DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Suicide Risk Assessments, Continuity of Care, and Leadership at the South Bend Vet Center in Indiana

HEALTHCARE INSPECTION | REPORT #21-02511-28 | JANUARY 19, 2023

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations and concerns related to the quality of care provided to several clients and leadership at the South Bend Vet Center (facility) in Indiana.[1] The facility is one of 54 vet centers aligned under Readjustment Counseling Service's (RCS) Midwest district 3. The facility is composed of a small team of multidisciplinary staff and is overseen by a vet center director (VCD).

RCS, an autonomous branch within the Veterans Health Administration (VHA), is responsible for the provision of readjustment counseling. Readjustment counseling is provided by vet center counselors (counselors) who work with veterans and servicemembers (clients) and their family members to address military-related psychological and psychosocial readjustment challenges and support a successful transition from military to civilian life.

VCDs and counselors assess and manage clients at risk for suicide, substance abuse, and other medical and mental health conditions. To evaluate a client's risk for suicide, counselors complete a risk assessment at the client's initial counseling session and consider the client's risk factors and known clinical information.[2] Based on the evaluation, counselors determine a client's suicide risk level. Depending on the level of risk, counselors employ increased contact and safety measures to assist the client in mitigating risk. Counselors reassess the client's risk for suicide during subsequent counseling visits when risk factors are identified.

The OIG substantiated that facility staff inaccurately assessed the level of risk for suicide of three clients, including one client (Client 1) who subsequently died by suicide. The facility VCD, counselors, and a former counseling intern (intern) were aware of and documented risk factors that may contribute to suicide for the client(s) they had assessed but failed to account for the risks when assigning each client's risk level for suicide.[3] The OIG found these suicide risk assessments to be rated lower than clinically indicated. Consequently, the three clients did not have safety measures such as personalized safety plans, clinical consultations, and heightened contact protocols in place.

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[1] VHA Directive 1500(2), *Readjustment Counseling Service*, January 26, 2021, amended December 30, 2021. By law, readjustment counseling services are to be provided without a medical diagnosis; therefore, "those receiving readjustment services are not considered patients, and they are neither subject to VA medical eligibility nor required to be recorded in the VA medical record." To be consistent with vet center policy and terminology, the OIG refers to veterans receiving such services as clients in this report.

[2] During the inspection review period, two assessment tools (lethality assessment and suicide risk assessment) were used to assess a client's risk for suicide. The lethality assessment was replaced by the suicide risk assessment in October 2020. The assessments share foundational elements; counselors must evaluate and rate a client's suicide risk level at the initial assessment, update the assessment and rating level when clinically appropriate, and initiate safety measures, as indicated, to mitigate suicide risk.

[3] The intern was in the second year of a Master of Social Work program per the OIG's review of internal documents and interviews.

The OIG found multiple factors contributed to the inaccurate ratings including the VCD's guidance to keep ratings low to avoid RCS leader involvement, a lack of the staff's understanding of evaluation and management of clients' suicidal risk, and competency deficits in the VCD's clinical and leadership practices.[4]

During the course of the inspection, the OIG learned that, in November 2021, the District Director removed the VCD from clinical care pending the results of a separate factfinding review of the VCD's suicide risk assessment ratings.[5] The OIG reviewed the factfinding report and noted that the conclusions, albeit focused on the VCD, mirrored the OIG's findings and concerns regarding inaccurate suicide risk ratings, the failure to reevaluate risk, the lack of safety planning, and deficits in VHA mental health collaboration and consultation of clients at risk for suicide.

VHA requires organizational leaders to file a report with the state licensing board when a licensed health care professional whose behavior or clinical practice "substantially failed to meet generally accepted standards of clinical practice as to raise [a] reasonable concern for the safety of [clients]."[6] VHA policy includes lack of diagnostic or treatment ability as actions that provide a reasonable basis for concern for a client's safety.[7] Further, reporting to the state licensing board must be initiated as soon as there is substantial evidence and not wait on other ongoing reviews or personnel actions.[8]

In January 2022, the District Director told the OIG that the concerns regarding the VCD's clinical client care identified in the factfinding had been referred to human resources for guidance. The District Director informed the OIG team that as of June 10, 2022, the VCD remained "suspended from all clinical duties," as well as VCD duties but continued to wait for guidance from human resources before taking administrative action to include state licensing board reporting. In September 2022, an RCS leader reported the matter remained under review. The OIG determined that district leaders should have initiated a report with the state licensing board after identifying deficiencies in the VCD's clinical assessments and care of clients in

[4] The lethality assessment risk levels included non-lethal, mild, moderate, and severe. The suicide risk assessment risk levels include low, intermediate, or high.

[5] Per district leaders and document reviews the OIG learned that effective November 5, 2021, three days prior to this inspection, the VCD was removed from clinical care pending a factfinding review of the VCD's suicide risk assessment ratings. The review was initiated after district leaders learned the VCD had rated a client's suicide risk level as low and maintained the low rating level despite the client being hospitalized for suicide-related behavior.

[6] VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards,* January 28, 2021. A licensed healthcare professional is a provider who is licensed, certified, or registered in a healthcare profession. The VCD was licensed in a healthcare profession; therefore, the OIG considers the VCD a licensed healthcare professional.

[7] VHA Directive 1100.18.

[8] VHA Directive 1100.18. "Substantial evidence is the degree of relevant evidence that permits a reasonable person might accept as adequate to support a conclusion, even if it is possible to draw contrary conclusions from the evidence, for believing that the professional so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients or the community."

December 2021, as required. Further, the OIG found RCS did not have a clearly defined process for reporting licensed health care professionals to state licensing boards, which may have contributed to the District Director deferring action while seeking guidance.

The OIG substantiated that the VCD failed to facilitate a time-sensitive transition of care between the intern and a counselor regarding Client 1, who later died by suicide, and to ensure follow-up action consistent with the client's recent high-risk behaviors, hospitalization, and post-hospitalization needs. Although the VCD reported taking, and directing staff to take, actions consistent with the client's risk factors to the OIG, the evidence within the client's record did not support the VCD's account.

Although it is unknown if increased clinical efforts would have prevented Client 1's death by suicide, the OIG determined the VCD failed to take measures necessary to mitigate risk. The OIG found that the VCD's failure to ensure a time-sensitive transition and coordination of the client's care from the intern to a counselor was an adverse event, as defined by VHA. VHA policy defines adverse events as "untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers."[9] The OIG found that RCS leaders did not disclose the adverse event to the client's personal representative. Initially, RCS leaders were unclear whether the VHA policy regarding the requirement to disclose the "occurrence of adverse events related to the patient's clinical care" to the patient or the patient's representative, was applicable to RCS.[10] RCS leaders later confirmed the policy was applicable and planned to seek consultation with VHA Medical-Legal Risk Management on initiating additional action.[11]

The OIG substantiated that the VCD, based on a reluctance to raise concerns from RCS leaders, guided facility staff to rate clients' risk levels for suicide low. During OIG interviews, facility staff and district leaders reported either being informed by the VCD or having awareness of the VCD's practice to have facility counselors keep suicide risk assessment ratings low to avoid involvement from RCS leaders. The OIG found that the VCD's clinical practice and guidance to facility counselors to keep suicide ratings low contributed to the inaccurate assessment of clients' risk for suicide.

The OIG determined that the VCD failed to provide adequate oversight of the intern including facility orientation, appropriate case assignment, and effective supervision. RCS policy states that VCDs assign clients a primary counselor based on case complexity and staff credentials; provide individual clinical supervision; and review electronic client records to ensure

[9] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[10] VHA Directive 1004.08.

[11] "Quality and Patient Safety (QPS)," VA, accessed May 10, 2022, https://www.va.gov/QUALITYANDPATIENTSAFETY/qm/index.asp. Clinical Risk Management is a program within VHA's Quality and Patient Safety division that oversees disclosure of adverse events.

documentation and provision of care is thorough and accurate. The OIG determined the VCD failed to instruct the intern on actions to ensure Client 1's safety despite awareness of the high-risk factors and clinical complexity. As a result, neither the VCD nor the intern implemented safety measures to mitigate Client 1's risk for suicide, as required. The OIG found the lack of a formal intern training curriculum and plan as well as deficits in the VCD's intern oversight contributed to these failures.

The OIG found that district leaders were aware of quality concerns related to readjustment counseling services at the facility but failed to initiate timely actions to address the reported concerns. Specifically, the OIG found repeat deficiencies from annual quality reviews conducted from late summer 2019 through spring 2021. The OIG concluded that, other than training for facility staff in the summer of 2021, no actions were initiated to address unmet standards and repeat deficiencies from the 2019–2021 annual quality reviews. Further, the OIG did not find evidence that the Deputy District Director addressed the lack of remediation for the deficiencies with the VCD.

The Deputy District Director reported not having the opportunity to do intensive work with the VCD because factfindings were underway. RCS leaders informed the OIG that the VCD was terminated effective September 30, 2022.

The OIG made three recommendations to the Chief Readjustment Counseling Officer related to disclosure of adverse events, intern orientation and oversight, and reporting to state licensing boards. The OIG made five recommendations to the Midwest District 3 Director related to suicide risk assessments, mitigation of suicide risk, continuity of care during counselor transitions, disclosure of adverse events, and reporting to state licensing boards.

VA Comments and OIG Response

The Chief Readjustment Counseling Officer and the Midwest 3 Director concurred with the recommendations and provided an acceptable action plan (see appendixes A and B). Based on information provided, the OIG considers recommendation 4 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are complete.

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Contents

Abbreviations

AIB	Administrative Investigative Board
EHR	electronic health record
OIG	Office of Inspector General
PTSD	posttraumatic stress disorder
RCS	Readjustment Counseling Service
VCD	vet center director
VHA	Veterans Health Administration

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations regarding inaccurate assessment of three veterans' suicidality and inadequate vet center director (VCD) oversight of treatment at the South Bend Vet Center (facility) in Indiana.

Background

The facility is one of 54 vet centers aligned under Readjustment Counseling Service's (RCS) Midwest district 3. The Midwest district 3 is comprised of three zones; each zone is led by a deputy district director. The facility, part of zone 1, is composed of a small team of multidisciplinary staff and is overseen by a VCD. From October 1, 2020, through September 30, 2021, the facility served 349 clients.[1]

Readjustment Counseling Service

RCS is an autonomous branch within the Veterans Health Administration (VHA) responsible for the provision of readjustment counseling services. Readjustment counseling is provided at vet centers by vet center counselors (counselors) who work to address veterans, servicemembers, and their family members' psychological and psychosocial readjustment challenges related to military service and deployment stressors and service-related traumas to support a successful transition from military to civilian life. VCD's and counselors assess and manage clients at risk for suicide, substance abuse, and other medical and mental health conditions and coordinate care needed outside of the vet center.[2] VCDs, in addition to administrative duties, also provide readjustment counseling services to clients and are responsible for duties inherent to the counselor role.[3] Vet center staff document client visits and client-related information in the web-

[1] VHA Directive 1500(2), *Readjustment Counseling Service*, January 26, 2021, amended December 30, 2021. By law, readjustment counseling services are to be provided without a medical diagnosis; therefore, "those receiving readjustment services are not considered patients, and they are neither subject to VA medical eligibility nor required to be recorded in the VA medical record." To be consistent with vet center policy and terminology, the OIG refers to veterans receiving such services as clients in this report.

[2] VHA Directive 1500(2).

[3] RCS Chief Officer memorandum, RCS-CLI-003, "Revised Clinical Site Visit (CSV) Protocol," January 25, 2019. Although rescinded on October 7, 2021, this protocol was in effect during the time of related clinical site visit events reviewed in this report. VHA Directive 1500, *Readjustment Counseling Service,* January 26, 2021; VHA Directive 1500(1), *Readjustment Counseling Service,* January 26, 2021, amended May 3, 2021; VHA Directive 1500(2), *Readjustment Counseling Service,* January 26, 2021, amended December 30, 2021. VHA Directive 1500 was amended in May and December of 2021; however, the content and language related to the topics discussed in this report remained unchanged.

based software system, RCSNet, which serves as the electronic client record that is independent from the VHA electronic health record (EHR).[4]

Readjustment Counseling Service—Operations and Alignment

The Chief Readjustment Counseling Officer reports to VHA's Under Secretary for Health and has direct line authority over RCS staff. The Chief Readjustment Counseling Officer is responsible for RCS assets, strategic planning, and coordination of services with other VA services, and serves as the "primary policy expert for VHA on readjustment counseling issues…."[5] The Deputy Chief Officer "is responsible for the oversight of all RCS readjustment counseling services provided and the development and implementation of all RCS national counseling service policies."[6] The RCS Operations Officer is responsible for daily operations through direct supervision of the district directors.[7]

RCS is organized into five districts with each district having approximately three zones.[8] A district director oversees each district, and a deputy district director is assigned to each zone. Deputy district directors have two associate district directors who assist the deputy in providing clinical and administrative support and oversight to each zone.[9]

Each vet center has a VCD, who reports to a deputy district director.[10] VCDs are responsible for vet center operations including supervision of small multidisciplinary teams, clinical programs, administrative and fiscal operations, outreach events, and community relations.[11]

Figure 1 shows the RCS, district, zone, and vet center leadership organizational structure specific to the Midwest district 3 zone 1, and South Bend Vet Center.

