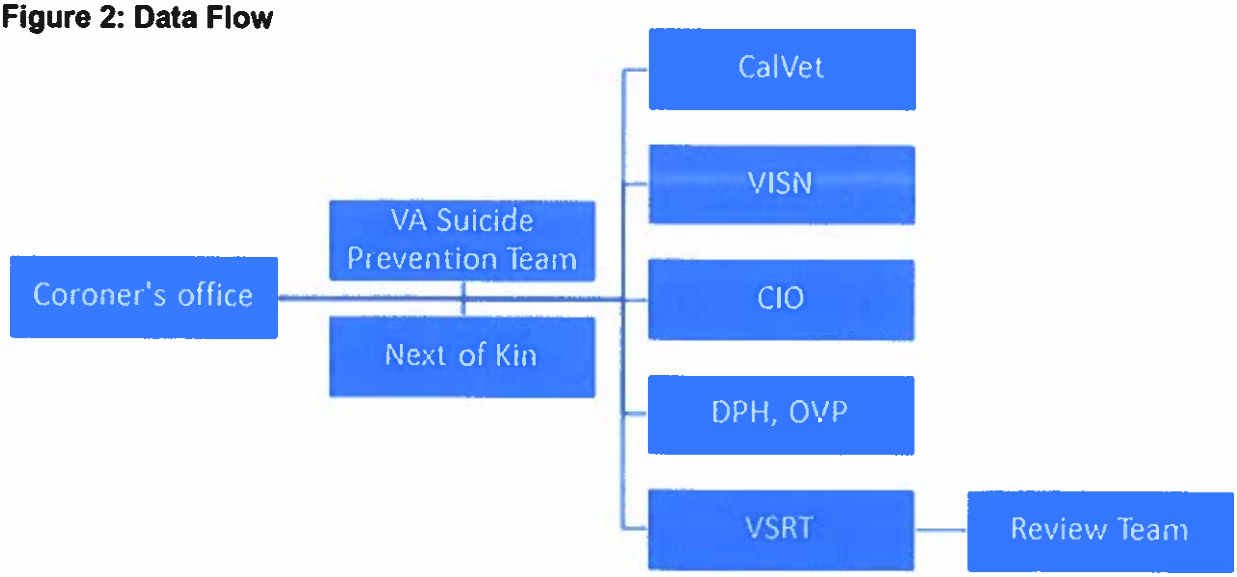


Figure 2: Data Flow



Report Back on Implementing the Los Angeles County Veteran Suicide Review Team:

Data Analysis of Identified Veteran Suicide 2015-2019

Andrew Perry
Program Specialist III
January 2022

Data Analysis of Identified Veteran Suicide 2015-2019

OVERVIEW OF VETERAN SUICIDE DATA

To better understand the impact of suicide on the veteran population, the VSRT WG reviewed available data on veteran suicides. The data revealed that suicide rates are higher and rising faster among our veterans compared to non-veteran adults.

- On average, 20 veterans die by suicide each day in the United States. The suicide rate for veterans was one and a half times the suicide rate for non-veteran adults (adjusting for population differences in age and sex)[1].
- In California, there was an 8% increase in veteran suicide deaths from 2017 to 2018. In 2017, 4,172 adults died from suicide, with veterans accounting for 636 (15.2%) of these deaths. In 2018, of the 4,371 California suicides, veterans accounted for 690 (15.7%) of them.[2]
- In Los Angeles County, there was a 16% increase in veteran suicides from 2017 to 2018. In 2017, 93 veterans committed suicide, compared to 108 veterans in 2018.[3]

The Chief Information Office (OCIO) within the LA County Chief Executive Office (CEO) worked with the LA County Medical Examiner-Coroner (DMEC) and the Greater Los Angeles Veteran Affairs Healthcare System (GLAVA) to produce an analysis of veterans and other individuals who died by suicide between January 1, 2015, and December 31, 2019. GLAVA staff received from DMEC a list of decedents determined to have died by suicide, and they searched for those individuals in VA medical records. Of the 4,464 total suicide decedents, 546 (12.2%) were found to have records in the VA healthcare system. Of these 546, 47.8% (261) could be confirmed to be veterans. The veteran status of the remaining 52.2% (285 individuals) could not be confirmed, and that group likely includes a mix of veterans, dependents, VA staff, and other patients. GLAVA securely transmitted the list of VA-linked decedents to OCIO, where it could be further linked to the DMEC data residing in the Information Hub, OCIO's integrated data system (IDS). As a result, OCIO was able to find County service histories for some of the identified veteran suicides, as well as to compare their DMEC records to the records of non-veteran suicides to find commonalities and differences. The following analysis, then, distinguishes among these three groups: confirmed veterans, decedents who were present in VA records but whose veteran status is unconfirmed, and decedents who were not found in the VA records searched ("not in file").

[1] "2019 National Veteran Suicide Prevention Annual Report." Office of Mental Health and Suicide Prevention. U.S. Department of Veterans Affairs.https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf

[2] "Suicide Deaths Among Veterans in California, 2017-2018". June 2020. California Department of Public Health, Injury and Violence Prevention Branch.

[3] Ibid.

Data Analysis of Identified Veteran Suicide 2015-2019

Demographic Patterns and Means of Suicide

Figure 1. Baseline: Means of Suicide Among All Identified Suicides in LA County, 2015-2019

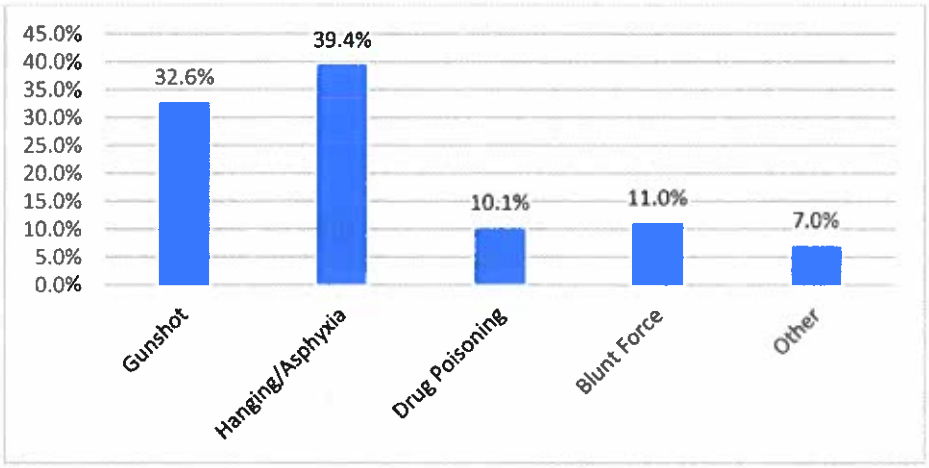
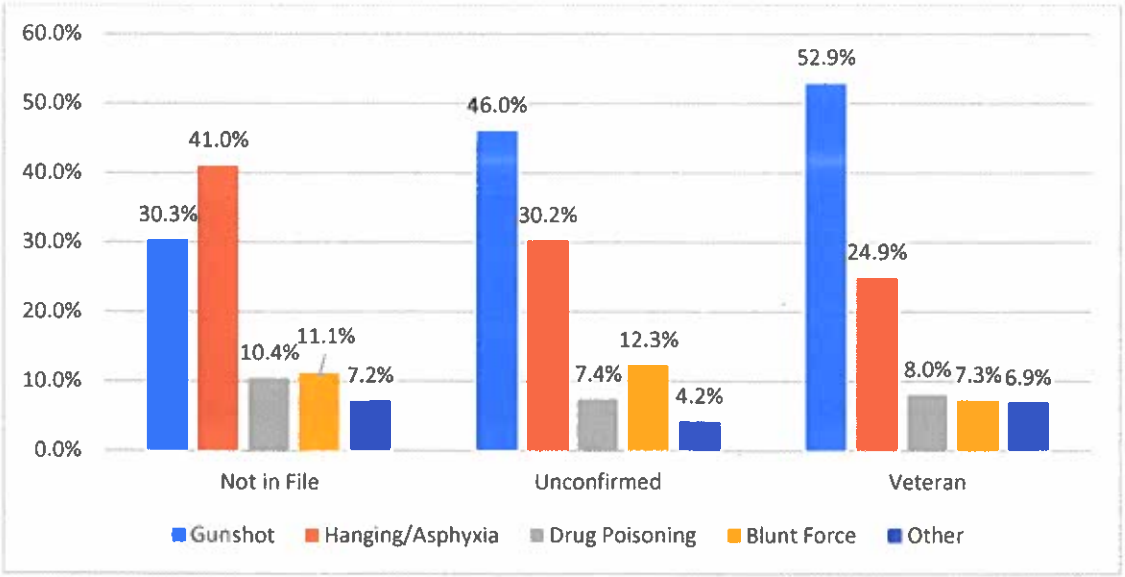


Figure 1 shows the baseline distribution of means of suicide across all 4,464 decedents in the Coroner's suicide file. Gunshot, hanging, and other forms of asphyxia account for more than 70% of suicides in the County in this period. Drug poisoning (including controlled substances and medications) and blunt force trauma (most commonly incurred by jumping from a height or jumping in front of a moving vehicle) account for another 21%. Some 7% of suicides employed other means, including ingested or inhaled poisons, sharp force trauma, and drowning.

By contrast, Figure 2 shows the distribution of means of suicide within each of the three discrete groups identified above. The figure reveals that confirmed veterans were about 75% more likely to use a firearm to commit suicide than were decedents not in the VA file. Decedents of unconfirmed veteran status used firearms at a rate in between those of the other two groups, suggesting the accuracy of the assumption that this category includes a mix of veterans and non-veterans.

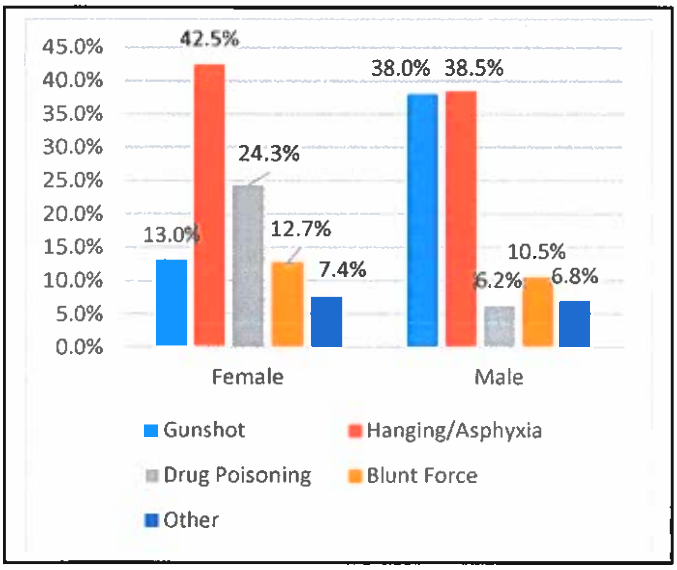
Figure 2. Means of Suicide by Veteran Status



Data Analysis of Identified Veteran Suicide 2015-2019

Veteran status is not the only variable affecting the distribution of means of suicide among decedents in the Coroner's 2015-2019 file. The distribution also varies by race, ethnicity, gender, and age. Comparing these distributions—and their intersections with veteran status—may be helpful to the Veteran Suicide Review Team (VSRT) in formulating culturally competent policies and intervention strategies to reduce suicides in the future.

