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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Crisis Management of a Client, Crisis Reporting, and Documentation Practices at the Everett Vet Center in Washington

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate allegations related to the crisis management of a client at the Everett Vet Center in Washington.[1] The OIG also evaluated allegations that district 5, zone 1 (district) and Everett Vet Center leaders added "a consultation note (after the fact)" to the client's clinical record to justify lack of action and altered notes to appear in compliance with safety protocols.[2] Additionally, the OIG identified concerns related to the adequacy and timely entry of a counselor's documentation, Everett Vet Center staff and leader's failure to update the client's safety plan, and the Vet Center Director's (VCD's) inappropriate provision of clinical consultation to staff.

Synopsis of the Patient's Care

The client, in their twenties at the time of the care under review, had a medical history including post-traumatic stress disorder (PTSD), major depressive disorder, attention deficit hyperactivity disorder, and opioid use disorder.[3] The client first received psychiatric care at the VA Puget Sound Health Care System (support facility) in mid-fall 2020 and received ongoing medication management into 2024.[4]

In an early 2024 psychiatrist visit, the client reported increased symptoms of depression and PTSD and passive suicidal ideation. The client agreed to follow up with long-term individual therapy at the Everett Vet Center.

Approximately two weeks later, on day 1, the client presented to the Everett Vet Center and told the readjustment counselor (counselor) about depression, anxiety, and suicidal ideation within the prior four days. The client reported experiencing suicidal thoughts, preparatory behavior, and an opioid overdose in the past. The counselor documented the client's suicide risk level as "Intermediate Acute/Intermediate Chronic" and completed a safety plan with the client.[5]

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[1] 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." VHA Directive 1500(4), *Readjustment Counseling Service*, January 26, 2021, amended November 21, 2023; To be consistent with vet center policy and terminology, the OIG refers to veterans receiving readjustment services as clients in this report.

[2] Readjustment Counseling Service (RCS) is divided into five districts, with each district consisting of zones. VHA Directive 1500(4); The subject vet center is located in district 5, zone 1.

[3] The OIG uses the singular form of they, "their" in this instance, for privacy purposes; The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[4] RCS requires each vet center to be aligned with a support VA medical facility to ensure access to clinical services and coordination of care for shared clients.

[5] RCS defines intermediate acute suicide risk as suicidal ideation without intent or a suicide plan. Intermediate chronic suicide risk refers to "persistent suicidal ideation" without previous attempts. VHA Directive 1500(4).

The following week (day 9), during a visit, the client reported being "high and not stable" after relapsing the previous night and taking 11 hydrocodone pills "before" the appointment, as well as a plan to obtain and take more pills after the appointment. The counselor documented the client denied suicidal intent or a plan and stated, "I just want out of the pain, I don"t [*sic*] care what happens to me, I just want to get high." Additionally, the client admitted to "fantasies of torturing people" during periods of anger but denied having a specific person in mind.

The VCD joined the appointment, and the counselor documented speaking with a support facility "emergency psychiatric services" nurse who advised the client to go to the support facility emergency department for screening. The nurse explained that the client would not be admitted unless the client presented as a danger to self or others. The counselor documented that the client agreed to present to an emergency department but declined to do so prior to taking more opioids; the counselor noted paging the support facility suicide prevention team (suicide prevention team) and not receiving a return call.[6] The VCD noted that the counselor discussed calling 911 following the client's departure from the Everett Vet Center, but "we decided that this did not warrant police attention at this point."[7]

In a consultation on day 13, the counselor told the VCD that the client presented to a non-VA hospital on day 9, reported ingesting 21 opioid pills with suicidal ideation, and on day 10 was transferred to another non-VA facility inpatient mental health unit. The counselor discussed a plan with the VCD to increase the client's suicide risk level to high, completed a risk assessment with the client's acute and chronic risk levels assessed as high, and notified the psychiatrist about the client's vet center visit the day before.[8]

The next day, on day 14, the counselor documented that the support facility external consultant (external consultant) concurred that calling 911 for the client on day 9 was not warranted "for someone who wants to go out and get high." Two days later (day 16), the VCD documented, in the client's clinical record, having a discussion with the Associate District Director for Counseling (ADDC) regarding the counselor's progress notes and risk assessment. The VCD concluded that the notes for this client were "not entered in a manner that is appropriate or in line with RCS [Readjustment Counseling Service] standards." The VCD documented, "We are in the process of correcting the notes and rewriting a risk assessment to ensure they are clear, accurate, meet the RCS normal standard and are in line with policy."