[4] VHA Directive 1500(2). 38 C.F.R. § 17.2000–816 (e). Vet centers do not disclose clients records unless a client authorizes release or there is a specific exemption.

[5] VHA Directive 1500(2).

[6] VHA Directive 1500(2).

[7] VHA Directive 1500(2).

[8] VHA Directive 1500(2). The OIG obtained these numbers via an RCS National Organization Chart signed by the RCS Chief Readjustment Counseling Officer and the Executive in Charge, Office of the Under Secretary for Health, on June 8, 2018.

[9] VHA Directive 1500(2).

[10] VHA Directive 1500(2).

[11] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration,* November 23, 2010. Per the Deputy Chief Officer, these guidelines were in the process of being phased out as RCS employees became familiar with and transitioned to the guidance and requirements in the new VHA Directive 1500 published in January 2021, which was later amended by VHA Directive 1500(1), and again by VHA Directive 1500(2). These guidelines and directives were in effect during part of the time of the events discussed in this report. Unless otherwise specified, requirements in the 2021 directives use the same or similar language as the rescinded November 2010 guidelines.

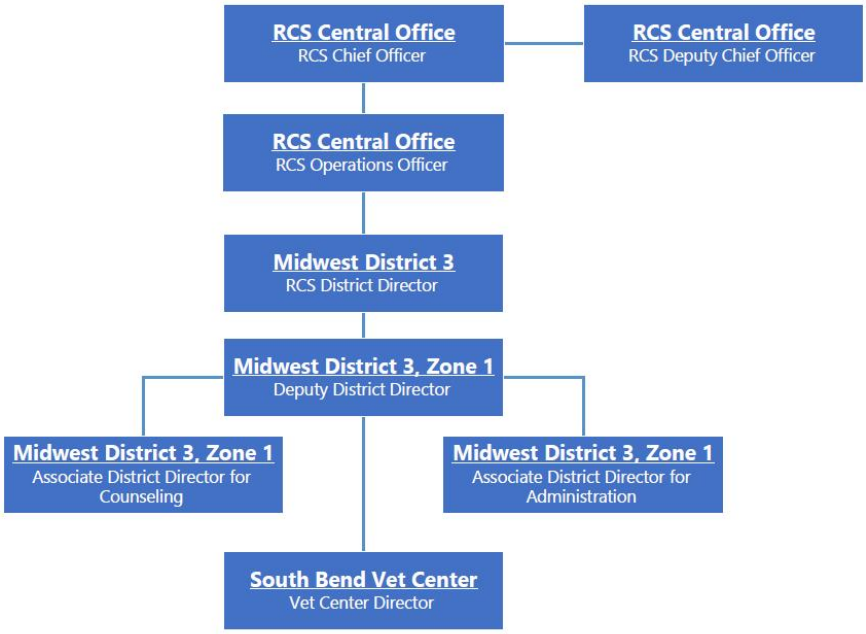

Figure 1. *RCS Central Office, Midwest district 3 zone 1, and South Bend Vet Center leaders. Source: VA OIG analysis of central office and district organization charts.*

VA Medical Center Collaboration

According to RCS policy, vet centers and VA medical centers maintain collaborative partnerships to better serve clients through referral and coordination of services. Each vet center is laterally aligned with a VA medical center that provides supportive administrative and clinical services. The aligned VA medical center's director assigns a licensed, credentialed VHA mental health professional as an external clinical consultant. The VA external clinical consultant provides vet center counseling staff professional consultation concerning mental health care and services to support clients' readjustment.[12]

Suicide Risk Assessment

The VA's National Veteran Suicide Prevention Annual Report published in the fall of 2021 found that after adjusting for age and gender differences, the suicide rate was 52.3 percent greater for veterans than for non-veteran adults.[13] In 2017, VHA identified RCS as a key office in the suicide prevention strategy. VHA recognized that the community based, psychosocial

[12] VHA Directive 1500(2).

[13] VA Office of Mental Health and Suicide Prevention, "2021 National Veteran Suicide Prevention Annual Report," accessed February 15, 2022, https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf.

readjustment perspective of vet centers could help identify opportunities to better identify veterans' risk of suicide and thereby improve clinical outcomes of veterans under VHA care.[14]

RCS developed procedures and implemented suicide risk assessment tools to assist counselors in evaluating and estimating client risk. In 2010, RCS established procedures for counselors to assess a client's risk for suicide and homicide using a "lethality assessment."[15] In 2015, RCS issued an additional policy requiring counselors complete lethality assessments in conjunction with clients' psychosocial and military assessments, recognizing that suicide and violence are particularly concerning as "combat Veterans with PTSD [posttraumatic stress disorder] and other associated readjustment difficulties are a high-risk population."[16] Counselors were to complete client lethality assessments; assign a risk rating as non-lethal, mild, moderate, or severe; and tailor clinical interventions to mitigate risk.[17]

In the fall of 2020, RCS developed and implemented a new risk assessment tool, the suicide risk assessment, which replaced the lethality assessment.[18] The suicide risk assessment incorporated suicide risk evaluation terminology that is in alignment with the VA/Department of Defense (DoD) clinical practice guideline regarding management of patients at risk for suicide.[19] Although the terminology changed, the process remained the same as counselors complete a suicide risk assessment and assign acute and chronic suicide risk assessment ratings of low,

[14] VHA Deputy Under Secretary for Health for Operations and Management memo, "*Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services*," November 13, 2017.

[15] *RCS Guidelines for Administration*, 2010.

[16] RCS Acting Chief Officer memorandum, "*Interim Policy for Vet Center Assessment and Management of High Risk Veteran Clients,*" June 19, 2015. Mayo Clinic, "Post-traumatic Stress Disorder (PTSD)," accessed December 10, 2020, https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967. "Post-traumatic stress disorder (PTSD) is a mental health condition triggered by a terrifying event—either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event."

[17] *RCS Guidelines for Administration*, 2010. VHA Directive 1500. VHA Directive 1500(1). VHA Directive 1500(2). The guidelines and directives were in effect during part of the time of the events discussed in this report. Unless otherwise specified, requirements in the 2021 directives use the same or similar language as the rescinded November 2010 guidelines.

[18] The lethality assessment and suicide risk assessment share foundational elements including being required at a client's initial assessment and updated when clinically appropriate. Both tools require considering risk factors and clinical information collected to guide follow-up steps to mitigate suicide risk. In this report, references to assessing suicidal risk encompass the lethality assessment and the suicide risk assessment.

[19] *Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services (RCSNet)*, updated October 5, 2020; *VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*, accessed January 19, 2022, https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskFullCPGFinal5088212019.pdf.

intermediate, or high based on a client's risk factors and protective factors.[20] Commensurate with a client's level of risk, counselors implement interventions and safety protocols to mitigate risk and promote the client's safety.[21]

Prior OIG Reports

The OIG Vet Center Inspection Program staff conducted a review of selected vet centers in the Midwest district 3 zone 1 in October and November of 2021.[22] The report, published on January 19, 2023, included district 3 level recommendations relevant to this inspection. The OIG made 10 recommendations related to the remediation of annual quality review deficiencies, completion of suicide risk assessments and safety plans, clinical consultation and coordination of care with VA medical centers, and the VCD's compliance with chart audits and weekly staff supervision.

Allegations and Concerns

On April 26, 2021, the OIG received allegations regarding deficiencies in client care and the VCD's leadership at the South Bend Vet Center. During the review, the OIG identified additional client care and leadership concerns.

- Specifically, the OIG team reviewed allegations and concerns related to client care including the accuracy of suicide risk assessments for three clients, timely transition and coordination of care for a client with high-risk factors, and disclosure of an adverse event.
- Additionally, the OIG reviewed allegations and concerns related to leadership effectiveness. Specifically, the VCD's policy regarding suicide risk assessment ratings and the adequacy of the VCD's orientation to and supervision of counseling interns, as well as RCS leaders' oversight of quality review deficiencies and reporting care concerns to state licensing boards.

On June 7, 2021, the OIG initiated a healthcare inspection to assess the validity of the allegations. On July 12, the OIG suspended the inspection after learning that RCS leaders had initiated an administrative investigation board (AIB) on July 7 to review several allegations

[20] VHA Directive 1500(2). Risk factors include suicidal ideation and intent, preparatory suicidal behavior, previous suicide attempts, psychosocial instability, and emotional distress. Protective factors include supports and coping skills available to a client to maintain their safety. *VA/DoD Clinical Practice Guideline*, accessed January 19, 2022, https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskFullCPGFinal5088212019.pdf. Preparatory behaviors are "Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away)."

[21] RCS Chief Officer memorandum, RCS-CLI-003, "Revised Clinical Site Visit (CSV) Protocol," January 25, 2019.

[22] VA OIG, *Vet Center Inspection of Midwest District 3 Zone 1 and Selected Vet Centers*. Report No. 21-03231-38, January 19, 2023. The OIG's Vet Center Inspection Program provides focused evaluations of the quality of care delivered at vet centers.

surrounding the VCD's management and facility practices that were similar to the allegations received by the OIG.[23] The OIG learned that RCS leaders placed the VCD on a detail while the AIB was convened. During the detail, the VCD maintained the provision of readjustment counseling services to clients, but leadership and supervisory responsibilities were removed. On August 12, OIG leaders met with legislative staff from the offices of Senators Mike Braun and Todd Young and Representative Jackie Walorski to discuss similar concerns regarding leadership, continuity of care, and suicide risk management received by the congressional offices.

In October 2021, an RCS leader notified the OIG that the AIB was complete. The OIG resumed the healthcare inspection on November 8, 2021.

Scope and Methodology

The OIG conducted virtual interviews from December 7 through December 20, 2021, with select interviews conducted in January and February 2022. The OIG team interviewed the RCS Operations Officer and Deputy Chief Officer, the RCS District Director, Deputy District Director, former and Acting Associate District Directors for Counseling, and a supervisory human resources specialist. Additional interviews included the facility VCD, former and current Acting VCDs, counselors, and a former counseling intern (intern).[24]

The OIG team reviewed relevant records and documents including EHRs and electronic client records of three clients, VHA and RCS policies, quality and administrative reports, and other documents relevant to the inspection. The OIG obtained and reviewed email communication regarding oversight and transfer of care for one client. The OIG issued a subpoena for one client's community hospital medical records; these records were received and reviewed.

In the absence of current VA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take

[23] VA Handbook 0700, *Administrative Investigations,* July 31, 2002. The handbook was in effect during the time of the events discussed in this report. This handbook was rescinded and replaced by VHA Handbook 0700, *Administrative Investigation Boards and Factfindings*, August 17, 2021. Unless otherwise specified, requirements in the 2021 handbook use the same or similar language as the rescinded July 2002 handbook. Administrative Investigation Board (AIB) is a type of administrative investigation for "collecting and analyzing evidence, ascertaining facts, and documenting complete and accurate information regarding matters of interest to VA."

[24] The intern was in the second year of a Master of Social Work program per the OIG's review of internal documents and interviews.

place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Client Case Summaries

Client 1

Client 1, who was in their 30's at the time of their death by suicide in the fall of 2020, first sought VA medical care in 2009.[25] The client's VA treatment began in fall 2009, when a case manager at the Richard L. Roudebush VA Medical Center in Indiana contacted Client 1 to assist the client in establishing medical care.[26] The case manager documented that Client 1's screenings for depression, posttraumatic stress disorder (PTSD), suicide risk, and alcohol use were negative and determined no case management was needed.[27]

In early 2010, a VA primary care physician evaluated Client 1 at an initial health care visit. Client 1 denied having medical concerns. Client 1 was subsequently seen for an audiology consult on April 22.