Figure 3. Means of Suicide by Gender, All Decedents



As shown in Figure 3, the distribution of means of suicide varies even more greatly by gender than by veteran status. Women (n=967) were about one-third as likely as men to use a firearm to commit suicide, but they were almost four times as likely to use drugs as their means of suicide. Among male decedents (n=3,494), hanging/asphyxia and gunshot were about equally common means of suicide, while women employed hanging or asphyxia more than three times as often as they employed firearms.

Data Analysis of Identified Veteran Suicide 2015-2019

Figure 4. Gender Distribution, by Veteran Status and Means of Suicide

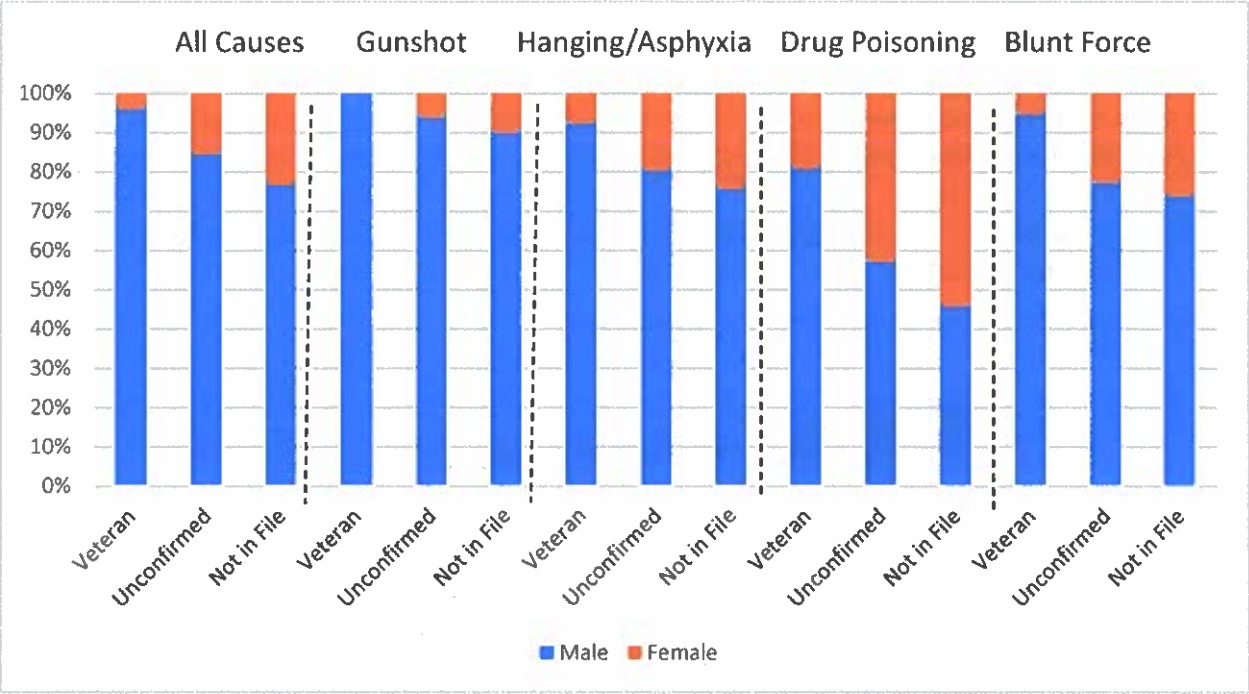


Figure 4 shows the distribution of gender among the decedents by veteran status and means of suicide. As one might expect, it reveals that where a decedent's gender and veteran status would each predict different likelihoods of a given means of suicide, the actual means employed seem to have been influenced by both variables. For example, among confirmed veterans who died of drug poisoning, about one in five was female. Among drug poisoning decedents not in the veteran file, more than half were female. This is in part a function of the relative proportions of men and women in the veteran and non-veteran groups of decedents (only 3.8% of identified veterans are women, vs 23.3% of decedents not in the VA file), but it is also in part a function of differences in preferred means of suicide between the two groups.

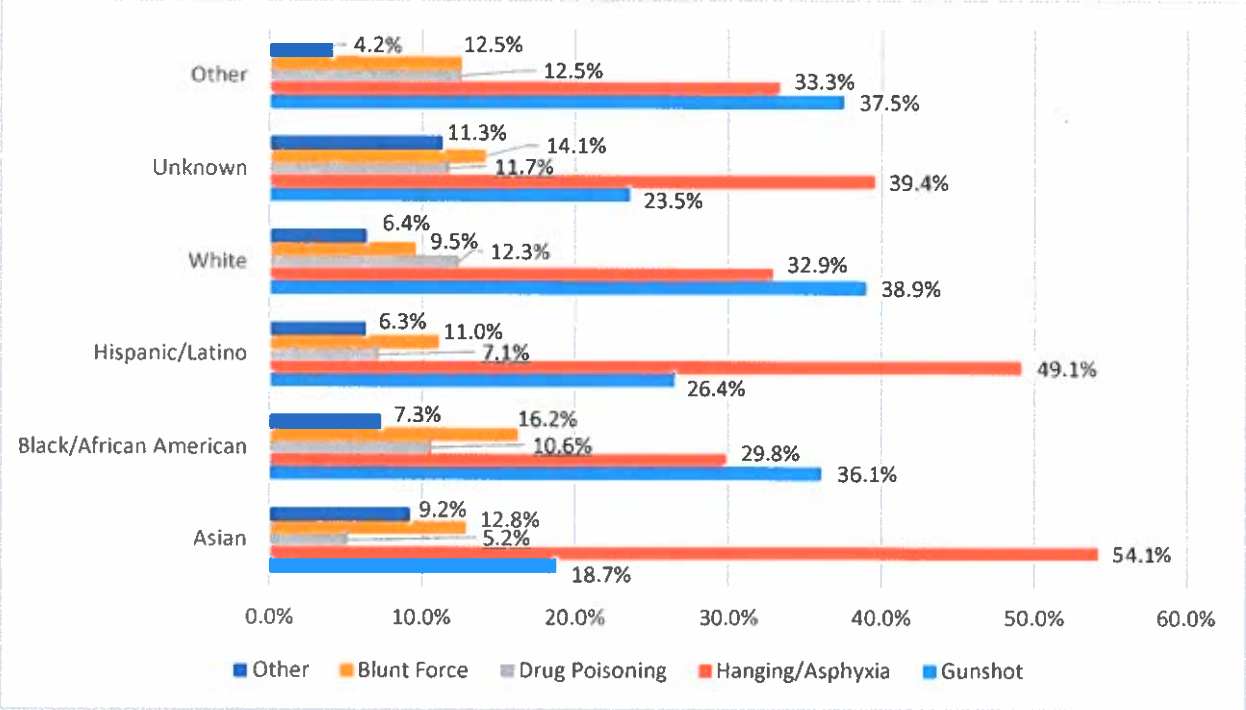
Figure 5 shows the distribution of means of suicide within racial and ethnic categories. It shows that both white and African American decedents used firearms to commit suicide more often than did Latinx or Asian American decedents, both of whom were significantly more likely to die by hanging or asphyxia than was the overall study population. It also reveals that, compared with that population, African American decedents were almost 50% more likely to die by blunt force trauma, while Asian American decedents were about 50% less likely to die of drug poisoning.

Data Analysis of Identified Veteran Suicide 2015-2019

Table 1. Count of Suicides by Race/Ethnicity, All Decedents

Race/Ethnicity	Decedents	%N
Asian	523	11.7%
Black/African American	302	6.8%
Hispanic/Latino	1,077	24.1%
Native American/Alaska Native	11	0.2%
Native Hawaiian/Pacific Islander	12	0.3%
Two or More Races	1	0.0%
Unknown	213	4.8%
White, Non-Hispanic	2,325	52.1%

Figure 5. Means of Suicide by Race and Ethnicity, All Decedents



As was true of gender and veteran status, the intersection of race/ethnicity and veteran status also proves meaningful, as it reveals specific pockets of disproportionate representation (Figure 6). For example, African Americans constitute 7% of veteran suicides, but they constitute 14% of veteran suicides by drug poisoning, meaning that a veteran who commits suicide by drug poisoning is twice as likely to be African American as is a veteran who commits suicide in general. Similarly, among decedents who died by suicide by blunt force trauma, Latinx veterans are overrepresented (21% of the blunt force suicides vs 16% of all veteran suicides), Asian Americans are overrepresented among both veterans (16% vs 6%) and unconfirmed members of the veteran file (20% vs 8%), and African Americans are overrepresented in all three veteran status categories (veterans: 11% vs 7%; unconfirmed: 17% vs 11%; not in file: 9% vs 6%). By contrast, white decedents are underrepresented across the board among both deaths by hanging/asphyxia (veterans: 60% vs 66%; unconfirmed: 55% vs 65%; not in file: 42% vs 50%) and deaths by blunt force trauma (veterans: 53% vs 66%; unconfirmed: 51% vs 65%; not in file: 44% vs 50%).