[6] On day 13, the counselor documented that the lack of response from the suicide prevention team may have been due to a phone issue at the Everett Vet Center.

[7] The National 911 Program coordinates police, fire department, and medical assistance for individuals in emergency situations. "Calling 911," 911.gov, accessed November 20, 2024, https://www.911.gov/calling-911/.

[8] High acute suicide risk is defined as suicidal ideation with intent and plan and a history of previous attempts, with an "inability to maintain safety without external support." RCS considers high chronic suicide risk to be suicidal ideation with a "history of previous attempts," ongoing risk factors, and concurrent protective factors such as tools for coping and motivation to continue living. VHA Directive 1500(4).

On day 24, the client was discharged from the non-VA inpatient mental health unit and engaged in post-discharge follow-up treatment including medication management, psychotherapy, and participation in substance use disorder groups at the support facility.

OIG Findings

Deficiencies in Crisis Management and Reporting

The OIG substantiated that Everett Vet Center staff and leaders inadequately managed the client's crisis, including that the VCD advised the counselor to allow the client to leave the clinic without notifying law enforcement authorities.

The OIG found that the VCD and counselor failed to fully consider duty-to-warn obligations since the VCD lacked knowledge of duty-to-warn requirements and the counselor deferred to the VCD. Further, the OIG was unable to determine if the client's circumstances necessitated vet center staff to fulfill duty-to-warn obligations because vet center staff did not obtain adequate information from the client to assess the imminent risk the client posed while driving after using opioids and reporting the intent to take more.

Mental health providers in Washington state have a "duty to warn or to take reasonable precautions to provide protection from violent behavior where the client has communicated an actual threat of physical violence against a reasonably identifiable victim or victims" to include "foreseeable" victims.[9] The duty to warn in Washington state can also extend to reasonably foreseeable victims of patients impaired by drugs and driving when a provider knows of the impairment and intention to drive.[10]

RCS leaders reported an expectation that counselors remain aware of relevant state laws pertaining to duty to warn and consult with the VCD and ADDC; and consider consulting with the Office of General Counsel and external consultants, to inform any necessary action.[11]

The counselor told the OIG about considering calling 911 due to concern and uncertainty about what would occur when the client left the Everett Vet Center; however, reported not calling 911 based on direction from the VCD. The VCD reported considering the possibility that the client

[9] "Mental Health Professionals' Duty to Warn," National Conference of State Legislatures, accessed June 20, 2024, https://www.ncsl.org/health/mental-health-professionals-duty-to-warn; "Guidance on New Duty to Warn or Protect Standard," Washington State Medical Association, accessed June 25, 2024, https://www.wsha.org/wp-content/uploads/Volk-recs-FINAL.pdf. The Supreme Court ruled in Volk v. DeMeerleer, 386 P.3d 254, 187 Wn.2d 241 (2016) that it is the "duty of health care providers to warn or protect potential victims of violence" and that the duty to warn "extends to all individuals who may be 'foreseeably' endangered by a patient," even if there is no specific target identified.

[10] Volk, 187 Wn.2d at 258.

[11] The Office of General Counsel's mission is to, "identify and meet the legal needs of the Department of Veterans Affairs (VA)." "Office of General Counsel," VA Office of General Counsel, accessed June 2, 2025, https://www.va.gov/OGC/.

might pose a risk to others but also noted that the client did not appear to be under the influence of drugs and asserted that 911 should not have been called.