In early 2014, a VA nurse documented Client 1's return health care visit and recorded Client 1's depression, PTSD, and alcohol use screens were negative. On the same day, a nurse practitioner evaluated Client 1 who reported "sleep disturbance since return from Afghanistan" and requested to establish primary care at a VA clinic located in South Bend, Indiana.[28] An administrative

[25] The OIG uses a singular form of their to protect client privacy.

[26] The Richard L. Roudebush VA Medical Center, located in Indianapolis, Indiana, is a part of Veterans Integrated Service Network 10.

[27] Diagnostic and Statistical Manual of Mental Disorders, "Depressive Disorders," accessed March 16, 2022, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm04 (access restricted). Depression is "the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function." Diagnostic and Statistical Manual of Mental Disorders, "Substance-Related and Addictive Disorders," accessed March 16, 2022, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm16 (access restricted). "A problematic pattern of alcohol use leading to clinically significant impairment or distress."

[28] The Columbia Place VA Clinic, South Bend, Indiana, is an outpatient clinic under the VA Northern Indiana Health Care System within Veterans Integrated Service Network 10.

assistant from the VA clinic in South Bend documented that Client 1 did not attend a new patient appointment that day and that a missed appointment letter was mailed. An EHR review did not identify additional documentation or evidence that Client 1 received health care at VA medical facilities since early 2014.

In spring 2020, Client 1 came to the facility seeking counseling services. Client 1 reported being married, having children, and having served two tours in support of Operation Iraqi Freedom. Client 1 acknowledged having a problem with alcohol and reported past alcohol treatment at a community mental health hospital in fall 2018.

Client 1 was assigned to the intern and their first counseling session was in spring 2020.[29] Client 1 reported wanting to understand "whether [the client] has PTSD" and requested help with family stressors and keeping alcohol consumption under control. Client 1 reported being bothered by incidents during deployments, which contributed to why the client began drinking alcohol. Additionally, Client 1 reported pending felony legal charges, involvement with family services, and concerns regarding maintaining a position with the military. The intern documented these stressors and rated Client 1's suicide risk level as non-lethal.

Client 1 had another session with the intern five days later and reported ongoing stressors, including legal difficulties and a recent alcohol relapse. Nine days later, the intern documented a session with Client 1 to build coping skills. A scheduled session for the following week was rescheduled due to the client's work schedule. Counseling continued with discussions on coping mechanisms and decision making. Client 1 did not answer the telephone for a scheduled appointment two weeks later but responded to the intern's call two weeks after that and scheduled an appointment for a few days later. At this visit, Client 1 indicated finding "it helpful to 'have someone to talk to.'"

At a counseling session two weeks later, Client 1 reported several stressors that led to feelings of anger and helplessness. The intern discussed options for continued vet center services after the intern's last day at the facility. Client 1 did not attend a scheduled session and a week later, the intern unsuccessfully attempted to contact Client 1.

A few days later, Client 1 was admitted to a community mental health hospital for the exacerbation of depression, suicidal threats, and reports of drinking regularly. A psychiatrist at the community mental health hospital documented that Client 1 rapidly improved in the inpatient setting and that the client's hopelessness and mood changes were resolved. At the time of discharge a few days later, the client was reportedly anxious and apprehensive but denied thoughts of hurting self or others. Client 1 did not want medication treatment and was discharged home with a diagnosis of recurrent major depression and a plan to follow up with the facility.

[29] This counseling session, and all subsequent sessions, were conducted by phone.

The following day, Client 1's spouse left a message at the facility requesting a return call. While attempting to contact the spouse, the intern reached Client 1 and held a telephone counseling session. Client 1 informed the intern about the recent hospitalization, reported work and marriage related stressors, and expressed a desire for couples counseling. Due to the intern's pending departure from the facility, the intern documented "will advocate with supervisor for a referral which will address needs of Veteran and [client's] family…Per supervisor, transfer to [Counselor 1]. Message given [Counselor 1] to schedule client."

Two weeks later, Counselor 1 documented "left [voice mail] for [client] to schedule, as [client's] case was recently transferred to this clinician." Fifteen days after that, Counselor 1 left a second message for the client to "call back to schedule if [client] is still interested in services." Sixty-four days after the client was discharged from community inpatient treatment, Counselor 1 closed the case and documented "This clinician has not met or had any contact with veteran."[30]

Several days later, Client 1's spouse informed facility staff that Client 1 died by suicide. Two weeks later, a legal assistant at a VA medical center documented receiving notification that Client 1 died.[31]

Approximately three months later, a VA psychologist documented a review of Client 1's VA and non-VA medical records for benefit purposes. The VA psychologist documented that "the cumulative effects of trauma during [the client's] deployments" and "other negative life events that occurred during and between periods of active duty all likely contributed to PTSD and depressive symptoms and an increase in drinking which contributed substantially or materially to the [client's] cause of death from suicide."

Client 2

Client 2 was in their 20's when first seeking VA medical care in 2010. In fall 2010, a social worker at the Battle Creek VA Medical Center in Michigan documented that Client 2's screenings for PTSD, depression, and alcohol use disorder were positive. At this time, Client 2 accepted a consult to the care management team for further evaluation.[32] Approximately six weeks later, a program support assistant documented that Client 2 had not completed the eligibility and enrollment process and that a primary care physician had not been assigned. A

[30] Although the OIG could not find parameters or a definition of a closed case that would have been in effect during this episode of care, per VHA Directive 1500(2), counselors close cases after a period of inactivity and send the clients a follow-up letter that includes an invitation to return for readjustment counseling.

[31] The Marion VA Medical Center, Marion, Indiana, is part of the VA Northern Indiana Health Care System within Veterans Integrated Service Network 10.

[32] The Battle Creek VA Medical Center in Battle Creek, Michigan, offers inpatient mental health and medical beds, and residential rehabilitation treatment program beds. The Battle Creek VA Medical Center is within Veterans Integrated Service Network 10.

review of the EHR and electronic client record revealed Client 2 did not receive mental health care at any VA facilities until summer 2020.

In summer 2020, Client 2 contacted the VA's Veterans Crisis Line and requested assistance obtaining substance use treatment and family therapy. [33] At the time of the crisis line call, the client denied suicidal intent.

A few days later, a program support assistant from the Marion VA Medical Center in Indiana documented a telephone call from Client 2 requesting to have a primary care provider assigned at the VA outpatient clinic in Mishawaka, Indiana.[34] Client 2's spouse had left a message at the clinic and shared that the client was in need of substance use and mental health treatment. A VA outpatient clinic mental health social worker contacted the client and documented a plan to connect the client with the VA community-based outpatient clinic staff in Mishawaka for follow-up and recommended a medical evaluation.

A week later, Client 2 presented to the facility to initiate counseling services after being referred by VA staff. Two weeks later, Counselor 2 contacted Client 2 and scheduled an appointment.

The following week, Client 2 attended an initial counseling session with Counselor 2. Client 2 reported feeling overwhelmed and hopeless about having a substance abuse problem. Client 2 shared having attended a rehabilitation program "more than once and it did not work…."

Three weeks later, Client 2 contacted Counselor 2 and reported having passive suicidal ideation and relayed missing work due to feeling hopeless and helpless.[35] Counselor 2 documented that Client 2 denied having a suicidal plan and reported family as a protective factor. With consent, Counselor 2 notified the client's spouse of the passive suicidal thoughts and arranged for Client 2 to meet with the VCD on this date. Counselor 2 rated Client 2's suicide risk level as mild. The VCD met with Client 2 and documented the client was drinking alcohol daily and had been unable to sleep. The VCD and Client 2 contacted the Battle Creek VA Medical Center and scheduled a screening for a substance abuse program for the following week.

A few days later, Client 2 was hospitalized for three days and treated at the Battle Creek VA Medical Center for alcohol intoxication and withdrawal symptoms. A physician diagnosed the client with chronic alcohol dependence and inflammation of the liver related to alcohol use. Following hospital discharge and while pending admission into a substance abuse treatment

[33] VHA, "VA's Veterans Crisis Line Saves Lives Every Day," accessed August 25, 2022, https://www.va.gov/HEALTH/NewsFeatures/2015/February/VAs-Veterans-Crisis-Line-Saves-Lives-Every-Day.asp. The Veterans Crisis Line is a free, confidential resource that connects the caller to a real person trained to support veterans and their loved ones.

[34] The VA community-based outpatient clinic in Mishawaka, Indiana, is Saint Joseph County VA Clinic. The clinic is part of the VA Northern Indiana Health Care System.

[35] Jaclyn C. Kearns et al., "Temporal sequences of suicidal and nonsuicidal self-injurious thoughts and behaviors among inpatient and community-residing military veterans," *Journal of Affective Disorders* (2021) 430-440. Passive suicidal ideation are thoughts of wishing one were dead.

program, the client met with Counselor 2 six times over the following month and continued sessions throughout the next three months.

In early 2021, the client's spouse informed Counselor 2 that Client 2 went to Battle Creek VA Medical Center's urgent care the previous day. Client 2 was hospitalized for three days and treated for alcohol dependence at the Battle Creek VA Medical Center.

A few days later, Client 2 was admitted to a substance abuse treatment program at the Battle Creek VA Medical Center for six weeks for treatment of chronic alcoholism. Client 2 was discharged against medical advice after the client reported having a family emergency.

Two weeks later, Client 2 presented to a community hospital emergency department for suicidal ideation. Client 2 was evaluated, held for several hours, and discharged home.

After two weeks, Counselor 3 documented a clinical consultation with district leaders and the VA external clinical consultant (clinical consultant) about closing Client 2's case with an option for the client to return upon completion of an addictions program.[36] The following day, Counselor 3 documented having communicated with Mishawaka VA Clinic staff and a VA suicide prevention coordinator regarding Client 2's history of suicidality and alcohol use.[37]

Two days later, a registered nurse at the Marion VA Medical Center documented that Client 2 presented to a community hospital emergency department for increased suicidal thoughts, alcohol use, and having fired a gun. Client 2 remained at the community hospital for three days and later acknowledged having attempted suicide. One week later, the clinical consultant called the client and documented that Client 2 shared having attempted suicide after the spouse requested a divorce. The following week, a VA suicide prevention coordinator placed a High Risk for Suicide Patient Record Flag in Client 2's EHR.[38]

A few days later, Counselor 4 documented consulting with the clinical consultant regarding the closure of Client 2's case and completed a closing note three weeks later. As of February 2022, Client 2 continued to receive services through VA medical centers.

[36] The VCD documented transferring Client 2's care to Counselor 4 because of the counselor's experience treating substance abuse. The clinical consultant was employed at the aligned VA medical center, specifically, the Fort Wayne VA Medical Center.

[37] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide,* July 18, 2008. The suicide prevention coordinator position at VA medical centers has the responsibility for coordination of suicide prevention strategies and maintaining High Risk for Suicide Patient Record Flags.

[38] VHA Directive 2008-036. VA medical centers use a High Risk for Suicide Patient Record Flag to identify a patient as high risk for suicide in their medical record, requiring intensive follow-up by VA medical providers while the patient is flagged. RCS-CLI-006, *High Risk Suicide Flag Outreach*, April 27, 2020. A list of clients with a High Risk for Suicide Patient Record Flag is available to RCS VCDs via a computerized list.

Client 3

Client 3, who was in their 30's when receiving care from the facility in 2020, began care with VA medical centers in late 2011. Over the next seven years, Client 3 had nine hospitalizations at three different VA medical centers for treatment of PTSD, depression, alcohol abuse, or drug abuse. Five of the nine hospitalizations included either a suicide attempt or suicide ideation with or without a plan. Client 3 attended a residential PTSD treatment program in spring 2019 and was discharged after not returning from a weekend pass, relapsing on methamphetamine, and requesting a discharge.

During a hospitalization in summer 2019, a suicide prevention coordinator added a High Risk for Suicide Patient Record Flag to the client's EHR. Nine months later, a suicide prevention coordinator inactivated the High Risk for Suicide Patient Record Flag following a negative suicide risk screening. While multiple mental health outpatient appointments were scheduled from 2013 through 2020, Client 3 frequently did not attend the appointments.

In late spring 2020, Client 3 met with a staff member at the facility to seek services and attended an initial counseling session with Counselor 3 five days later. During the session, Client 3 reported PTSD symptoms, depression, suicidal thoughts, and a "history of addiction, [but] has been crack free for 2.5 years, and meth [methamphetamine] free for 6 months." Counselor 3 documented these stressors and rated Client 3's suicide risk level as mild.

Client 3 did not attend the next scheduled visit two weeks later or two subsequent appointments. After Client 3 did not respond to Counselor 3's telephone messages or to a follow-up letter, Counselor 3 closed the electronic client record.