Data Analysis of Identified Veteran Suicide 2015-2019

Figure 6. Race/Ethnicity, By Veteran Status and Means of Suicide

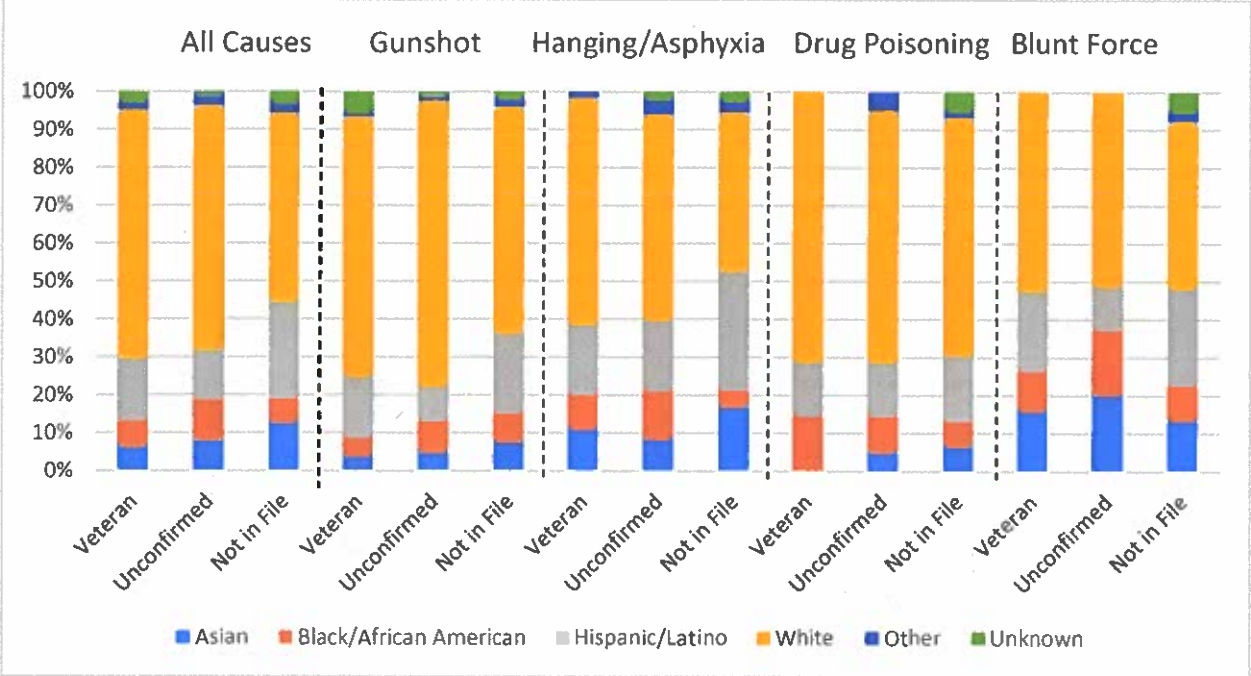
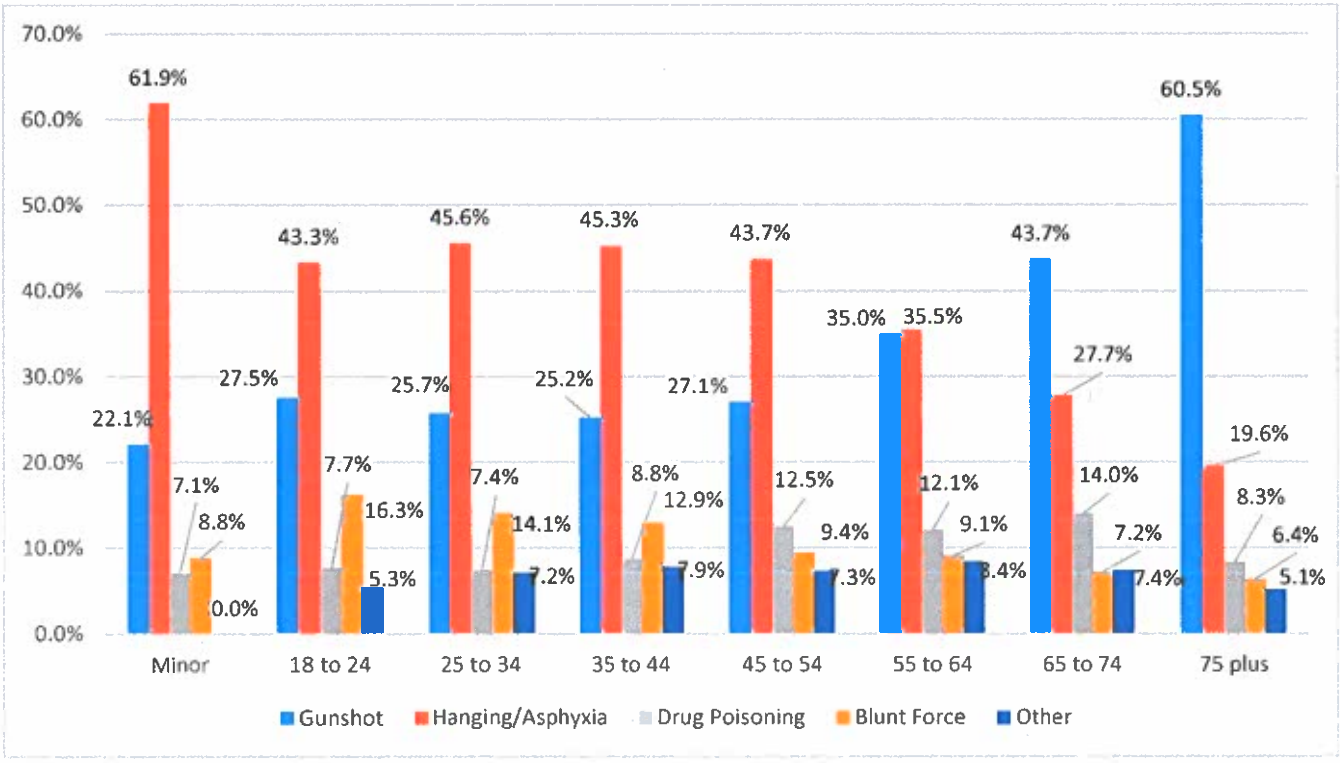


Table 2. Count of Suicides by Age, All Decedents

Age	Decedents	%N
1 to 17	113	2.5%
18 to 24	455	10.2%
25 to 34	781	17.5%
35 to 44	674	15.1%
45 to 54	794	17.8%
55 to 64	778	17.4%
65 to 74	458	10.3%
75 plus	408	9.1%
Unknown	3	0.1%

Perhaps the most suggestive dimension of analysis is the distribution of means of suicide by age grouping. Figure 7 shows a very clear stair-step progression from younger to older decedents. The greater a decedent's age, the more likely they were to use firearms as a means of suicide and the less likely they were to use hanging or asphyxia. The pattern becomes most dramatic among decedents 55 and older, as the percentage of decedents dying of gunshot wounds grows from 35.0% among 55-to-64-year-olds to 60.5% among those 75 and over. At the same time, the percentage dying by hanging/asphyxia shrinks from 35.5% among 55-to-64-year-olds to 19.6% among those 75 and over.

Figure 7. Means of Suicide by Age, All Decedents



Geographic Analysis

In response to the VSRT Working Group's interest in death locations, OCIO geocoded the suicide file and mapped the resulting values across the County. The first three maps in the appendix display ranges of aggregate suicide counts by city, unincorporated area, and (within the City of Los Angeles) neighborhood. Map 1 indicates that the communities with the greatest absolute number of suicides include Lancaster, Palmdale, Santa Clarita, Glendale, Pasadena, Pomona, Woodland Hills, North Hollywood, Hollywood, Downtown LA, the Wholesale District, Santa Monica, Torrance, San Pedro, and Long Beach. Map 2, displaying only suicides from the VA file[4], indicates that the greatest absolute numbers of suicides were located in the communities of Lancaster, Santa Clarita, Glendale, North Hollywood, Downtown LA, Torrance, Long Beach, and San Pedro.

Not visible on the included maps is another pattern worth highlighting: A string of the identified suicides took place along several major freeways in the County. When suicide locations are plotted on the individual level, one can see lines of suicides hugging the 10, the 405, and several other freeways. These lines suggest one potential avenue for suicide prevention, if the locations of greatest risk could be outfitted with signs including information on suicide prevention hotlines and other resources.

[4] Because the number of confirmed veteran suicides is small, especially relative to the size of LA County, OCIO included all decedents in the VA file, both confirmed and unconfirmed, in an effort to ensure that patterns of distribution would be visible.

OCIO also performed a cluster analysis on the distribution of suicides across the County at the Census tract level. Global Moran's I analysis was employed. The result of this sort of analysis is a score that measures statistically significant distributions in space. To understand how this analysis works, consider a series of events distributed truly at random across Los Angeles County. These events would not be evenly spaced out, because even spacing requires intentional placement. Rather, because their location was random, there would naturally be some areas with more events and some with fewer events. To determine whether concentration of events in some areas rather than others is meaningful, statistical analysis is necessary. Global Moran's I analysis identifies locations where the level of clustering or dispersal is statistically significant, meaning that it is unlikely that the pattern observed would result simply by chance. A high positive score (color coded red on the maps) indicates that a significant cluster is present—that is, some non-random factor or factors are causing the events to occur near one another. A high negative score (color coded blue on the maps) indicates that a significant dispersal is present—that is, some non-random factor or factors are causing the events to occur far from one another.

The cluster maps included in Appendix 1 are thus only the beginning of the geographic analysis that could be employed to better inform patterns of suicide among veterans and other LA County residents. Their immediate import is merely to suggest that the geographic locations of many suicides in the County are non-random. They are influenced by multiple factors, some of which create clusters and others of which create patterns of dispersal. Identifying specific causes of these patterns is beyond the scope of the current study, but the cluster maps are included to show where such patterns seem to exist.

Decedents' Use of County Services

To gauge the extent to which decedents were consumers of County services, OCIO matched the full DMEC file of suicides to other County departmental data sets residing in the Information Hub. The results of this match are suggestive but should be considered tentative due to the disparate date ranges covered by different departmental data sets. For example, Information Hub caseload records from the Department of Public Social Services (DPSS) go back only to November 2017, while records of arrest present in the Los Angeles Sheriff's Department (LASD) data go back to 2010. Thus, even if an equal number of decedents received benefits from DPSS and had LASD records, the present match would produce fewer results for DPSS than for LASD, since individuals who died before 2017 would be unmatchable to their DPSS service histories. Future matches involving decedents post-2019 will be more comprehensive.