The OIG found that the VCD was not aware of state guidelines pertaining to duty to warn nor how to access the information. The OIG concluded that this lack of knowledge likely contributed to the VCD's and counselor's failure to engage in sufficient decision-making to determine the applicability of duty to warn.

The OIG substantiated that the VCD and counselor failed to immediately seek consultation from the external consultant, as required by RCS.[12] The counselor contacted the external consultant five days after the client's visit, on day 14. Due to a lack of documentation by the counselor, the OIG was unable to determine if the counselor fully informed the external consultant about the potential risk of harm related to the client's opioid use and plan to drive. The external consultant did not recall being informed about the client's intent to operate a vehicle by the counselor and noted that had the counselor provided that information, the external consultant may have recommended preventing the client from driving but may not have considered a duty to warn. The counselor's failure to consult with the external consultant at the time of the client's visit may have contributed to the external consultant's incomplete knowledge of the situation and therefore compromised the information provided to the counselor regarding the duty to warn.

The OIG substantiated that the VCD and counselor failed to follow up with the suicide prevention team about the client's increased suicide risk level on day 9 as well as on day 13 when the risk assessment was completed, as required by RCS.[13] The counselor documented not receiving a response from the suicide prevention team on day 9 due to having provided the counselor's direct office phone number rather than the main number to the Everett Vet Center. The counselor explained not contacting the suicide prevention team on day 13 based on the belief that emailing the psychiatrist, consulting with the VCD, and knowing the client was hospitalized was sufficient. The VCD's and counselor's failure to follow up with the suicide prevention team about the client's increase in risk level prevented the suicide prevention team's reconsideration of a high risk for suicide patient record flag placement that may have prompted additional outreach to the patient.[14]

[12] RCS requires that a counselor seeks immediate consultation from the external consultant when a serious mental health condition is suspected, or the counselor detects evidence of serious mental health conditions. VHA requires that the support medical facility director and VCD assign support facility staff in the roles of clinical liaison and external clinical consultant to the vet center. The clinical liaison assists the vet center with coordination of VA services and suicide prevention activities. The external clinical consultant is an independently licensed mental health professional who provides a minimum of four hours of consultation monthly to vet center counseling staff regarding mental health care and services and clinically complex concerns. VHA Directive 1500(4).

[13] VHA Directive 1500(4). Counselors must report clients considered "acute high-risk" for suicide to the suicide prevention coordinator at the support VA medical facility.

[14] Approximately two weeks prior to the client's initial vet center visit, the support facility's suicide prevention coordinator documented that the client did not meet criteria for a high-risk flag.

The OIG substantiated that the counselor delayed crisis reporting because the counselor and VCD were uncertain about whether the client's circumstances met the criteria for reporting the event.[15] The OIG also found that RCS leaders did not establish clear written guidance regarding crisis reporting criteria and monitoring responsibilities.[16] The VCD acknowledged to the OIG that because the client was referred to an emergency department, a crisis report should have been entered. However, the VCD also explained that the criteria for crisis reporting are unclear unless a client is "suicidal," and this lack of clarity may cause a delay in the crisis report entry. The OIG concluded that the lack of clarity regarding criteria to prompt the entry of a crisis report contributed to the delay in crisis report entry for the client.

Deficiencies in Clinical Record Documentation

The OIG substantiated that the VCD backdated a progress note in the client's clinical record and found that the backdating occurred because of the VCD's lack of awareness of RCS documentation requirements.[17] The OIG found that on day 16, inconsistent with RCS policy, the VCD entered into the client's record a non-visit progress note dated day 9 detailing events that occurred on days 9 and 14. Backdated notes and inclusion of information that occurred after the progress note entry date may contribute to an inaccurate understanding of a client's care and timeline of related events.