Over the next eight months, Client 3 received outpatient mental health services at four VA locations and had a VA medical center hospitalization for suicidal ideation. During the hospitalization, a suicide prevention specialist reactivated the High Risk for Suicide Patient Record Flag. In late 2020, the High Risk for Suicide Patient Record Flag was inactivated after Client 3 attended a mental health appointment and did not have any documented suicidal ideation; a follow-up mental health appointment was scheduled.

In spring 2021, Client 3 contacted the facility requesting to restart counseling. A few weeks later, Client 3 attended an initial session with Counselor 4 and reported methamphetamine and alcohol use. Two weeks later, Counselor 4 held a phone session with Client 3 and spouse and documented that the spouse would take the client to an emergency department due to being heavily under the influence of substances. Client 3 was hospitalized for four days at a VA medical center for suicidal ideation; drug screens were positive for amphetamine, alcohol, and cannabis. Upon discharge, Client 3 continued to receive outpatient mental health services from a VA medical center.

In spring 2021, Counselor 4 consulted with the VCD regarding Client 3 and documented "a serious addictions' situation which involve[s] potential for suicidality" and "the pending likely

'warm-hand-off' of Veteran" to VA medical center services. Two weeks later, Counselor 4 reviewed Client 3's case with clinical consultants and facility clinical staff and documented a plan to temporarily close the client's electronic record while the client received substance abuse treatment through a VA medical center. Although scheduled to begin an intensive outpatient treatment program, Client 3 did not attend the program.

The former Acting VCD attempted to contact Client 3 approximately two months later, and left a telephone message requesting a callback to check-in for treatment needs. The following day, the former Acting VCD made two additional attempts to contact Client 3 and documented "discontinue attempts to call at this time." No further documentation was recorded in the electronic client record.

Inspection Results

Deficiencies in Client Care

The OIG identified deficiencies in facility staff's provision of client care. Specifically, the OIG substantiated that facility staff inaccurately rated the risk of suicide for three clients. Further, the OIG found deficiencies in the transition and coordination of care for a client with high-risk factors and the disclosure of an adverse event.

Inaccurate Assessment of Clients' Risk for Suicide

The OIG substantiated that facility staff inaccurately assessed three clients' risk ratings for suicide, including Client 1 who subsequently died by suicide. The facility VCD, counselors, and the intern were aware of and documented risk factors for the client(s) they had assessed but failed to account for the identified risk factors and changes in risk conditions when assigning a "non-lethal" level of risk for suicide in one client and a "mild" level of risk for suicide in two clients. The OIG found that the suicide risk assessments completed by the VCD, counselors, and the intern were lower than clinically indicated given the presenting risk factors and changes in risk conditions for the three clients. Consequently, the three clients did not have safety measures such as personalized safety plans, clinical consultations, and heightened contact protocols in place.

RCS requires that counselors conduct a risk assessment to evaluate the level of risk for suicide on each client and implement interventions commensurate with the level of risk.[39] A risk assessment must be completed during the first counseling session and during subsequent

[39] *RCS Guidelines for Administration*, 2010. VHA Directive 1500. VHA Directive 1500(1). VHA Directive 1500(2). The guidelines and directives were in effect during part of the time of the events discussed in this report. Unless otherwise specified, requirements in the 2021 directives use the same or similar language as the November 2010 guidelines.

counseling visits when risk factors are identified.[40] The risk assessment includes the identification of risk factors that may contribute to suicide and guides counselors in estimating risk. These risk factors include the presence of suicidal ideation, suicidal plans, prior suicide attempts, access to weapons, recent losses, substance use, the lack of social support, medical and mental health conditions, current stressors, and mental health status.[41]

RCS also requires counselors to initiate actions such as safety planning, clinical consultation, and increased client contact to mitigate suicide risk for clients when indicated. A counselor is required to develop a personalized safety plan with a client whose suicide risk assessment rating is above *low* to identify individualized protective behaviors and coping strategies for the client to implement when having suicidal ideation.[42] Further, RCS requires counselors to seek clinical consultation through the VCD, Associate District Director for Counseling, VA external clinical consultant, or other VHA mental health professionals when a risk assessment indicates that a client may be suicidal. Clinical consultation serves to increase the accuracy of assessing risk and ensure the appropriate level of intervention is implemented to manage risk. For a high-risk client who misses an appointment, RCS requires counselors to attempt contact within the hour to make a clinical assessment of that high-risk client's wellbeing.[43] In January 2019, RCS added guidance for counselors to continue contact efforts until a high-risk client who missed a scheduled appointment was reached or the client's status (safety) was confirmed.[44] In addition, when counselors learn of a suicidal crisis including a client's suicide attempt or death, counselors must notify RCS leaders through a crisis report. These heightened levels of intervention, contact, consultation, and leader notification are intended to ensure RCS provides thorough counseling services to mitigate risk and maintain safety for high-risk or suicidal clients.[45]

Client 1

The OIG reviewed Client 1's electronic client record and found that in spring 2020, Client 1 attended the first counseling session with the intern at the facility. The intern documented that Client 1 reported increased alcohol use, was bothered by incidents during military deployments, had significant pending legal and family issues, and had concerns regarding military career. The intern documented Client 1's risk of suicide to be "non-lethal" (lowest possible risk). At a

[40] RCS Chief Officer memorandum, RCS-CLI-003, "Revised Clinical Site Visit (CSV) Protocol," January 25, 2019. VHA Directive 1500. VHA Directive 1500(1). VHA Directive 1500(2).

[41] RCS Acting Chief Officer memo, "Interim Policy for Vet Center Assessment and Management of High Risk Veteran Clients," June 19, 2015.

[42] VHA Directive 1500(2). Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services (RCSNet), updated October 5, 2020.

[43] *RCS Guidelines for Administration*, 2010; VHA Directive 1500. VHA Directive 1500(1). VHA Directive 1500(2).

[44] RCS Chief Officer memorandum, RCS-CLI-003, "Revised Clinical Site Visit (CSV) Protocol. VHA Directive 1500. VHA Directive 1500(1). VHA Directive 1500(2).

[45] *RCS Guidelines for Administration*, 2010. VHA Directive 1500. VHA Directive 1500(1). VHA Directive 1500(2).

counseling session approximately two months later, the intern documented that Client 1 was navigating a "life crisis" related to ongoing family and legal stressors. Again, two weeks later, Client 1 discussed life stressors and reported feeling angry and helpless. The intern noted that Client 1 "is facing a variety of legitimate stressors any one of which would typically be overwhelming." Throughout this time, the intern did not complete an updated suicide risk assessment or develop a safety plan, and the initial non-lethal suicide risk rating remained.

One month later, the intern contacted Client 1 and held a counseling session. Because the internship was concluding, this was the intern's final session with Client 1. During the session, Client 1 reported going to an emergency room the week prior because of life stressors and drinking alcohol. Client 1 informed the intern that, after emergency department staff voiced concerns about a "depressive disorder," Client 1 was admitted to a community mental health hospital for four days. The electronic client record did not reflect that the intern reassessed Client 1's level of risk, engaged the client in safety planning, or sought clinical consultation; the initial non-lethal rating remained. An OIG review of the community mental health hospital records confirmed that Client 1 was admitted to the hospital for exacerbation of depression, suicidal threats, and reports of drinking regularly. A review of the electronic client record and the client's EHR revealed that Client 1 died by suicide in fall 2020.

The OIG team interviewed the intern regarding the appropriateness of Client 1's initial risk assessment rating of non-lethal and the absence of reassessments following discharge from the hospital. The intern stated that, given the information Client 1 initially provided, the rating was a "reasonable judgement." The intern did not recall whether an updated risk assessment was completed post-hospitalization but said that, in retrospect, one should have been done. The intern did not remember receiving training on suicide risk assessments or policies and practices on how to respond to a suicidal client and later added not feeling prepared to assess risk. The Former Associate District Director for Counseling reported that there were missed opportunities with the care provided to Client 1 and the client's report of a community mental health hospitalization was reason to increase the client's suicide risk rating.

The OIG concluded that although Client 1 presented with risk factors that may contribute to suicide, during the initial session, the intern inaccurately rated Client 1's suicide risk level as non-lethal. Despite significant risk factors evident through Client 1's counseling sessions, including a mental health hospitalization, Client 1's documented suicide risk rating remained at the non-lethal level throughout the client's care at the facility, and no clinical consultations or safety plans were in place. Although it is not known whether these safety measures would have prevented Client 1's death by suicide, the OIG found that mandatory RCS measures to mitigate suicide risk were not followed.

Client 2

The OIG reviewed Client 2's electronic client record and found that in late summer 2020, Client 2 attended the first counseling session at the facility. Counselor 2 met with Client 2 and

the client disclosed having access to weapons and feeling overwhelmed and hopeless about an ongoing, 10-year problem of alcohol abuse. A few weeks later, Client 2 called Counselor 2 and expressed having passive suicidal ideation and relayed having missed work due to feeling too hopeless and helpless. With consent, Counselor 2 notified the client's spouse of the passive suicidal thoughts and arranged for Client 2 to meet with the VCD on this date to discuss treatment options. Counselor 2 rated Client 2's risk for suicide as mild.

Six months later, the VCD documented having spoken with Client 2 who reported being discharged from a substance abuse treatment program. The following day, the VCD completed a suicide risk assessment and rated Client 2 at low acute and low chronic risk despite Client 2's recent discharge from a substance use treatment program, prior suicidal ideation with a history of access to weapons, and marital discord. A few days later, Client 2 presented to a community hospital emergency department for suicidal ideation and was discharged the same day. Approximately two weeks later, a registered nurse at the Marion VA Medical Center documented that Client 2 presented to a community hospital emergency department and was hospitalized for increased suicidal thoughts, alcohol use, and having fired a gun.

Several days after Client 2's second community hospital emergency department visit, Counselor 4 rated Client 2's suicide risk as high acute and high chronic. Three days later, a VA medical center suicide prevention coordinator documented placement of a High Risk for Suicide Patient Record Flag in the client's EHR.[46]

The OIG concluded that Client 2's initial suicide risk level assigned by Counselor 2, and the suicide risk level assigned by the VCD in spring 2021, were lower than clinically indicated. Given Client 2's risk of harm based on having recent suicidal ideation, increased mental health stressors, and an admission to a substance use treatment program, the client's suicide risk warranted a higher rating and additional interventions such as completion of a safety plan, increased contact, and clinical consultation.

Client 3

An OIG review of the electronic client record revealed that in late spring 2020, Client 3 attended the first counseling session at the facility with Counselor 3. Client 3 reported having suicidal thoughts, prior suicide attempts with the most recent attempt occurring six months earlier, access to weapons, and having lost five friends to suicide. Counselor 3 left 8 of 14 questions on the lethality assessment unanswered and assessed Client 3's risk of suicide as mild. Following three missed appointments, each followed by an attempt to contact the client, Counselor 3 closed Client 3's case approximately three weeks later due to lack of engagement.

Client 3 contacted the facility's outreach specialist eight months later, requesting to reinitiate counseling services. Several weeks later, the VCD completed a suicide risk assessment and rated

[46] The VA medical center referenced was the VA Northern Indiana Healthcare System.

Client 3's risk of harm low acute and low chronic despite also documenting past suicidal ideation, two previous suicide attempts, survivor's guilt, nightmares, mental health diagnosis, and substance use.[47] The VCD completed a mental wellbeing scale indicating Client 3 answered "none of the time" to dealing with problems, feeling useful, feeling relaxed, thinking clearly, and able to make up own mind about things.[48] The VCD assigned Client 3 to Counselor 4 who documented in a session two weeks later that Client 3 reported methamphetamine, marijuana, and alcohol use. During this counseling session, Counselor 4 completed a risk assessment and rated Client 3's risk as intermediate acute and low chronic; however, no safety plan was completed. Client 3 was hospitalized two days later for suicidal ideation with the intent to kill oneself. Counselor 4 completed a suicide risk assessment a few days later and rated the client's risk of harm as intermediate acute and intermediate chronic but did not complete a safety plan.

The OIG concluded that Client 3's suicide risk assessments completed by Counselor 3 in late spring 2020 and by the VCD eight months later did not accurately reflect the client's risk for suicide. The VCD assigned a low risk rating despite the client having reported risk factors of increased substance use, past suicide attempts, and increased mental health symptoms. Further, Counselor 3's single contact attempts with Client 3 after missed appointments in summer 2020 were missed opportunities to assess and ensure Client 3's wellbeing.[49] The OIG found that, because of Client 3's inaccurate risk assessment level, neither Counselor 3 nor the VCD took additional safety measures, such as the development of a safety plan, increased contact, and clinical consultation. Although the OIG found risk assessment ratings from spring 2021 to be reasonable given the risk factors, Counselor 4 failed to develop a safety plan with Client 3.