Figure 8. County Service History, Decedents in VA File

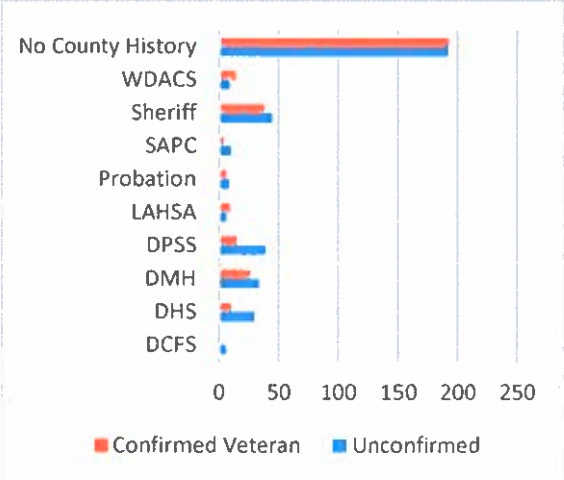
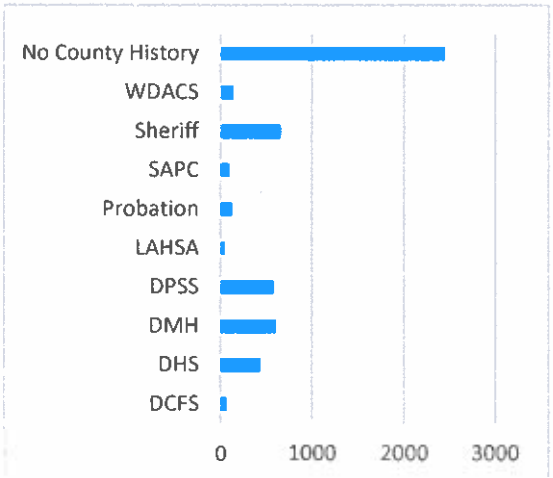


Figure 9. County Service History, Decedents Not in VA File



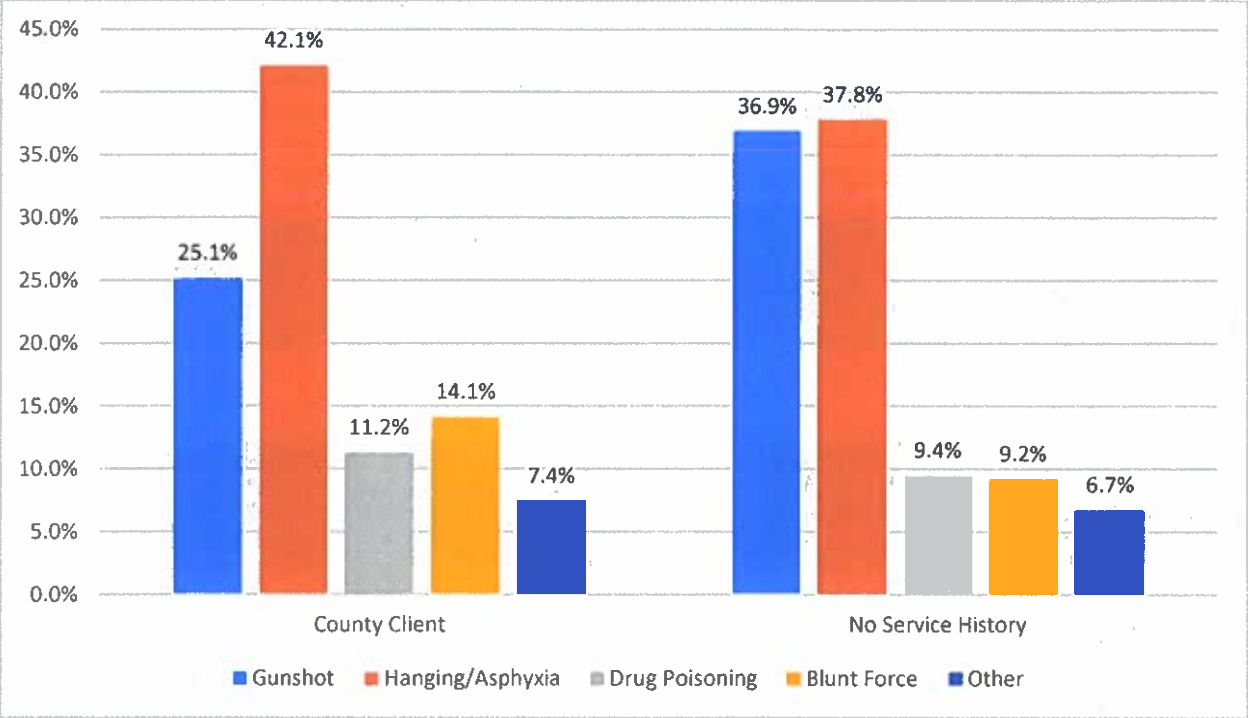
Even with that caveat, the present match results are instructive. Almost 64% of all decedents, and almost 74% of confirmed veteran decedents, had no identifiable service history in any County department with records in the Information Hub. This match rate suggests that LA County residents who commit suicide come from a broad swath of the population, representing a wide variety of income levels and service needs.

The difference in match rate between confirmed veterans and non-veterans is likely due to veterans' access to health care and benefits through the Veterans Administration. Confirmed veterans were 70% less likely to have DHS records than were decedents not in the VA file, and they were 64% less likely to have DPSS records. They were also 38% less likely to have records of DMH service use. Moreover, among veterans and non-veterans alike, no single County department emerged as a primary service provider for those decedents who did touch County systems. Decedents' service use is dispersed among various departments in a fashion that presents challenges for formulating a comprehensive strategy for suicide prevention. Combined, the dispersed pattern of County service use and the high number of decedents with no such use suggest that a concerted focus on the VA as the primary outreach entity to reduce veteran suicide may be warranted. A broader strategy of suicide prevention by the County would likely require proactive community outreach, rather than concentrating only on existing consumers of County services.

Finally, OCIO used the results of the County service history match to compare the distribution of means of suicide between identified County clients and those without identifiable service histories. Significantly, decedents with service histories were 32% less likely to use a firearm to commit suicide than were decedents with no service histories (Figure 10). While specific likelihood varied by department, decedents were less likely to use firearms across the board if they had any history of service receipt in any County department with records in the Information Hub. This may be a function of persons with County service records having less access to firearms than the general population, if for example they are justice-involved, experiencing mental illness, experiencing homelessness, or simply unable to afford a firearm.

Data Analysis of Identified Veteran Suicide 2015-2019

Figure 10 . Means of Suicide by County Service History, All Decedents



The data highlights the disproportionate suicide rates among our veteran population and the need to closely examine the risk and protective factors that impact their suicide rates. While suicide prevention continues to be a priority for the VA, most veterans do not access the Veteran Health Administration (VHA) for services. A 2019 VA report[5] found that among veterans who died by suicide in 2017, only 38% had accessed VHA services in the two years prior to their death. It is estimated that only 20% of veterans residing in Los Angeles County have accessed VHA services. Therefore, implementing prevention and intervention strategies to address veteran suicides will require a partnership with the VA, local government and service providers. Because veterans have unique risk and protective factors related to military service, closer examination of veteran suicide data using mortality review teams could help further define the problem of suicidal behavior among veterans and inform intervention, prevention and postvention strategies.

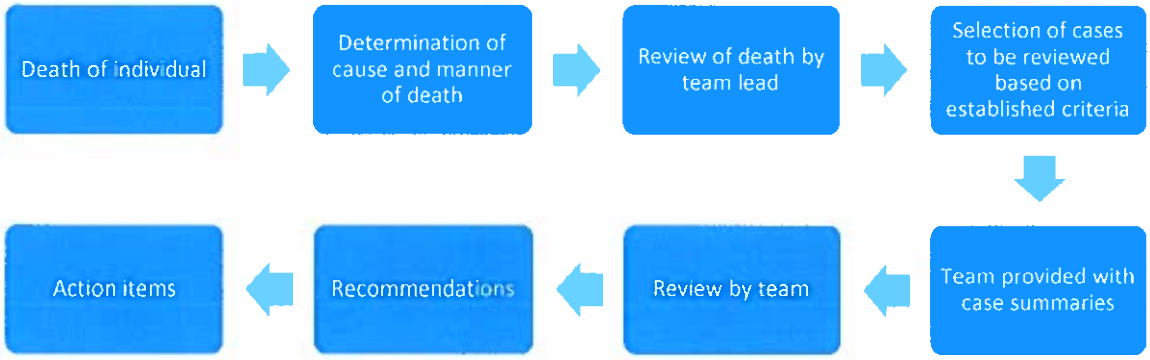
MORTALITY REVIEW TEAMS

A mortality review team is a multi-disciplinary committee that conducts a comprehensive review of deaths to identify system level interventions that might prevent similar deaths. (Figure 3). Mortality review teams help better understand: 1) in-depth characteristics of cases; 2) circumstances of death; 3) risk and protective factors that led to the death; 4) prevention and intervention opportunities and 5) recommended systemic improvements. During the review process all relevant data is shared and reviewed by the committee, as permitted by law. This

[5] "2019 National Veteran Suicide Prevention Annual Report". Office of Mental Health and Suicide Prevention. U.S. Department of Veterans Affairs. https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf

includes historical information (e.g., health, mental health, court records, etc.) concerning the deceased individual and their family, and the circumstances surrounding their death. The mortality team meetings conclude with identification of recommendations to prevent future deaths. Recommendations are often compiled in an annual report that is shared with policymakers, agencies, service providers and other identified stakeholders.

Figure 3



VSRT PURPOSE, TEAM COMPOSITION AND SELECTION, "VETERAN" DEFINITION, AND CASE REVIEW CRITERIA AND PROCESS

The review of the mortality review models provided valuable information for the VSRT WG by highlighting best practices and identifying implementation challenges for the group to consider. The VSRT WG concluded that creating a mortality review team that is focused on veteran suicides would enable a coordinated response to address systemic issues and could help reduce the occurrence of veteran suicides. In response to the Board motion, the VSRT WG developed the VSRT Guiding Document providing a recommended framework for a proposed Los Angeles County VSRT. The VSRT Guiding Document outlines the following:

1. **VSRT "Veteran" Definition**
2. **VSRT Purpose, Goals, and Objectives**
3. **VSRT Team Composition**
4. **VSRT Case Review Criteria and Case Review Process**

The VSRT Guiding Document serves as a foundational document for the establishment of the VSRT. It is not intended to serve as an implementation plan, but rather as a guide that will evolve once a lead department is identified, and an implementation plan is fully developed.

Alignment with California Department of Public Health's Suicide Prevention Initiative.