The OIG did not substantiate that the ADDC added or altered documentation or advised the VCD to add or alter documentation in the client's clinical record to justify "not calling the authorities" and appear in compliance with RCS practices. The OIG found that after consultation with the ADDC, consistent with RCS practice at that time, the VCD directed the counselor to add new progress notes to provide more detail to existing documentation. Approximately three weeks after the client's visit, the counselor added 19 progress notes to the client's record to address incorrect formatting, improper copying and pasting from the client's support facility electronic health record, and lack of clarity regarding consultation about the client's care.

The OIG determined that although the VCD provided reasonable justification for instructing the counselor to add notes to the client's record, the delayed entry of clinical information may

[15] VCDs are responsible to ensure that a report of a crisis event (crisis report) is entered into the "Log-a-Crisis" software program prior to close of business on the day of notification of the crisis event. A crisis report entry generates an email alert of the crisis event to the RCS Deputy Chief Officer and district directors. VHA Directive 1500(4).

[16] According to RCS policy, a counseling crisis event (crisis event) occurs when a client presents with "suicide ideation (with inability to maintain safety)," a suicide attempt, or dies by suicide. VCDs are responsible to ensure that a report of a crisis event (crisis report) is entered into the "Log-a-Crisis" software program prior to close of business on the day of notification of the crisis event. VHA Directive 1500(4).

[17] RCS differentiates visit and non-visit progress notes and requires that vet center staff document both in the clinical record "within two working days from the date of the visit." Vet center staff must document client-related administrative and consultative information, such as internal and external consultation, in non-visit progress notes. VHA Directive 1500(4).

prevent other vet center staff from accessing valuable data about a client's care in real time. The addition of late-entry notes to the client's record without identification of the actual date of note entry prevents transparency regarding clinical documentation modifications. Further, by documenting clinical information at a later date, it may be difficult to identify an accurate timeline of care provided to a client.

The OIG found that approximately two months after the client's visit, the ADDC removed five of the counselor's non-visit progress notes from the client's clinical record. The ADDC told the OIG that at the time of the client's visit, ADDCs had the ability to delete progress notes from clinical records. The Chief Officer, RCS told the OIG about directing a National Service Support program analyst to remove the delete function for district leaders and establish a process for progress note review and deletion after learning of the ADDCs' capability to delete progress notes from the clinical record in September 2024.[18] The OIG concluded that a lack of written guidance and oversight of progress note deletion likely contributed to the ADDC's deletion of progress notes without documented justification.

Inadequate Risk Assessment, Delayed Documentation, and Safety Plan Update

The OIG found that the counselor did not document a required risk assessment with the client on day 9 when the client's risk level increased as a result of reported opioid use and passive suicidal ideation.[19] The OIG also found that the counselor and VCD did not ask the client for more information about the time frame of pill ingestion. The VCD acknowledged "it was probably a mistake" not to ask the client when the pills were taken. The OIG would have expected the counselor and VCD to attempt to gain more information about the timing of the client's opioid use to determine if the client was at risk for onset of opioid effects, especially since the client planned to drive and reported being "high." On day 13, the counselor learned that the client had been hospitalized, documented a risk assessment without the client present, and assessed the client's acute and chronic risk levels as "High." Given the client's increased suicide risk due to opioid use and the RCS requirement to complete a risk assessment when clinically indicated, the OIG would have expected the counselor to complete and document a thorough risk assessment at the time of the client's day 9 visit.

[18] RCS National Service Support maintains the "RCS System of Records and all service data collection and management." VHA Directive 1500(4); In August 2024, the Deputy Chief Officer, RCS alerted VA OIG leaders that an internal RCS review had been initiated in response to reports of documentation concerns at two other vet centers.

[19] VHA Directive 1500(4). The directive further notes that risk assessments are conducted to evaluate a client's suicidal ideation, intent, preparatory behavior, and previous suicide attempts and to identify the client's suicide risk level as acute or chronic and low, intermediate, or high. Counselors are required to conduct risk assessments with clients at the initial visit to a vet center and subsequently as clinically indicated and must document the risk assessment in the client's clinical record.