Factors Contributing to Inaccurate Suicide Risk Ratings

The OIG team asked the former Acting VCD about the VCD's and counselors' knowledge of suicide risk assessments and ability to accurately evaluate risk levels. The former Acting VCD reported providing multiple trainings to facility counselors on evaluation and management of clients' suicidal risk during the summer of 2021. The former Acting VCD stated that some of the

[47] RCS, *Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services (RCSNet)*, updated October 5, 2020. Low suicide risk (acute): "Potential existence of suicidal ideation without intent, plan or preparatory behavior." Low suicide risk (chronic): "…the absence of suicidal ideation or fleeting suicidal ideation during periods of stress."

[48] Warwick Medical School, "About WEMWBS [Warwick-Edinburgh Mental Wellbeing scale]," accessed on December 1, 2021, https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/about. "The Warwick-Edinburgh Mental Wellbeing scale was developed to enable the monitoring of mental wellbeing in the general population" with "the original 14-item scale and the short 7-item scale." Warwick Medical School, "WEMWBS: 14-item vs 7-item scale," accessed on July 28, 2022, https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/about/wemwbsvsswemwbs. The seven-item scale asks the following questions: I've been feeling optimistic about the future, feeling useful, feeling relaxed, dealing with problems well, thinking clearly, feeling close to other people, and being able to make up my own mind about things.

[49] The OIG learned that the concern for follow-up with missed appointments was also identified as a facility deficiency in the RCS annual quality reviews dated July 25, 2019; February 15, 2020; and February 16, 2021.

training provided appeared to be new information to the counselors. The former Acting VCD also reported having concerns about the VCD's clinical skills and mitigation of clients' suicide risk factors and reported addressing these concerns with the VCD.

During the course of the inspection, the OIG learned that on November 5, 2021, the District Director removed the VCD from clinical care pending the results of a separate review of the VCD's suicide risk assessment ratings (factfinding).[50] The summary report emphasized, "Appropriate suicide risk [assessment] rating and follow up are imperative to ensuring continuity of care, appropriate level of care for veterans in crisis, and overall therapeutic benefit of mental health services."

The OIG reviewed the RCS' factfinding report and noted that the conclusions, albeit focused on the VCD, mirrored the OIG's findings and concerns regarding inaccurate suicide risk ratings, the failure to reevaluate risk, the lack of safety planning, and deficits in VHA mental health collaboration and consultation of clients at risk for suicide.[51] The District Director informed the OIG team that as of June 10, 2022, the VCD remained removed from clinical care.[52]

Inadequate Transition and Coordination of Care for Client 1

The OIG substantiated that the VCD failed to facilitate a time-sensitive transition of Client 1's care from the intern to Counselor 1 and ensure follow-up action consistent with Client 1's recent high-risk behaviors, subsequent hospitalization, and post-hospitalization needs. Although the VCD had advanced notice of the intern's departure and was aware of Client 1's recent discharge from a community mental health hospital, the VCD did not document a plan to transition Client 1's care to Counselor 1 or ensure that Counselor 1 was aware of Client 1's risk factors. The OIG found the VCD's verbal account of actions taken to transfer and coordinate care was inconsistent with the documentation in the electronic client record and supervisory records. Counselor 1 did not attempt to contact Client 1 for two weeks after the transfer and made one additional unsuccessful attempt prior to closing the client record.

RCS policy recognizes that "transition and coordination of services between different providers introduces a period of high-risk" for clients and is a clinical priority.[53] When transferring a client's care, mental health professional literature recommends that the departing counselor schedule joint appointments with the incoming counselor and that a supervisor can be a point of

[50] Per district leaders and document reviews the OIG learned that effective November 5, 2021, three days prior to this inspection, the VCD was removed from clinical care pending a factfinding review of the VCD's suicide risk assessment ratings. The review was initiated after district leaders learned the VCD had rated a client's suicide risk level as low and maintained the low rating level despite the client being hospitalized for suicide-related behavior.

[51] The OIG did not independently review or validate the RCS leaders' review of the VCD's risk assessment ratings.

[52] Further discussion regarding RCS leaders' actions or inactions are addressed in this report under the section *Inadequate RCS Leaders' Response to Quality Concerns*.

[53] RCS Chief Officer memorandum, RCS-CLI003, "Revised Clinical Site Visit (CSV) Protocol," January 25, 2019.

contact during this transition to facilitate continuity of care between the counselors.[54] RCS requires the VCD to address internal case coordination during weekly counselor supervisory sessions. Follow-up documentation of coordination of services is also required.[55] Further, mental health professional literature emphasizes that the period following discharge from a mental health hospitalization is one of heightened risk for suicide and suicide attempts, which can be reduced via follow-up contacts by care providers.[56]

In summer 2020, the intern documented informing Client 1 that the intern would be leaving the facility when the internship was completed the following month. During the final counseling session, the intern learned that Client 1 had presented to a community emergency department a few days earlier and was admitted to a community mental health hospital for four days, related to becoming upset about life circumstances and drinking alcohol. The intern documented that the client reported stress from work, emotional distancing from the spouse, and concern for a family member, and noted the intent to advocate with the VCD for referrals to address the needs of Client 1 and family. The intern also documented messaging Counselor 1 to follow up with Client 1. The OIG reviewed email communication and found that the intern emailed Counselor 1 with relevant clinical information for Client 1, including the recent hospitalization and request for marital therapy.

The OIG found documentation in the electronic client record that Counselor 1 made two attempts to contact Client 1 by telephone approximately two and four weeks later. Counselor 1 documented having left messages for the client to schedule or call if interested in facility services. After hearing no response from Client 1, Counselor 1 closed the client's case a few weeks later without addressing Client 1's need for follow-up for depression and post-hospitalization treatment, as well as couples and family support. Several weeks later, Client 1's spouse came to the facility seeking bereavement care, sharing that Client 1 had died by suicide. According to the client's EHR, Client 1 died approximately two weeks prior to the client's case being closed.

When asked by the OIG team about Client 1's post-hospitalization transition and the transfer of care to a new counselor, the VCD recalled being informed "right away" by the intern of the client's community hospitalization. The VCD reported asking the intern to contact the community hospital and coordinate Client 1's transition of care back to the facility.[57] Per the intern, the internship ended in summer 2020, and the VCD stated reassigning the case to

[54] Lee Williams and Hawley Winter, "Guidelines for an Effective Transfer of Cases: The Needs of the Transfer Triad," *The American Journal of Family Therapy*, 37 (2009): 146-158.

[55] RCS Chief Officer memorandum, RCS-CLI-003, "Revised Clinical Site Visit (CSV) Protocol," January 25, 2019.

[56] David D. Luxton, Jennifer D. June, and Katherine A. Comtois, "Can Postdischarge Follow-Up Contacts Prevent Suicide and Suicidal Behavior? A Review of the Evidence" *Crisis*, (2013): 32-41.

[57] The client electronic record and the intern's verbal report revealed that neither the intern nor the VCD were aware of the hospitalization until informed by Client 1 post-discharge.

Counselor 1 around that time. When questioned about Client 1's transition to a new counselor, the VCD reported that Counselor 1 was unavailable to attend a joint session with the intern and Client 1 and, therefore, asked the intern to discuss Client 1's case with Counselor 1. The VCD recalled communicating the urgency of Client 1's case to Counselor 1, "I remember talking to [Counselor 1] about it and saying…this is a high-risk case [and] we need to be on top of [it]…." When questioned about Counselor 1's two-week delay in contacting Client 1, the VCD stated that Counselor 1 could have reached out to the client sooner but added that Counselor 1 had a heavy caseload at that time. The VCD stated that they discussed the case prior to Counselor 1 closing it but did not provide any insight as to why more rigorous efforts to contact the client had not been made. The OIG team attempted to interview Counselor 1 but did not receive a response to the interview request.[58]

The OIG reviewed the electronic client record and supervision notes provided by the VCD and did not find evidence to support that the VCD provided clinical oversight of Client 1's care transition from the intern to Counselor 1. The OIG found that the VCD met with Counselor 1 but did not document review of Client 1's care or that the VCD documented having transferred Client 1's case to Counselor 1. The VCD's supervision notes with Counselor 1 do not list Client 1 as a case reviewed during supervision, and the notes do not reference Client 1's high-risk status or recent hospitalization.

Interviews with former and current RCS clinical leaders supported that the transfer of care from the intern to Counselor 1 could have been handled better. The Deputy Chief Officer noted that the transfer should have happened face-to-face so that a connection could have been made between the client and the new counselor. The Former Associate District Director for Counseling stated that transfer of care between providers is the VCD's responsibility.

The OIG concluded that the VCD failed to facilitate a time-sensitive transition of Client 1's care from the intern to Counselor 1 and ensure continuity of care for a high-risk client post-hospitalization. The OIG found that, although the timing of the intern's departure was known in advance, a transition of care between the intern, Counselor 1, and Client 1 did not occur. Further, the VCD did not document verification that Counselor 1 had received pertinent clinical information. The intern had one session with the client post-hospitalization; however, the newly assigned counselor did not attempt to contact Client 1 for two weeks and documented a closing note after making a second unsuccessful attempt to contact the client. The OIG found that during a period of heightened risk, the VCD failed to take measures necessary to mitigate Client 1's risk for suicide.

[58] The OIG was informed that Counselor 1 was no longer employed at the facility.

Failure to Disclose Adverse Event

Although it is unknown if increased clinical efforts would have prevented Client 1's death by suicide, the OIG determined the VCD failed to take measures necessary to mitigate the client's risk. The OIG found that the VCD's failure to ensure a time-sensitive transition of Client 1's care from the intern to Counselor 1 and make diligent efforts to coordinate services following Client 1's mental health hospitalization was an adverse event, as defined by VHA. The OIG identified that RCS leaders had not considered disclosing the adverse event to Client 1's personal representative prior to the OIG team's inspection.

VHA established policy to "ensure the consistent practice in disclosing to patients or to the patient's personal representative the occurrence of adverse events related to the patient's clinical care."[59] VHA policy defines adverse events as "untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers."[60] The disclosure of adverse events entails a forthright, empathetic discussion of clinically significant facts between providers and patients or their personal representatives about the occurrence of a harmful adverse event. VHA policy requires providers to complete a clinical disclosure of an adverse event when a "harmful or potentially harmful adverse event has occurred during the patient's care."[61] According to VHA policy, leaders and clinicians use an institutional disclosure process to "inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[62] Although the VHA policy does not specifically reference RCS, the OIG notes that counselors are VA employees who often have professional health care licenses and provide mental health care to clients.[63]

The OIG interviewed RCS leaders to determine whether VHA's *Disclosure of Adverse Events to Patients* directive was applicable to RCS services. When asked whether RCS follows policy regarding institutional disclosure to clients, the RCS Operations Officer stated that if it is a VHA policy, then RCS would follow that policy. However, when the Deputy Chief Officer was questioned on the applicability of the policy, the Deputy Chief Officer stated that RCS reviews VHA policy to see if RCS is named in the policy and did not think RCS was included in VHA's disclosure policy.[64] The Deputy Chief Officer said that ethically RCS should do the right thing and that "if somebody is harmed in some way, I don't think we should be hiding that." The

[59] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.
[60] VHA Directive 1004.08.
[61] VHA Directive 1004.08.
[62] VHA Directive 1004.08.
[63] VHA Directive 1004.08.
[64] VHA Directive 1004.08.

Deputy Chief Officer expressed being in agreement with the basis of the policy, but explained that mental health, such as predicting a client's risk for self-harm and suicide, is more complicated. The Deputy Chief Officer stated that after reviewing Client 1's electronic client record, the case was complicated and "fraught with opportunities to do things different and have…potentially different outcomes."

The RCS Operations Officer later clarified in an email to the OIG that RCS does follow VHA's Disclosure of Adverse Event policy.[65] In April 2022, when asked if RCS leaders had determined whether to complete disclosure to Client 1's personal representative, the RCS Operations Officer reported discussing this issue with the RCS Chief Officer and planned to seek further consultation. In June 2022, the OIG was informed that RCS leaders would be meeting with the Director, VHA Medical-Legal Risk Management Program for additional consultation.[66]

The OIG found that, despite being aware of the VCD's client care concerns, RCS leaders failed to notify Client 1's personal representative of the adverse event. The OIG concluded that although the VHA policy on adverse event reporting does not specifically reference RCS, when occurrence of harm or potential harm directly associated with care or services delivered by VA providers, RCS leaders should be accountable to disclose adverse events.