The Board also directed the VSRT WG to identify ways the VSRT can work with the California Department of Public Health's initiative on suicide prevention. The State released its "Striving for

Zero: California's Strategic Plan for Suicide Prevention 2020-2025"[6], which outlines a policy agenda for suicide prevention. The plan adopts a Public Health Model to preventing suicide, which requires the following four steps: 1) describe the problem; 2) identify risk and protective factors; 3) develop and evaluate prevention interventions; and 4) implement interventions and disseminate results to increase the use of effective interventions. The State's plan also outlines local and regional objectives intended to help local communities prevent suicides using best practices. If implemented, the VSRT case review process would adopt a similar Public Health approach to addressing veteran suicide and would support two of the State's Suicide Prevention Strategic Plan objectives:

- *Objective 3f: Consider the use of death review teams for clinical and forensic review of suicide deaths. Team members should include representatives of coroners and medical examiners, law enforcement, subject matter experts, and others with legal access to confidential information. Data compiled by the team should be used to support prevention goals using the Public Health Model.*

- *Objective 3g: Partner with coroners, medical examiners, and local health department representatives to identify and eliminate barriers to the electronic reporting of suicide death data into the California Violent Death Reporting System. The effort should enable access to data to strengthen suicide prevention, while establishing policies and procedures to protect privacy.*

Additionally, both DMH and DPH worked closely with the Los Angeles County Suicide Prevention Network (LASPN) in developing the "The Hero in Each of Us: Suicide Prevention Plan 2020-2025", which is in alignment with the California Strategic Plan for Suicide Prevention. If the VSRT is implemented, its work should be closely aligned with existing County initiatives and suicide prevention work, including the LASPN, DMH's Partners in Suicide Prevention, DMH's Veteran Peer Access Network, and the Los Angeles City's "Mayor's Challenge to Prevent Suicide Among Service Members, Veterans and their Families."

OPERATIONALIZING THE VSRT

Confidentiality

The VSRT WG discussed confidentiality and information sharing in two contexts:

1. Individual case reviews

   One method for reviewing veteran suicides is a multidisciplinary, multiagency, detailed "deep dive" into individual cases. Mortality review teams such as the Inter-Agency Council on Child Abuse and Neglect's (ICAN's) Child and Adolescent [7] and the Montana Suicide Mortality Review Team referenced in the Board motion, have legislative authority that permits the collection and sharing of confidential and identifying Protected Health

[6] "Striving for Zero: California's Strategic Plan for Suicide Prevention 2020-2025." Mental Health Services Oversight & Accountability Commission. https://mhsoac.ca.gov/sites/default/files/Suicide%20Prevention%20Plan_Final.pdf

[7] The California Welfare and Institutions Code sections 18951 and 18961.7 permit the sharing of identifying information for child death review teams,

Information (PHI) for death reviews. Team members are also required to sign confidentiality agreements to ensure that PHI is not shared outside the mortality review team process. The collection and use of PHI without legislative authority potentially presents a challenge to implementing the VSRT.

Mortality review models without legislative authority obtain PHI and conduct case reviews with prior permission from the deceased's legal next-of-kin. In these instances, the team reviews only those cases where the legal next-of-kin has signed a Release of Information (ROI), authorizing the disclosure of protected information for purposes of the mortality review team process. As a public agency, the VSRT can request medical records directly from source providers for use in case reviews, but production is not obligatory. A second option is to have the Department of Medical Examiner-Coroner mandate the production of a decedent's records under its statutory authority. However, the subsequent use of those records without an ROI, i.e., sharing with the VSRT, is limited. To avoid a potential violation of confidentiality laws pertaining to PHI and to respect the privacy of family members, the VSRT should employ the approach adopted by other models and obtain an ROI from the veteran's legal next of kin and/or representative before conducting the case review with such records.

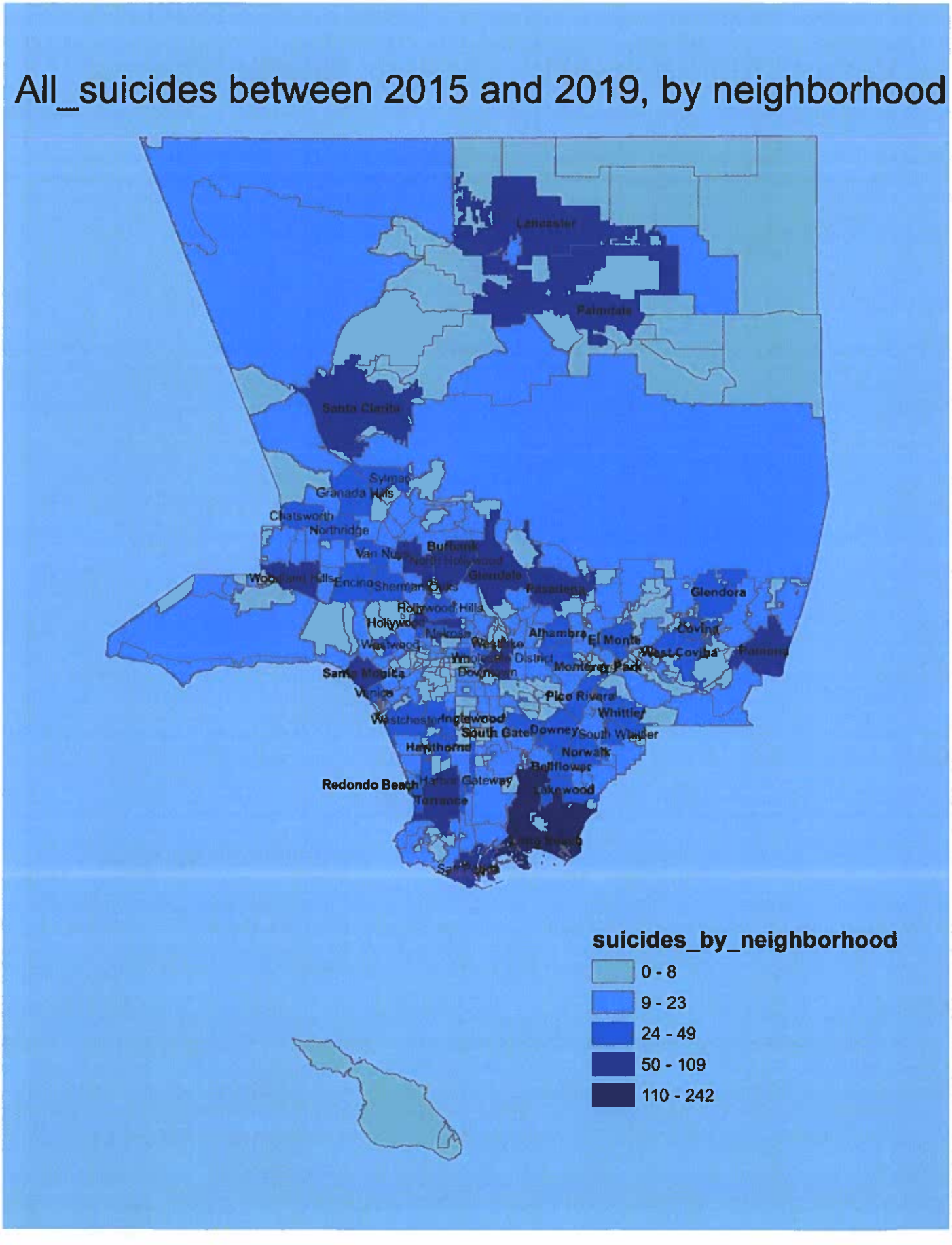
Alternatively, the County could explore seeking legislative authority to permit the VSRT to access confidential and PHI information for the case review process. However, even if successful, such legislation may be met with constitutional challenges and potentially protracted litigation. While this approach would avoid the necessity of an ROI, expediency suggests that the strategy of obtaining ROIs should be employed and evaluated either before or concurrently with legislative efforts.

One additional implementation challenge that has implications for confidentiality and information sharing is the impact of the COVID-19 pandemic on the VSRT's ability to hold in-person meetings. If the VSRT is implemented, the lead department, in coordination with County Counsel, should develop protocols and guidelines for document sharing for both in-person and virtual meetings.

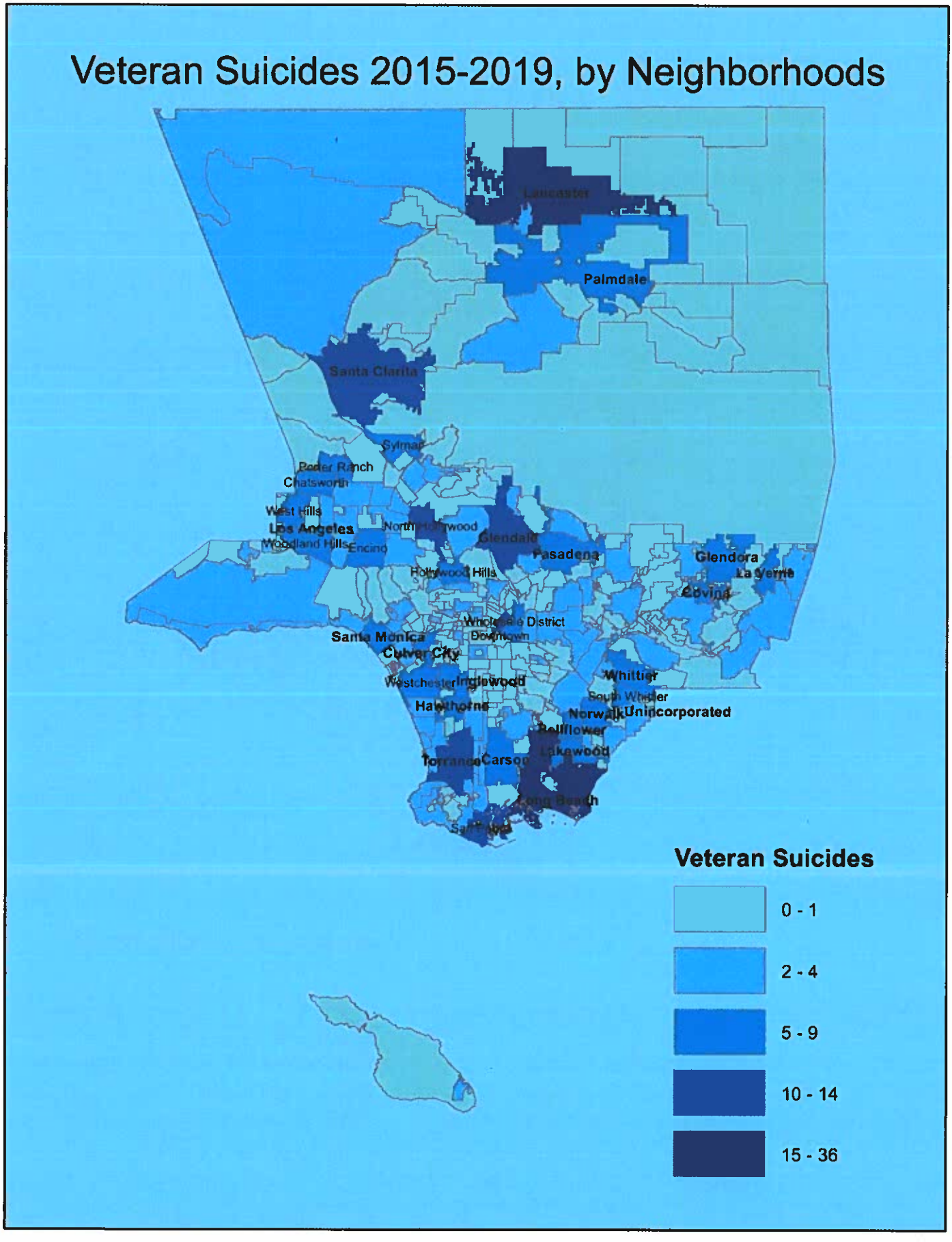
2. Data analysis

The second method for reviewing veteran suicides is aggregate analyses of larger datasets. Using de-identified data, the VSRT could also explore working with the CEO-Chief Information Office (CIO) to leverage the County's Enterprise Information Hub, which enables departments to securely exchange data and identify County clients' service and referral history. These de-identified datasets could be aggregated and provide useful information on the County's veteran population. County Counsel has advised that an ROI is not necessary to undertake this type of analysis.