Deficiencies in the VCD's Leadership

The OIG identified deficiencies in the VCD's leadership practices at the facility. Specifically, the OIG found that the VCD encouraged facility staff to rate clients' risk for suicide low to avoid attention from RCS leaders. Further, the VCD failed to provide competent supervision of an intern, resulting in a client not receiving clinical care commensurate with known risk factors for suicide.

VCD's Guidance to Rate Suicide Risk Assessments Low

The OIG substantiated that the VCD, based on a reluctance to raise concerns from RCS leaders, guided facility staff to keep clients' risk levels for suicide low.

RCS policy requires counselors to assess and rate a client's risk for suicide and tailor interventions consistent with the risk rating.[67] When a client's risk for suicide is rated above low, counselors must initiate clinical actions to mitigate the risk, which includes developing a personalized safety plan and conducting rigorous follow-up efforts to contact and assess the

[65] VHA Directive 1004.08.

[66] "Quality and Patient Safety (QPS)," VA, accessed May 10, 2022, https://www.va.gov/QUALITYANDPATIENTSAFETY/qm/index.asp. Clinical Risk Management is a program within VHA's Quality and Patient Safety division that oversees disclosure of adverse events.

[67] RCS, *RCS Guidelines for Administration*, 2010. VHA Directive 1500. VHA Directive 1500(1). VHA Directive 1500(2).

wellbeing of a client who misses a counseling appointment.[68] Further, if a client has a serious suicide attempt or dies by suicide, the VCD or counselor must complete a detailed crisis event report within 24 hours and notify district and RCS leaders within 48 hours of the event.[69]

During interviews with the OIG, facility staff reported either being informed by the VCD or having awareness of the VCD's practice to have facility counselors keep suicide risk assessment ratings low to avoid involvement from district leaders. Counselor 3 reported being taught by the VCD not to assign clients' suicide risk assessment ratings above moderate because higher ratings would cause a "whole bunch of problems" and trigger unwanted attention from RCS leaders. Counselor 4 informed the OIG that the VCD wanted suicide risk assessment "rating[s] dropped," and explained the reason as "[w]e don't want to upset RCS…they are going to get all upset, they are going to overly react." Neither counselor reported that the VCD's guidance was written but that the practice was discussed and understood. The VCD denied having given instruction or guidance to counselors to keep suicide risk assessment ratings low.

During interviews, the Former Associate District Director for Counseling and the Deputy District Director relayed concerns about the facility's VCD and counselors' adherence to policy regarding suicide risk assessment rating, crisis reporting, and follow-up on clients evaluated to be high risk.[70] The Former Associate District Director for Counseling reported that in August 2019, the VCD acknowledged the practice not to rate clients' level of risk for suicide above low to avoid raising concerns from RCS leaders.[71] Similarly, the Deputy District Director informed the OIG of having concerns about the VCD and counselors' suicide risk assessment ratings because of the absence of crisis reporting. The Deputy District Director reported discussing this concern with the VCD who reported following guidance given by a previous district manager. During interviews with the OIG, the former Acting VCD reported that when providing risk assessment training, the counselors questioned whether they had to lower suicide risk assessment ratings and opined that the VCD and counselors may have rated risk lower to avoid having to complete personalized safety plans. The former Acting VCD also reported having concerns

[68] RCS, *Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services (RCSNet)*, October 5, 2020. RCS, RCS Guidelines for Administration, 2010. VHA Directive 1500. VHA Directive 1500(1). VHA Directive 1500(2). RCS Chief Officer memorandum, RCS-CLI 003, "Revised Clinical Site Visit (CSV) Protocol," January 25, 2019.

[69] RCS, *RCS Guidelines for Administration*, 2010. VHA Directive 1500. VHA Directive 1500(1). VHA Directive 1500(2). Crisis reports following RCS policy guidelines should be submitted to Regional Office after a completed suicide; attempted suicide; suicide gesture; suicide intervention; completed homicide; attempted homicide; and homicide intervention.

[70] RCS, *RCS Guidelines for Administration*, 2010. VHA Directive 1500. VHA Directive 1500(1). VHA Directive 1500(2).

[71] The former Associate District Director for Counseling reported these concerns were consistent with deficiencies in mishandling of high-risk clients found in the August 2019 and February 2020 quality reviews.

about the VCD's clinical skills, mitigation of clients' suicide risk factors, and effective leadership and reported addressing the concerns with the VCD during supervision.

In review of the AIB report, the OIG learned that the board noted indications that the VCD "was motivated not to report crisis clients for fear of negative attention from [the RCS's] leadership…." Counselor 3's testimony regarding the VCD's direction on rating suicide risk assessments was consistent with the information relayed to the OIG. Counselor 2 reported that while employed, the facility was not completing crisis reporting and was unaware whether crisis reporting was required. AIB testimony further noted that the VCD stated being unable to recall whether having advised facility counselors to keep suicide risk assessment ratings low, and that if having done so, it was because of the way district leaders had responded to crisis reporting in the past.

The OIG concluded that the facility VCD guided facility counselors to keep suicide ratings low to avoid alerting district and RCS leaders. The VCD's clinical practice and guidance to facility counselors to keep suicide ratings low contributed to the inaccurate assessment of clients' risk for suicide.

VCD's Inadequate Intern Orientation and Supervision

The OIG determined that the VCD failed to provide adequate oversight of the intern including facility orientation, appropriate case assignment, and effective supervision. As a result of these failures, Client 1 did not receive clinical care commensurate with known risk factors for suicide.

Orientation

The OIG found that the orientation the VCD provided to the intern did not include the necessary knowledge and skills to enable the intern to successfully intervene with clients at risk for suicide.

VHA policy for the supervision of associated health trainees states "the quality of health care, Veteran safety, and the success of the educational experience are inexorably linked and mutually enhancing. In a system where direct practice and education of health care professionals occur together, there must be a clear delineation of responsibilities to ensure that both are of excellent quality."[72]

A memorandum of understanding between the facility and a VA medical center in Indiana established health trainee rotations through vet centers. The memorandum states that vet center supervisors will orient interns to the unique mission and services of the vet center and provide

[72] VHA Handbook 1400.04, *Supervision of Associated Health Trainees*, March 19, 2015. The guidelines included in the handbook are noted to be "…applicable to all patient care services delivered by VA medical facilities and their staff including inpatient care, outpatient care, community- or home-based care, long-term care, emergency care, care provided at Veterans Readjustment Counseling Centers, and telehealth care."

them guiding rules and regulations.[73] RCS guidelines state that all vet center staff, regardless of position, "must have some basic level of cross training" in core topics including post-war social and psychological readjustment problems, assessment and counseling for war-related PTSD, crisis response and suicide prevention, and clinical assessment and documentation.[74]

Near the beginning of the internship, the VCD and the intern signed an internship agreement document that outlined the orientation and supervision expectations. The expectations included orientation of policies and observation of the intern in individual and group sessions. The OIG reviewed the internship agreement and noted the VCD served as the intern's supervisor.

In an interview with the OIG, the intern recalled having received orientation, which included a series of video instructions and administrative tasks. The intern did not recall any training on suicide risk assessments or policies and practices on how to respond to a suicidal client. The intern indicated that only the VCD provided training. In an interview with the OIG, the VCD confirmed using videos to educate interns on the facility and acknowledged having no formal training curriculum. The VCD noted only accepting interns that are second year master's students who already have a year of training and tailored orientations based on what the intern thought was needed. When questioned about the observation as part of supervision, the intern stated that neither the VCD nor other counselors observed any of the intern's sessions. The VCD noted that the practice was to observe interns upon their request.

The OIG concluded that no formalized clinical orientation, the VCD's reliance upon the intern's first year of schooling and self-assessment of needed training, as well as the lack of clinical observation resulted in the intern missing vital training and oversight necessary to provide quality and safe care to the facility's high-risk client population, including Client 1.

Supervision of Intern's Care of Client 1

The OIG determined that the VCD, the intern's supervisor, failed to instruct the intern on actions to ensure Client 1's safety despite awareness of Client 1's high-risk factors and clinical complexity.

RCS policy states that VCDs assign clients a primary counselor based on case complexity and staff credentials, provide individual clinical supervision to counselors, and review electronic

[73] *Memorandum of Understanding Between Department of Veterans Affairs Medical Center VA Northern Indiana Health Care System Fort Wayne, Indiana, and Department of Veterans Affairs Readjustment Counseling Service Vet Center South Bend, Indiana*, October 2017.

[74] RCS, *RCS Guidelines for Administration*, 2010. VHA Directive 1500. VHA Directive 1500(1). VHA Directive 1500(2). Although the updated directive does not specifically state that employees must have cross training in core topics or list the specific topics, it states that "[t]raining content will specifically focus on all background knowledge and skill sets required for Vet Center staff to perform their assigned duties…."

client records to ensure documentation and provision of care is thorough, accurate, and demonstrates "professional efficacy of case presentation, planning and case recording."[75]

In an OIG interview, the VCD described having a process for case assignment that included looking at the skill of the counselor to determine who would work best with a client. The VCD noted it was not personal practice to give interns easy cases and felt like Client 1's case was "moderately difficult." The VCD described the intern as having more ability than most interns and being of "pretty high caliber."

According to the electronic client record, the VCD assigned Client 1 to the intern in summer 2020. In an interview with the OIG, the VCD reported discussing Client 1's case with the intern in weekly supervision meetings and instructing the intern to document the case well as this was an "at-risk case." Although the OIG found the VCD acknowledged the intern's progress notes in Client 1's electronic client record, no evidence was found of the VCD providing clinical guidance to the intern on reassessing or implementing interventions to mitigate Client 1's risk.

In interviews with the OIG, the VCD and the intern stated that they verbally discussed Client 1's hospitalization. The intern indicated the conversation was brief and not in-depth. The intern stated that although retrospectively Client 1's suicide risk should have been re-addressed post-hospitalization, at the time the intern did not recall receiving training on risk assessments or how to respond to a suicidal client. The intern did not recall the VCD making recommendations after becoming aware of Client 1's hospitalization and reported having limited knowledge of available VA resources that may have been helpful post-hospitalization. In AIB testimony, the intern reported that despite being aware that suicide prevention was a focus within the VA and that veterans are at increased risk for suicide, this topic was not discussed in supervision.

The OIG concluded that the VCD assigned a complex client to the intern and failed to provide the clinical supervision and intervention needed to mitigate Client 1's suicide risk. The OIG found Client 1's needs exceeded the intern's knowledge and awareness of suicide risk assessment and suicide safety protocols.

Inadequate RCS Leaders' Response to Quality Concerns

The OIG found that district leaders were aware of quality concerns related to readjustment counseling services at the facility but failed to initiate timely actions to address the reported concerns. Specifically, the OIG found repeat deficiencies from annual quality reviews conducted from late summer 2019 through spring 2021. Further, the OIG found district leaders failed to

[75] RCS Chief Officer memorandum, RCS-CLI --3, "Revised Clinical Site Visit (CSV) Protocol," January 25, 2019. RCS, *RCS Guidelines for Administration*, 2010. VHA Directive 1500. VHA Directive 1500(1). VHA Directive 1500(2).

report the VCD to the state licensing board for actions that suggest reasonable concern for the quality of care and safety of clients.

Unremedied Annual Quality Review Deficiencies

RCS leaders are responsible for assessing the quality of care provided to clients and their families.[76] To ensure vet center "staff compliance with RCS policy and procedures for the administration and provision of readjustment counseling" services, RCS requires district level staff to conduct an annual quality review of each vet center.[77]

RCS policy states that a RCS deputy district director ensures that annual quality reviews are completed, and deficiencies are remediated.[78] Associate district directors for counseling conduct quality reviews and document findings from the review in a written quality review report.[79] VCDs, in coordination with the associate district directors for counseling and administration, develop a remediation plan and timeline for all deficiencies identified during annual quality reviews no later than 30 days after the review date. All deficiencies must be remediated within 60 days of the remediation plan being developed.[80]

The OIG reviewed the facility annual quality review reports and remediation plans and found that the Associate District Director for Counseling completed three annual quality reviews in 2019–2021 and a follow-up quality review in October 2020. A Former Deputy District Director approved the 2019 annual quality review report and the Deputy District Director approved the 2020 and 2021 reports. The Associate District Director for Counseling identified several deficient standards on each report, assigned a satisfactory rating on the 2019 annual quality review report, and assigned an unsatisfactory rating on the 2020 and 2021 quality review reports. Deficient standards found on all annual quality review reports included untimely progress notes, and a missing non-visit and 30-day inactivity letter documentation.[81] Additional deficiencies on the 2020 and 2021 annual quality review reports included absence of first counselor visit suicide risk assessments, proof of veteran's eligibility, lack of follow-up with intermediate or high-risk clients following missed appointments, and insufficient documentation of client no-show visits. The VCD or Acting VCD developed a remediation plan to address the annual quality review deficiencies in 2020 and 2021, which were reviewed by an Associate District Director for

[76] RCS Acting Chief Officer memorandum, "Readjustment Counseling Service (RCS) Expectation and Outcome Improvement Program," May 4, 2016.

[77] VHA Directive 1500(2).

[78] RCS Chief Officer memorandum, RCS-CLI 003, "Revised Clinical Site Visit (CSV) Protocol," January 25, 2019. VHA Directive 1500(2).

[79] RCS Chief Officer memorandum, RCS-CLI 003, "Revised Clinical Site Visit (CSV) Protocol," January 25, 2019. VHA Directive 1500(2).

[80] VHA Directive 1500(2).

[81] VHA Directive 1500(2). Vet center staff enter non visit documentation for appointment scheduling, coordination of care and case assignments, transfers, staffing, and consultation.

Counseling, but no plan was developed following the 2019 annual quality review. The OIG reviewed the remediation plans in RCSNet and as of January 2022, found no documented remediation of unmet standards.

During interviews with the OIG, the Deputy District Director reported having signed off on the 2020 annual quality review remediation plan but stated the 2021 remediation plan "has not been completed to my knowledge." The Deputy District Director reported having conversations with the VCD about some of the RCS requirements including crisis report completion, client risk assessment accuracy, and a personalized safety plan, but was unable to give specific dates of the discussions and did not have documentation of the conversations. The Deputy District Director reported not having the opportunity to do intensive work with the VCD because factfindings were underway and an AIB was chartered. RCS leaders informed the OIG that the VCD was terminated effective September 30, 2022.

During an interview with the OIG, the District Director reported that the Deputy District Director was responsible to assure remediation plans were executed and updated. The District Director acknowledged previous inadequate actions to unsatisfactory annual quality reviews and unacceptable remediation plans in the district. The District Director reported initiating a process for annual quality reviews whereby an Associate District Director for Counseling worked with a VCD to address all annual review standards prior to an annual quality review. The District Director reported that the former Acting VCD, while assigned to the facility for a 90 day period (July–September 2021), provided training to the vet center staff to address some of the deficiencies from the 2021 annual quality review.

The OIG concluded that, other than training for facility staff in the summer of 2021, no actions were initiated to address unmet standards and repeat deficiencies from the 2019–2021 annual quality reviews. Further, the OIG did not find evidence that the Deputy District Director addressed the lack of remediation for the deficiencies with the VCD.

As a recommendation regarding the remediation of annual quality review deficiencies was issued in the Vet Center Inspection Program published report 21-03231-38, the OIG does not make a duplicate recommendation in this report.[82]

Failure to Report the VCD to the State Licensing Board

The OIG determined that district leaders should have initiated a report to the state licensing board after identifying deficiencies in the VCD's clinical assessments and client care. The District Director removed the VCD from clinical care pending the results of a separate factfinding in November 2021and reported that the factfinding was completed in December

[82] VA OIG, *Vet Center Inspection of Midwest District 3 Zone 1 and Selected Vet Centers*. Report No. 21-03231-38, January 19, 2023. The OIG's Vet Center Inspection Program provides focused evaluations of the quality of care delivered at vet centers.

2021. Although the factfinding conclusions identified significant clinical deficiencies and the VCD had not resumed clinical practice as of June 2022, the District Director had not reported the VCD's clinical practice to the state licensing board. In September 2022, the RCS Operations Officer reported that the matter remained under review and had not yet been reported to the state licensing board. Further, the OIG found RCS did not have a clearly defined process for reporting licensed health care professionals to state licensing boards.

VHA requires organizational leaders to file a report with the state licensing board when a licensed health care professional's behavior or clinical practice "substantially failed to meet generally accepted standards of clinical practice as to raise [a] reasonable concern for the safety of [clients]."[83] VHA policy includes lack of diagnostic or treatment ability as actions that provide a reasonable basis for concern for a client's safety.[84]

Reporting to the state licensing board must be initiated as soon as there is substantial evidence and not wait on other ongoing reviews or personnel actions.[85] The policy clarifies that "VA has broad authority to report" to state licensing boards as "VA must avoid even the appearance of sheltering or protecting its professionals from reasonable reporting standards which apply in the non-VA health care community."[86]

The OIG learned that in November 2021, district leaders identified a client care concern resulting in the District Director removing the VCD from providing clinical care pending the results of a separate factfinding initiated by the District Director to review the VCD's suicide risk assessment ratings. The OIG reviewed the RCS factfinding report conclusions, which identified significant deficiencies regarding the VCD's clinical client care including inaccurate suicide risk ratings, the failure to reevaluate risk, the lack of safety planning, and deficits in VHA mental health collaboration and consultation of clients at risk for suicide.

In January 2022, the District Director informed the OIG that the concerns regarding the VCD's clinical client care identified in the factfinding investigation had been referred to human resources for guidance. In June 2022, the District Director reported that the VCD remained "suspended from all clinical duties," as well as all VCD duties. Additionally, the OIG requested the District Director provide a status update on the guidance received from human resources and what, if any, administrative action had been taken on the VCD; the OIG also asked if the clinical

[83] VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards,* January 28, 2021. A licensed healthcare professional is a provider who is licensed, certified, or registered in a healthcare profession. The VCD was licensed in a healthcare profession; therefore, the OIG considers the VCD a licensed healthcare professional.

[84] VHA Directive 1100.18.

[85] VHA Directive 1100.18. "Substantial evidence is the degree of relevant evidence that permits a reasonable person might accept as adequate to support a conclusion, even if it is possible to draw contrary conclusions from the evidence, for believing that the professional so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients or the community."

[86] VHA Directive 1100.18.

care concerns identified had been reported to the VCD's state licensing board. The District Director reported there had been "some consultation on reporting [the VCD] to state licensing board" but was waiting for guidance from human resources before moving forward.

In an interview, the OIG team asked the Deputy Chief Officer about RCS's process for reporting licensed counselors to state licensing boards for clinical care concerns. The Deputy Chief Officer explained that some district leaders had been uncomfortable or did not want the responsibility for making the decision to report a concern to a state licensing board. To support district leaders, the Deputy Chief Officer established a process in early 2021 whereby district leaders could refer a case that may warrant reporting and an internal multidisciplinary group would review the case and provide guidance for the district leader's consideration.[87] The Deputy Chief Officer understood that when the district level leader made a decision to report to a state licensing board, the district leader would forward the information to the VHA quality manager who then made the notification. The Deputy Chief Officer stated that although there was a request made to review concerns at the facility for state licensing board reporting, the requestor did not provide the necessary information to complete the review.

The OIG concluded that findings from this inspection, coupled with the deficiencies identified from the RCS leaders' review of the VCD's suicide risk assessments and clinical care, and subsequent removal of the VCD from clinical counseling, suggest reasonable concern for the safety of clients treated by the VCD. The OIG found that the District Director did not initiate the process to report the concerns regarding the VCD's clinical practice to the state licensing board, as required. Further, the OIG found RCS did not have a clearly defined process for reporting concerns to state licensing boards, which may have contributed to the District Director deferring action while seeking guidance from human resources.

Conclusion

The OIG substantiated that facility staff inaccurately assessed the level of risk for suicide for three clients. The facility VCD, counselors, and intern were aware of and documented client risk factors but failed to account for the identified risk factors and changes in risk conditions when assigning a "non-lethal" level of risk for suicide in one client and a "mild" level of risk for suicide in two clients. The OIG concluded that the suicide risk assessments completed by facility staff were lower than clinically indicated given the presenting risk factors and changes in risk conditions for the three clients. Consequently, the three clients did not have safety measures such as personalized safety plans, clinical consultations, and heightened contact protocols in place.

[87] According to documentation provided to the OIG, the Deputy Chief Officer is responsible for "formulating national policy and guidance on clinical services and quality assurance for a national services providing direct readjustment counseling." Per an RCS leader, the Deputy Chief Officer retired in March of 2022, and as of March 3, 2022, the position was vacant.

The OIG substantiated that the VCD failed to facilitate a time-sensitive transition of Client 1, who died by suicide, from the intern to Counselor 1, and ensure follow-up action consistent with Client 1's recent high-risk behaviors, subsequent hospitalization, and post-hospitalization needs. Although the VCD had advanced notice of the intern's departure and was aware of Client 1's recent discharge from a community mental health hospital, the VCD did not document a plan to transition Client 1's care to Counselor 1 or ensure that Counselor 1 was aware of Client 1's risk factors. The OIG found the VCD's verbal account of actions taken to transfer and coordinate care was inconsistent with the documentation in the electronic client record and supervisory records. Counselor 1 did not attempt to contact Client 1 for two weeks after the transfer and made one additional unsuccessful attempt prior to closing the client record.

Although it is not known if increased clinical efforts would have prevented Client 1's death by suicide, the OIG determined the VCD failed to take measures necessary to mitigate risk. The OIG found that the VCD's failure to ensure a time-sensitive transition of Client 1's care from the intern to Counselor 1 and make diligent efforts to coordinate services following Client 1's mental health hospitalization was an adverse event. The OIG found that RCS leaders had not considered disclosing the adverse event to Client 1's personal representative prior to being questioned by the OIG team. RCS leaders informed the OIG that they were seeking consultation from the Director, VHA Medical-Legal Risk Management on the matter.

The OIG substantiated that the VCD, based on a reluctance to raise concerns from RCS leaders, guided facility staff to rate clients' risk levels for suicide low. The OIG found that the VCD's clinical practice and guidance to facility counselors to keep suicide ratings low contributed to the inaccurate assessment of clients' risk for suicide.

The OIG determined that the VCD failed to provide oversight of the intern including facility orientation, appropriate case assignment, and effective supervision. The VCD failed to adequately orient and observe the intern and assigned the intern a clinically complex client without providing thorough and competent supervision. The OIG found that no formalized clinical orientation, the VCD's reliance upon the intern's first year of schooling and self-assessment of needed training, as well as the lack of clinical observation resulted in the intern missing vital training and oversight necessary to provide quality and safe care to the facility's high-risk client population, including Client 1.

The OIG found that district leaders were aware of quality concerns of readjustment counseling services at the facility but failed to initiate timely actions to address the reported concerns. Specifically, the OIG found repeat deficiencies from annual quality reviews conducted from late summer 2019 through spring 2021. Other than training for facility staff in the summer of 2021, there was no documented evidence of actions initiated to address unmet standards and repeat deficiencies from the 2019–2021 annual quality reviews and that the Deputy District Director addressed the lack of remediation for the deficiencies with the VCD. The Deputy District Director reported having conversations with the VCD about some of the RCS risk assessment

requirements but not having the opportunity to do intensive work with the VCD because factfindings were underway and an AIB was chartered.

The OIG determined that district leaders should have initiated a report to the state licensing board after identifying deficiencies in the VCD's clinical assessment and client care. Although the factfinding conclusions identified significant clinical deficiencies and the VCD had not resumed clinical practice, as of September 2022 the RCS Operations Officer reported that the matter had not been reported to the state licensing board. Further, the OIG found RCS did not have a clearly defined process for reporting licensed healthcare professionals to state licensing boards.

Recommendations 1–8

1. The Midwest District 3 Director ensures the South Bend Vet Center Director and counselors complete suicide risk assessments and assign risk levels based on client risk factors, reevaluate levels when risk factors change, and monitors staff' compliance.
2. The Midwest District 3 Director ensures the South Bend Vet Center Director and counselors consistently mitigate clients' risk for suicide, as appropriate, by developing personalized safety plans, seeking clinical consultation, increasing client contact efforts, and completing crisis reports, and monitors compliance.
3. The Midwest District 3 Director ensures that when clients are transferred from one counselor to another, relevant clinical information is communicated, applicable safety measures are in place, services are not disrupted, and when possible, a joint session with the outgoing and incoming counselor is held with the client.
4. The Midwest District 3 Director reviews Client 1's post-hospitalization care and the care coordination from the intern to a new counselor and determines if an adverse event disclosure is warranted.
5. The Chief Readjustment Counseling Officer reviews VHA Directive 1004.08, *Disclosure of Adverse Events to Patients,* and develops a clear policy or protocol outlining the pathway for Readjustment Counseling Service leaders to comply with adverse event reporting, and monitors reporting compliance.
6. The Chief Readjustment Counseling Officer ensures that prior to Readjustment Counseling Service accepting new interns, Readjustment Counseling Service leaders develop and implement a formalized intern orientation and training curriculum, as well as a clear supervisory oversight and safety protocol.
7. The Midwest District 3 Director evaluates whether the Vet Center Director's clinical practice warrants reporting to the state licensing board and takes action, as indicated.