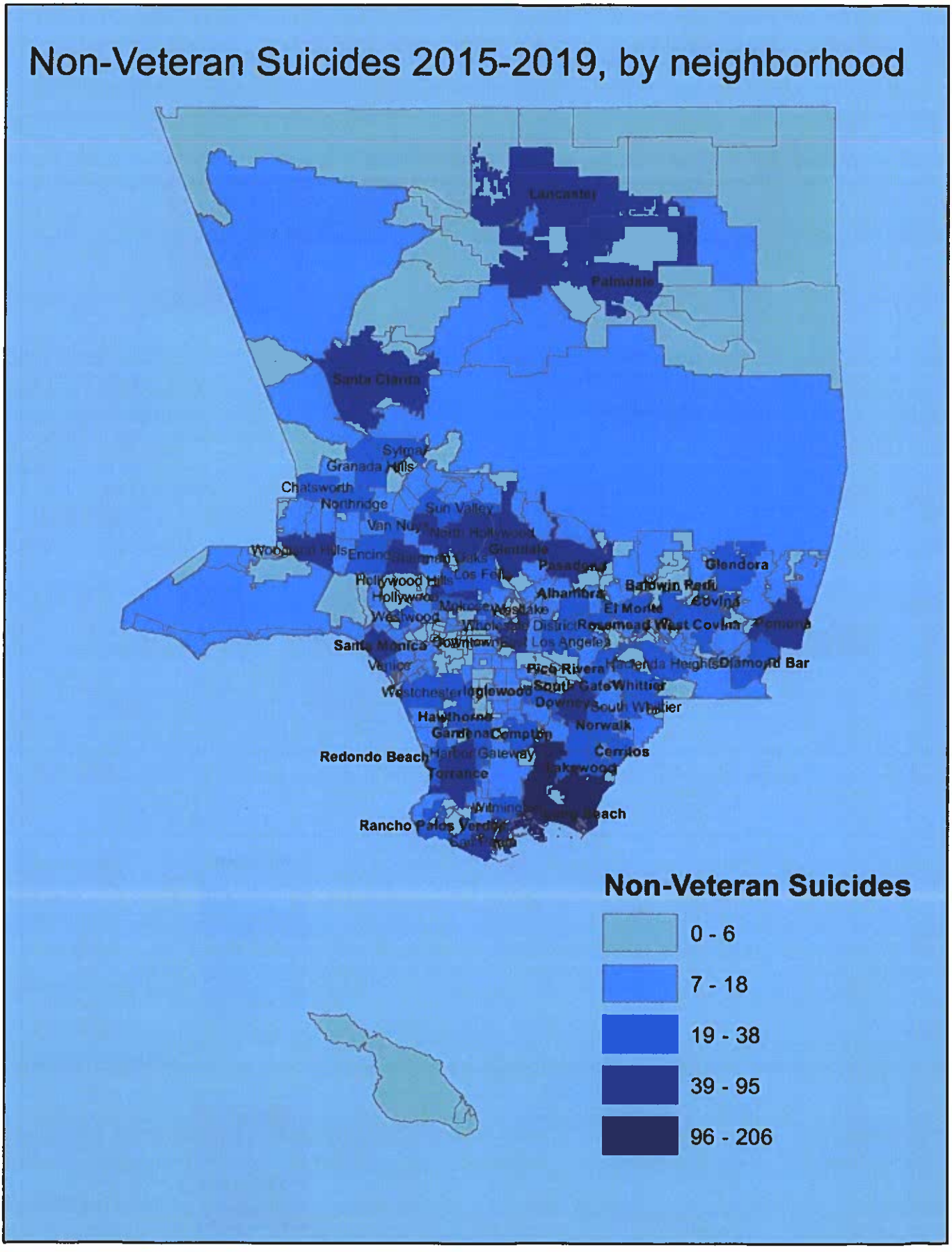
Data Analysis of Identified Veteran Suicide 2015-2019



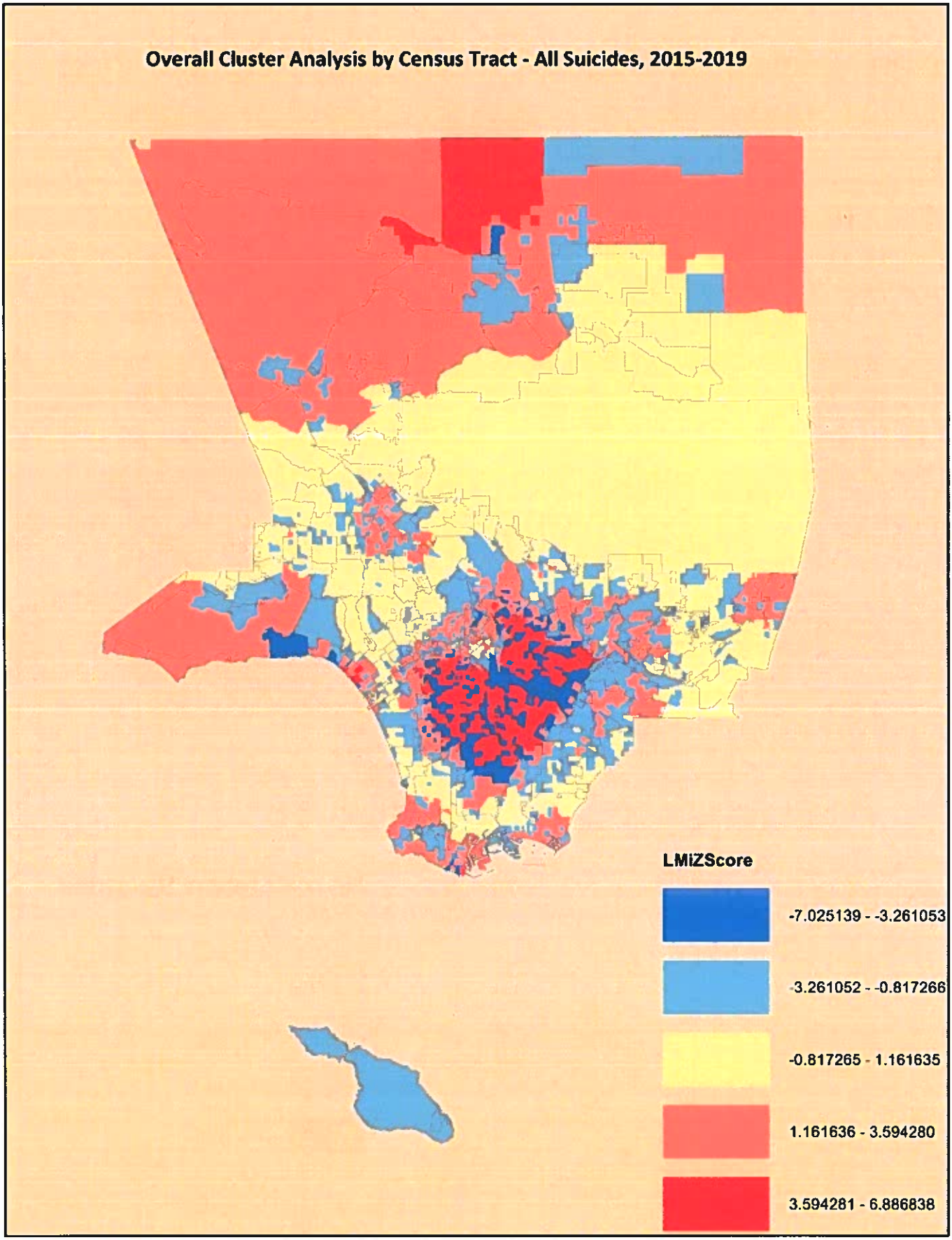
Data Analysis of Identified Veteran Suicide 2015-2019



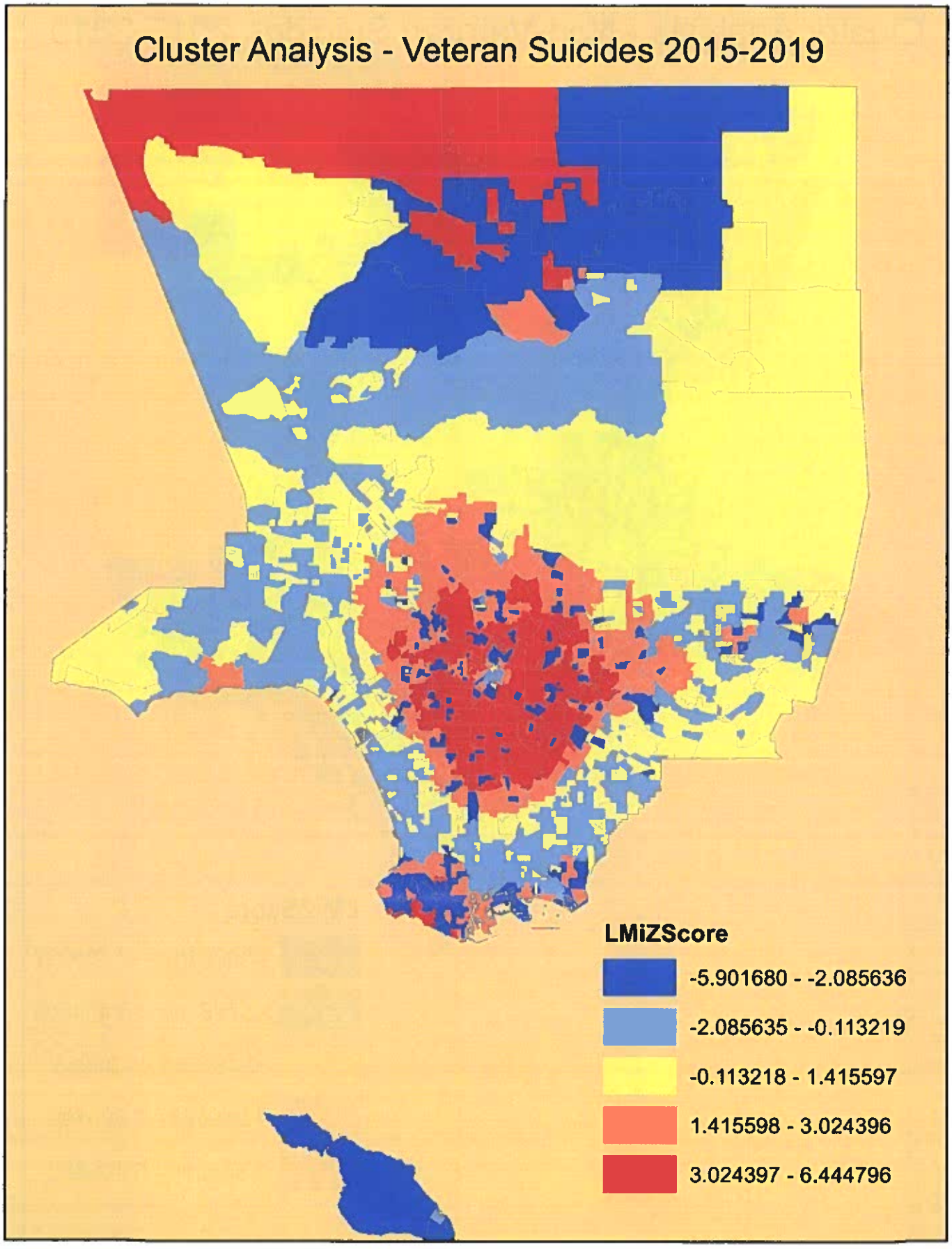
Data Analysis of Identified Veteran Suicide 2015-2019