8. The Chief Readjustment Counseling Officer reviews VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards,* and develops a clear policy or protocol outlining the pathway for Readjustment Counseling Service leaders to evaluate substandard care or ethical violations by licensed counselors, and when appropriate, reports concerns to state licensing boards.

Appendix A: RCS Chief Readjustment Counseling Officer Memorandum

Department of Veterans Affairs Memorandum

Date: November 17, 2022

From: Chief Readjustment Counseling Officer, RCS

Subj: Healthcare Inspection—Deficiencies in Suicide Risk Assessments, Continuity of Care, and Leadership at the South Bend Vet Center in Indiana

To: Director, Office of Healthcare Inspections (54HL09)
Director, GAO/OIG Accountability Liaison (VHA 10BGOAL Action)

1. Thank you for the opportunity to review and comment on the Office of Inspector General draft report, *Deficiencies in Suicide Risk Assessments, Continuity of Care, and Leadership at the South Bend Vet Center in Indiana*. The Veterans Health Administration (VHA) appreciates the opportunity to focus on continuous performance improvement. VHA concurs with the recommendations and provides action plans in the attachment.
2. Should you require any additional information please contact the Readjustment Counseling Service Action Group.

(Original signed by:)

Michael Fisher
Chief Officer, Readjustment Counseling Service

RCS Chief Readjustment Counseling Officer Response

Recommendation 5

The Chief Readjustment Counseling Officer reviews VHA Directive 1004.08, *Disclosure of Adverse Events to Patients,* and develops a clear policy or protocol outlining the pathway for Readjustment Counseling Service leaders to comply with adverse event reporting, and monitors reporting compliance.

Concur.

Target date for completion: April 2023

Chief Readjustment Counseling Officer Comments

The Chief Readjustment Counseling Officer will ensure that the RCS Clinical Policy and Oversight program office will develop policy outlining clear guidance for RCS leaders to comply with adverse event reporting and monitoring of reporting compliance based upon VHA Directive 1004.08, Disclosure of Adverse Events to Patients.

Recommendation 6

The Chief Readjustment Counseling Officer ensures that prior to Readjustment Counseling Service accepting new interns, Readjustment Counseling Service leaders develop and implement a formalized intern orientation and training curriculum, as well as a clear supervisory oversight and safety protocol.

Concur.

Target date for completion: April 2023

Chief Readjustment Counseling Officer Comments

Prior to accepting new interns, the Chief Readjustment Counseling Officer will ensure that the RCS Clinical Oversight and Policy program office will develop and implement a formalized intern orientation and training curriculum, as well as a clear supervisory oversight and safety protocol.

Recommendation 8

The Chief Readjustment Counseling Officer reviews VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards,* and develops a clear policy or protocol outlining the pathway for Readjustment Counseling Service leaders to evaluate substandard care or ethical

violations by licensed counselors, and when appropriate, reports concerns to state licensing boards.

Concur.

Target date for completion: December 2022

Chief Readjustment Counseling Officer Comments

RCS agrees that a method to evaluate substandard care or ethical violations by licensed counselors, and when appropriate, report concerns to State licensing boards is an important component of overall evaluation of the effectiveness of the delivery of Vet Center services. Based upon VHA Directive 1100.18, Reporting and Responding to State Licensing Boards, the Chief Readjustment Counseling Officer will ensure that RCS Clinical Oversight and Policy program office will develop a protocol outlining the pathway for RCS leaders to evaluate substandard care or ethical violations by licensed counselors, and when appropriate, report concerns to State licensing boards.

Appendix B: Midwest District 3 Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 17, 2022

From: District Director, Midwest District 3 (RCS3)

Subj: Healthcare Inspection—Deficiencies in Suicide Risk Assessments, Continuity of Care, and Leadership at the South Bend Vet Center in Indiana

To: Chief Readjustment Counseling Officer, RCS (VHA 10 RCS Action)

1. This memorandum is submitted in response to the Healthcare Inspection related to Deficiencies in Suicide Risk Assessments, Continuity of Care, and Leadership at the South Bend Vet Center in Indiana.

2. I have reviewed the draft report for the Vet Center in South Bend, Indiana and concur with the findings and recommendations.

3. The attached comments and supportive documentation are evidence that the recommendations made during the Healthcare Inspection – Deficiencies in Suicide Risk Assessments, Continuity of Care, and Leadership at the South Bend Vet Center in Indiana - were put forward into action and measures were put in place to ensure sustained improvement.

4. Please express my thanks to the team for their professionalism and assistance to us in our continuing efforts to improve the care we provide to our Veterans.

(*Original signed by:*)

Joseph J Dudley
Acting District Director

Midwest District 3 Director Response

Recommendation 1

The Midwest District 3 Director ensures the South Bend Vet Center Director and counselors complete suicide risk assessments and assign risk levels based on client risk factors, reevaluate levels when risk factors change, and monitors staff' compliance.

Concur.

Target date for completion: January 2023

Midwest District 3 Director Comments

The Midwest District 3 Director (DD), through the Deputy District Director (DDD) is working to ensure that the Vet Center Director (VCD) and counselors complete suicide risk assessments and assign risk levels based on client risk factors, reevaluate levels when risk factors change, and monitor staff compliance. The DD, through the DDD, conducts monthly peer review of 10% of the active counseling records for each full-time employee to ensure compliance with Vet Center readjustment counseling guidance and procedures according to VHA Directive 1500(02), Readjustment Counseling Services. The VCD will monitor Risk Assessment (RA) completion, risk level appropriateness, risk level changes and staff compliance with these elements during reviews. Additionally, cases above "low- acute /low- chronic" risk will be discussed and reviewed during case consultation and supervision with VCD to ensure these elements are completed.

Progress has been made since OIG's review was completed. In July 2022, Readjustment Counseling Service (RCS) leadership assigned an acting DD to Midwest District 3 to focus on quality and compliance with RCS guidance and procedures according to VHA Directive 1500 (02). The acting DD implemented strict adherence to RCS quality assurance requirements ensuring annual readjustment counseling quality review completion and that appropriate peer review of active counseling records were completed by the acting South Bend, Indiana, VCD.

In August 2022, the acting DD directed completion of an on-site annual readjustment counseling quality review to evaluate progress and compliance. The annual readjustment counseling quality review for the South Bend Vet Center was conducted by the Associate District Director for Counseling (ADDC). It was determined that South Bend Vet Center was 100% compliant with completing risk assessments, with 80% being completed on the first visit. The Vet Center has a remediation plan in place to ensure that risk assessments are completed and documented on the first counseling visit.

RCS procedures for monthly peer review of active counseling records are currently being followed by the acting VCD to include review of suicide risk assessments, assigned level of risk,

and reevaluation of level when risk factors change. These monthly peer reviews have been completed with 100% compliance for June through September 2022.

Recommendation 2

The Midwest District 3 Director ensures the South Bend Vet Center Director and counselors consistently mitigate clients' risk for suicide, as appropriate, by developing personalized safety plans, seeking clinical consultation, increasing client contact efforts, and completing crisis reports, and monitors compliance.

Concur.

Target date for completion: January 2023

Midwest District 3 Comments

DDD is working to ensure that the South Bend VCD and counselors consistently mitigate clients' risk for suicide, as appropriate, by developing personalized safety plans, seeking clinical consultation, increasing client contact efforts, and completing crisis reports, and monitors compliance. The DD, through the DDD, is also working to ensure that the VCD will monitor safety plan completion, clinical consultation notes and crisis log reports during monthly case audits. The VCD will develop a tracking document to ensure compliance. The tracking document will include the date of consultation, the participants, completion date of personalized safety plan, completion of crisis report, and the number of times that the client was contacted. The DDD will review compliance during individual supervision with the VCD. These items will be monitored during annual readjustment counseling quality review by the ADDC. Additionally, the VCD will review the completion of safety plans during individual supervision and external consultation with counselors RCS procedures for appropriate chart audits are currently being followed by the acting VCD.

Progress has been made since OIG's review was completed. In July 2022, RCS leadership assigned an acting DD to Midwest District 3 to focus on quality and compliance with RCS guidance and procedures according to VHA Directive 1500 (02). The acting DD implemented strict adherence to RCS quality assurance requirements ensuring annual readjustment counseling quality review completion and that appropriate peer review of active counseling records were completed by the acting South Bend, Indiana, VCD.

In August 2022, the acting DD directed completion of an on-site annual readjustment counseling quality review to evaluate progress and compliance. The annual readjustment counseling quality review for the South Bend Vet Center was conducted by the ADDC and it was determined that the South Bend Vet Center met the standard for VCD supervision, VCD monthly peer review of counseling records, external clinical consultation, and counselors seeking consultation for all clients who are assessed as intermediate or high risk. The crisis management plan was reviewed,

updated, and signed by staff and the VCD after the annual readjustment counseling quality review. The Vet Center also met the standard for actions in response to clients assessed at intermediate or high risk for suicide, crisis log reports, and calling any client assessed as intermediate or high risk who misses an appointment within 1 hour and periodically thereafter until the client and/or the responsible party has been contacted. Ongoing evaluation is completed by following RCS procedures for appropriate chart audits are currently being followed by the acting VCD.

Recommendation 3

The Midwest District 3 Director ensures that when clients are transferred from one counselor to another, relevant clinical information is communicated, applicable safety measures are in place, services are not disrupted, and when possible, a joint session with the outgoing and incoming counselor is held with the client.

Concur.

Target date for completion: July 2023

Midwest District 3 Comments

The DD, through the DDD, is working to ensure that the VCD will assign all new and transfer clients to an appropriate counselor throughout the district. A case transfer note is written on each transferred case and the case is staffed with the receiving counselor. The VCD will ensure a joint session is held between the outgoing and receiving counselor and the client to review current safety measures that are in place. The VCD will complete a review of the counseling record at the time of transfer to ensure that all documentation is updated and that a follow up appointment has been scheduled with the new counselor.

Progress has been made since OIG's review was completed. In July 2022, RCS leadership assigned an acting DD to Midwest District 3 to focus on quality and compliance with RCS guidance and procedures according to VHA Directive 1500 (02). The acting DD implemented strict adherence to RCS quality assurance requirements ensuring annual readjustment counseling quality review completion and that appropriate peer review of active counseling records were completed by the acting South Bend, Indiana, VCD.

In August 2022, the acting DD directed completion of an on-site annual readjustment counseling quality review to evaluate progress and compliance. The annual readjustment counseling quality review for the South Bend Vet Center was conducted by the ADDC and it was determined that the South Bend Vet Center met the standard for, "Vet Center client referrals to another counselor within the Vet Center, and/or to other community providers, VA and/or non-VA, are made as indicated for the eligible individual's readjustment, and follow-up coordination of services is confirmed and documented in the client charts." Ongoing evaluation is completed by following

RCS procedures for appropriate peer review of counseling records and are currently being followed by the acting VCD to include review of case transfers from one counselor to another. These review of counseling records have been completed with 100% compliance for June through September 2022.

Recommendation 4

The Midwest District 3 Director reviews Client 1's post-hospitalization care and the care coordination from the intern to a new counselor and determines if an adverse event disclosure is warranted.

Concur.

Target date for completion: June 2022

Midwest District 3 Comments

In June 2022, RCS Leadership reviewed Client 1's post-hospitalization care and the care coordination from the intern to a new counselor and consulted with the VHA Office of Medical-Legal Risk Management to help complete the determination if an institutional disclosure was required. It was determined during that consultation that institutional disclosure was not warranted in this situation.

OIG Comments

RCS leaders provided sufficient supporting documentation, and the OIG considers this recommendation closed.

Recommendation 7

The Midwest District 3 Director evaluates whether the Vet Center Director's clinical practice warrants reporting to the state licensing board and takes action, as indicated.

Concur.

Target date for completion: February 2023

Midwest District 3 Comments

The currently assigned acting DD will conduct a review to evaluate whether the VCD's clinical practice warrants reporting to the state licensing board and will take action if indicated. The target completion date includes required due process timeframes.

OIG Contact and Staff Acknowledgments

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