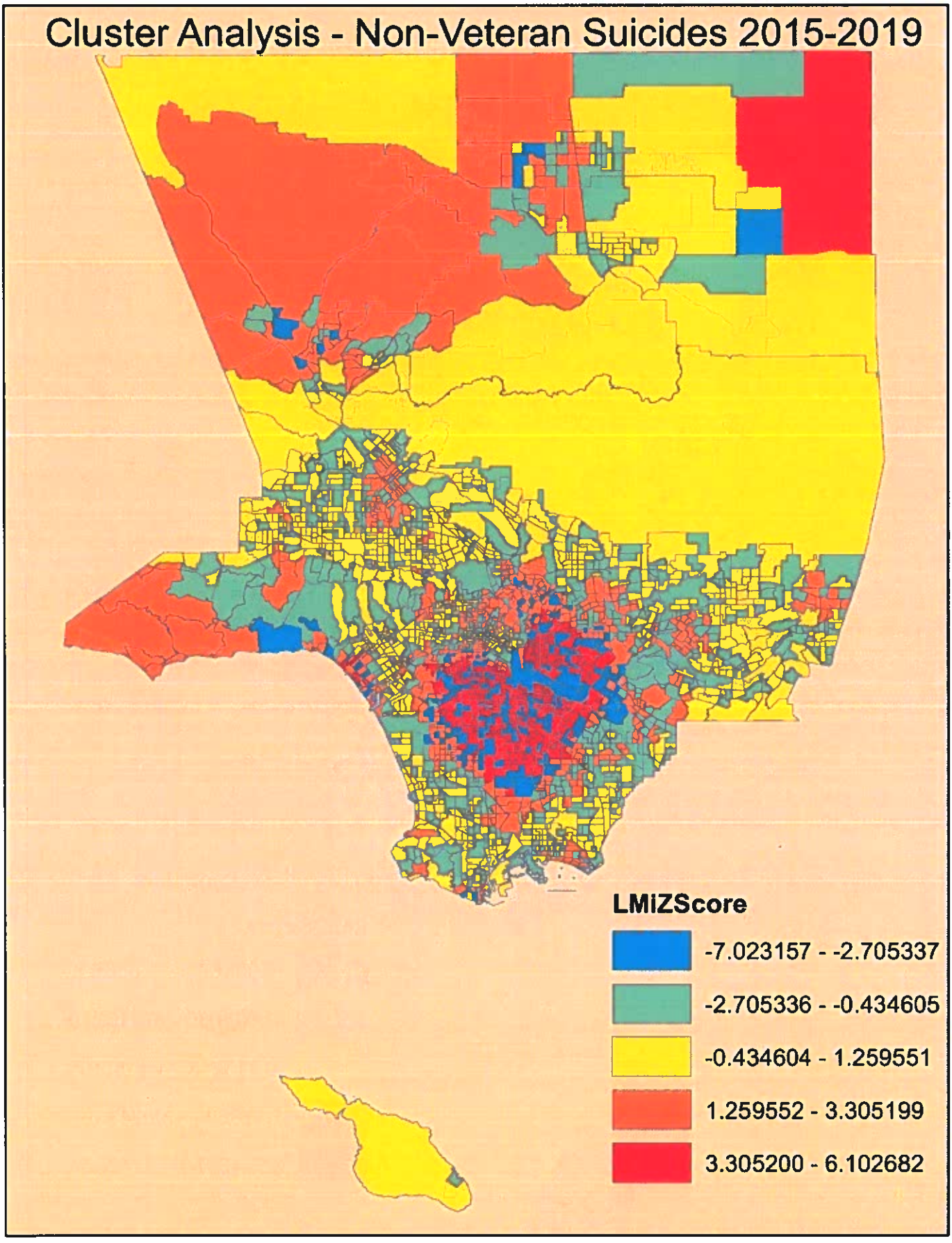
Data Analysis of Identified Veteran Suicide 2015-2019



Data Analysis of Identified Veteran Suicide 2015-2019



Data Analysis of Identified Veteran Suicide 2015-2019



Data Analysis of Identified Veteran Suicide 2015-2019

SUMMARY

Consisting of several LA County Departments (state, federal, and community-based organizations) the Veterans Suicide Review Team Work Group (VSRT WG) was established to in response to the May 5th Board Motion, worked on creating this plan over several months to create a plan for moving forward in the implementation process. The VSRT-WG was divided into three subcommittees to specifically address areas laid out in the May 5th Board Motion: roles and responsibilities, structure and protocols, and data collection and analysis.

Per the Board Motion's directive, the VSRT's purpose is to evaluate the circumstances leading to and surrounding the suicide deaths of veterans who died in Los Angeles County in order to develop and enhance intervention and prevention measures to prevent suicide amongst veterans. The goals and objectives of the VSRT is to reduce the number of suicides, increase efficiency in targeted outreach, develop a coordinated response and explore opportunities to expand resources allocated to prevent suicide through data driven recommendations by identifying specific barriers, gaps and opportunities for systems engaging veterans at risk for suicide. Additionally, the VSRT will be identifying risk factors and trends in suicide deaths and developing strategies for delivery of services to survivors of suicide loss.

The VSRT will be comprised of 4 co-chairs with representatives from DMH, DPH-OVP, VA VISN 22, and DMEC, as well as, Core team members from various county departments, community partners and special advisors who will meet on a regular basis to review cases. Both in-person and virtual/hybrid protocols will be established by the co-chairs, in addition to, providing confidentiality agreements to all participants. During the case review, the core team will be able to share, question and clarify all case information; discuss the cases identified and delivery of services; identify risk and protective factors; suggest system improvements by identifying actions needed to implement prevention/intervention recommendations; and to determine the final steps for concluding the case review by using data gathered from DMEC, VA, West LA, Long Beach, and Loma Linda (VISN 22), DPH-OVP, CalVets, and CIO.

Suicide is a public health crisis that affects every Los Angeles County resident, especially the veteran population. It has lifelong effects on individuals, families, and the community. The veteran suicide review process will assist us in better understanding veteran suicide deaths in Los Angeles County and therefore help us in promoting prevention and resilience strategies. Los Angeles County intends to build off of this model developed for veterans to eventually scale to all residents of Los Angeles County.

MEMORANDUM OF AGREEMENT

Between

United States Department of Veterans Affairs (VISN 22)

And

Los Angeles County Department of Mental Health

I. PURPOSE:

This Memorandum of Agreement (MoA) is entered between the United States Department of Veterans Affairs (VA or Department) Desert Pacific Healthcare (VISN22) Network, 300 Oceangate, Suite 700, Long Beach, CA 90802, and the Los Angeles County Department of Mental Health (LACDMH), 550 S. Vermont Avenue, Los Angeles, CA 90020, collectively referred to as the "Parties." This MoA sets forth a structure in which the Parties will work in a mutually beneficial manner to advance and improve the mental health and wellbeing of Veterans in Los Angeles County. VA enters this MoA pursuant to its authority to achieve the maximum feasible effectiveness, coordination, and interrelationship of services of programs and activities affecting Veterans and their dependents carried out by and under all other departments, agencies, and instrumentalities of the executive branch with those of VA. 38 U.S.C. § 523.

II. BACKGROUND:

Los Angeles County

The Veteran Peer Access Network (VPAN) is a newly launched, innovative Los Angeles County program designed to meet the needs of Veterans and their family members. LACDMH, in partnership with the Department of Veteran Affairs and other departments, is lead for the VPAN on behalf of Los Angeles County. The County is a local jurisdiction with a collective budget of over $36 billion and it serves over 2.5 million LA County residents a year with a range of health and human services.

VPAN is a cross sector collaboration between public, non-profit, and private sectors that trains, certifies and hires Veterans to act as peers (aka "access agents") to ensure that Veterans and their families get timely access to services and opportunities. Veteran peers employed by LACDMH, as well as Veteran peers employed across sectors by the community, are empowered as a whole to become master navigators of their host entity and, together as a well-coordinated team ("peer access network"), work with the entire community to traverse the myriad and at times overly complex systems of care and available assets.

The targeted outcome of the VPAN is to improve Veteran reintegration by reducing Veteran suicide, homelessness, and under/unemployment. Through the VPAN, LACDMH will hire Veteran peers, use technology to track referrals into and out of the network, push a robust marketing communication strategy and help convene key stakeholders to increase the community's collective capacity to empower Veterans and their families after service.

Department of Veterans Affairs

VA's mission is to fulfill President Lincoln's promise, "To care for him who shall have borne the battle and for his widow, and his orphan," by serving and honoring the men and women who are America's Veterans in accordance with Federal law. The Department's key priorities for advancing this mission include improving Veteran's experience with VA and improving Veteran's access to healthcare. The Department has identified these primary goals and set priority milestones across the Department in the Veterans Benefits Administration (VBA), Veterans Health Administration (VHA), and the National Cemetery Administration (NCA).

VA has prioritized initiatives focused on reducing Veteran suicide, community outreach and clinician education, and addressing the opioid epidemic among Veterans. These programs and initiatives are aimed at reducing barriers to seeking mental health care and promoting help-seeking behavior among Veterans and their families. VA is interested in collaborating with external organizations to expand the reach of these programs, help guide development of new external programs that complement existing VA efforts, and promote community collaboration with the goal of increasing availability of VA's resources.

The VA Desert Pacific Healthcare Network (VISN22) offers services to Veterans residing in Southern California, including Los Angeles County. Specifically, facilities providing services to Veterans within Los Angeles County include Greater Los Angeles VA Medical Center, Long Beach VA Medical Center and Loma Linda VA Medical Center.

III. RESPONSIBILITIES:

The VA Desert Pacific Healthcare Network (VISN22) *will:*

A. Participate in quarterly conference calls and meet with the VPAN to discuss potential ways to collaborate further with the VPAN.

B. Provide subject matter expertise related to veteran mental health and suicide prevention, as requested.

C. Share available VA-developed education resources, for example: military cultural competence training, Coaching Into Care Program, S.A.V.E. training, and the Suicide Prevention Toolkit. "S.A.V.E." stands for "Signs," "Ask," "Validate," and "Encourage and Expedite."

D. Share information with the LACDMH about existing VA resources that would support the VPAN's system of outreach and resources, as well as other county initiatives.

E. Explore opportunities to co-locate LACDMH staff with VA staff across VA Medical Centers, Ambulatory Care Centers, and Community-Based Outpatient Clinics to increase access.

F. Collaborate with LACDMH to develop and implement one or more mental health educational initiatives that align with VA and LACDMH priorities.

G. Work with the nationwide network of VA Suicide Prevention Coordinators (SPC) to encourage collaborative outreach with VPAN's local and regional offices as well as the VPAN support line to broaden the reach of suicide prevention initiatives to all Veterans specifically to those who aren't enrolled with VHA. VHA will provide Veterans Crisis Line materials for these outreach efforts and connect VPAN personnel with local SPC personnel. Explore local SPC directly referring to VPAN support line in instances that aren't emergent and don't require an immediate crisis response. As part of the direct referral process to VPAN there would be the potential of Personally Identifiable Information ("PII') veteran information shared in relation to mental health treatment and veteran's services. This PII information will be sent via encrypted media methods such as e-mail using Microsoft Office product Azura to ensure security.

H. Provide LACDMH publicly available information, including navigation/locator tools (e.g., locator for VA Medical Centers, Suicide Prevention Coordinators and Vet Centers).

I. Furnish or collaborate with LACDMH to produce LACDMH public service announcements or all employee messaging for mental health stigma reduction and to encourage help-seeking behavior among Veteran employees.

J. Participate in the LA County Veteran's Suicide Review Team (VSRT) for surveillance of Veteran suicide deaths in LA County intended to guide county-wide policy for Suicide Prevention efforts. Specifically, VISN 22 SPC lead and one POC from the following VA facilities: 1) Greater Los Angeles VA; 2) Long Beach VA; and 3) Loma Linda VA, shall participate in VSRT meetings as needed. As part of the review teams there would be discussion of PHI and PII veteran information, however Department of Veterans Affairs will not be sending electronic records for use or storage with PHI and PII information.

K. Provide data analysis of deceased veteran's PHI and PII received from LACDMH in efforts to investigate and prevent suicide and electronically transmit back in aggregated de-identified format on various data elements such as geographic location, age, gender, method of death, military service and primary diagnosis etc.

Los Angeles County will:

A. Participate in regular conference calls and meet with relevant VISN 22 POCs to share LACDMH priorities and discuss potential educational initiatives and outreach events.

B. Collaborate with relevant VISN 22 POCs to develop and implement one or more mental health educational initiatives, and conduct awareness activities for LACDMH employees around issues identified as priorities by LACDMH and VA.

C. Pursue opportunities for information and data sharing, as allowed by law, to ensure continuity of care from VA to County and vice versa for Veterans receiving services within both agencies as well as aggregate data analysis to help improve services across systems.

D. Widely distribute information about the Veterans Crisis Line to LACDMH employees and Employee Assistance Program (EAP) vendors.

E. Collaborate with relevant VISN 22 POCs to create awareness across Los Angeles County of existing VA resources for Veterans, such as: Veterans Crisis Line information, opioid overdose education, Coaching into Care Program, suicide prevention education, and mental health stigma reduction.

F. Provide relevant VISN 22 POCs, on a quarterly basis, the total number of Veterans who are seen for peer support.

G. Invite VISN 22 to events organized for Veterans by the VPAN.

H. LACDMH will maintain administrative leadership over Veteran Suicide Review Team (VSRT) and shall be responsible for convening stakeholders, aggregating data, and providing annual reporting of comprehensive data for LA County Veteran suicide decedents. The annual report shall include specific findings of trends and recommendations.

I. Provide deceased veteran's PHI and PII data to the Department of Veterans Affairs for analysis in a combined effort to investigate and prevent suicide. This PHI and PII data will be sent via encrypted media methods such as e-mail using Microsoft Office product Azura to ensure security.

IV. OBJECTIVES:

VA and LA County have a shared goal to improve Veterans' health and well-being and enhance Veterans' access to health services and improve Veteran reintegration by reducing Veteran suicide, homelessness, and under/unemployment. This cooperative relationship will be mutually beneficial as the Parties work together through a set of objectives to achieve this goal. This MoA

sets forth a framework of intent and cooperation between the Parties to achieve the following objectives:

A. Collaborate to expand the reach and awareness of educational tools and web-based resources to Veteran staff in LACDMH, including but not limited to the VPAN workforce.

B. Collaborate to create mental health awareness and wellbeing educational opportunities for all Los Angeles County employees who are Veterans.

C. Explore opportunities for identifying Veterans employed by Los Angeles County who are not enrolled in VHA to increase awareness of VHA enrollment opportunities and to share Veteran-focused resources.

V. OUTCOMES:

The VA and Los Angeles County seek to enhance services to Veterans through this cooperative relationship in order to reduce suicide, homelessness, and under/unemployment. The ability to quantitatively and qualitatively capture objective performance through metrics that demonstrate the impact of this relationship is critical. Therefore, the Parties agree to use the following metrics to capture and record progress on the stated objectives through related outcomes, outputs, measurable, and/or impacts, as appropriate:

A. Number of LACDMH employees trained to use VA curricula such as S.A.V.E. Training, the gatekeeper training for suicide prevention.

B. Number of community awareness programs conducted by LACDMH staff specifically to reach Veterans.

C. Number of Veterans in attendance at events organized by LACDMH with VA staff in attendance.

D. Number of collaborative LACDMH and VA public service announcements that target mental health stigma reduction and encourage help-seeking behavior.

E. Number of Los Angeles County employees who are Veterans.

F. Number of LACDMH encounters with Veterans.

G. The annual homeless Point in Time count organized in LA County for data on Veteran homelessness.

H. The Los Angeles County Veteran Suicide Review Team for data specific to Veteran suicide.

I. Department of Labor employment statistics for data specific to Veteran employment.

J. Development and implementation of Veteran Suicide Review Team (VSRT) to aggregate data on Veteran suicide decedents in LA County and provide annual recommendation for prevention efforts.

VI. POINTS OF CONTACT:

Department of Veterans Affairs
Dr. Michael Fisher
VA Desert Pacific Healthcare Network
Director
VISN 22 Healthcare Network
300 Oceangate, Suite 700,
Long Beach, CA 90802
(562) 628-7940
Michael.Fisher5@va.gov

LA County Department of Mental Health
Dr. Jonathan E. Sherin
Director
LA County Department of Mental Health
550 S. Vermont Avenue
Los Angeles, CA 90020
(213) 738-4601
jsherin@dmh.lacounty.gov

VII. LIMITATIONS:

A. The purpose of this MoA is to create a cooperative, voluntary, collaborative, working relationship between VA and LACDMH. This MoA does not create a binding agreement or obligation, obligate either of the Parties to expend appropriations or reimburse the other Party for any costs, or create any rights between the Parties.

B. The VA and LACDMH shall have no obligation under this MoA to participate, develop, or implement any specific programs.

C. Neither the VA nor LACDMH will use this MoA to sell or promote any products or services. No payment shall be due to either Party for services provided under this MoA.

D. Neither Party will use the name of the other Party or any of its components, except in factual publicity and with prior approval of the other Party. Factual publicity includes announcements of dates, times, locations, purposes, agendas, and speakers involved with awareness activities or events described in Section III. Such factual publicity shall not imply that the involvement of the other Party serves as an endorsement of the general policies, activities, or products of the other Party. Each Party may use the other Party's logo, seals, flags, and other symbols only pursuant to a written determination by the other

Party that the proposed use by advances the aims, purposes, and mission of the other Party. Approval is not guaranteed.

E. Any publicity released by either Party concerning this MoA, the services or supports provided within, or any resulting outcomes, will be subject to prior approval of the other Party.

F. This MoA shall not be used to obligate or commit funds or as the basis for the transfer of funds. Neither Party may commit the other to any transfer of funds under this MoA.

G. This MoA is an internal government agreement that describes the general terms upon which the Parties intend to cooperate. This MoA does not intend to create any rights, privileges, obligations, or benefits, substantive or procedural, enforceable by any individual or organization against the United States; its departments, agencies, or other entities; its officers or employees; or any other person.

H. The VA and LACDMH agree to comply with all applicable privacy/confidential statutes and regulations including, but not limited to, the Health Insurance Portability and Accountability Act of 1996, the Privacy Act (5 U.S.C. §552a), and 38 U.S.C. §7332.

VIII. DURATION, AMENDMENT, AND CANCELLATION:

This MoA is in effect when signed by both Parties and will remain in effect for five years or until cancelled in writing by either Party, whichever occurs first. This MoA may be cancelled at will, without liability for any costs, direct or indirect. Notice of cancellation should be provided in writing within thirty calendar days before official cancelation so the non-cancelling party will have sufficient notice. Amendments must be executed bilaterally in writing, signed by authorized representatives of both entities. No oral or unilateral amendments will be effective.

IX. APPROVALS:

Department of Veterans Affairs
Veterans Healthcare Administration

By: _____
Michael Fisher, M.D.
VISN 22 Network Director
Veterans Healthcare Administration
Department of Veterans Affairs

Date: 7/20/2021

Los Angeles County
Department of Mental Health

By: _____
Jonathan E. Sherin, M.D., Ph.D.
Director
Los Angeles County
Department of Mental Health

Date: 7/20/21