Further, the counselor did not update the client's safety plan as required on day 9.[20] Given that the counselor and VCD identified the client as in crisis but deemed appropriate to leave the Everett Vet Center, the OIG would have expected the counselor to have provided the client with a written safety plan to ensure the client's awareness of resources to maximize safety.

Inconsistent VCD Position Descriptions

The OIG found that in 2024, after the client's visit, the Everett VCD may have been provided with a Title 5 position description that included higher-level clinical responsibilities such as the provision of clinical consultation to staff, inconsistent with the limitations identified in the position description issued by RCS Central Office approximately three years prior in 2021.[21] Additionally, the 2021 position description stated that the VCD is "responsible for making non-clinical recommendations to the interdisciplinary treatment team," can provide assistance with "less complicated cases without prior approval," and must refer staff to appropriate resources for "difficult and complex cases." In contrast, the 2024 position description included expectations that the VCD provide crisis intervention and "highly skilled readjustment counseling services to clients with difficult and complex problems of social, emotional and vocational adjustment."

The OIG found that conflicting information provided to the Everett VCD about the scope of the VCD's clinical responsibilities may have contributed to the VCD's failure to consult immediately with the ADDC on day 9 as required by an applicable 2021 VCD position description. The absence of consultation may have contributed to an incomplete understanding of the client's clinical condition, potential risks, and relevant factors in the consideration of the duty to warn.

Recommendations

The OIG made four recommendations to the Chief Officer, RCS to provide written guidance regarding crisis reporting, clinical record documentation, and risk assessments; and to ensure VCDs are issued and performing within the scope of correct position descriptions. The OIG made five recommendations to the District 5 Director to conduct a review of the client's care, ensure knowledge of duty-to-warn state laws and adherence to consultation and safety planning requirements, and conduct a review of the care provided to complex clients by the VCD.

[20] VHA Directive 1500(4). The directive further notes that counselors must complete a safety plan with the client and provide a copy to the client following a determination of intermediate or high suicide risk.

[21] Title 5 positions do not require "clinical knowledge, skills, and abilities" of a healthcare professional. VHA Handbook 5005/161, *Staffing*, January 29, 2024. At the time of the events discussed in the report, the VCD was a licensed mental health counselor. District leaders told the OIG about conducting a "Zone 1 VCD Sequester" in July 2024 and providing the Title 5 VCDs with a position description.

VA Comments and OIG Response

During the Veterans Health Administration's (VHA's) review of an OIG draft report, it is usual practice for VHA to submit comments for consideration and discussion.[22] For this report, VHA provided the OIG comments in the Facility Director memorandum during the draft phase. The OIG considered and reviewed the comments. Based on the review, a minor change was made to the report for clarification, but no changes were made to OIG recommendations. The Under Secretary for Health; Chief Officer; and District Director concurred with the recommendations and provided acceptable action plans (see appendixes B, C, and D). The OIG will follow up on the planned actions until they are completed.

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

[22] VA OIG Directive 306, *Comments to Draft Reports*, April 10, 2024, amended April 24, 2019.

Contents

Abbreviations

ADDC	Associate District Director for Counseling
EHR	electronic health record
NSS	National Service Support
OIG	Office of Inspector General
RCS	Readjustment Counseling Service
VCD	Vet Center Director
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate allegations related to the crisis management of a client following a report of opioid use at the Everett Vet Center in Washington.[1] The OIG also evaluated allegations that district 5, zone 1 (district) and Everett Vet Center leaders added "a consultation note (after the fact)" to the client's clinical record to justify lack of action and altered notes to appear in compliance with safety protocols.[2] Additionally, the OIG identified concerns related to the adequacy and timely entry of a counselor's documentation, Everett Vet Center staff and leader's failure to update the client's safety plan, and the Vet Center Director's (VCD's) inappropriate provision of clinical consultation to staff.

Background

Readjustment Counseling Service and Vet Centers

Readjustment Counseling Service (RCS) is an autonomous organizational element in the Veterans Health Administration (VHA) with authority and oversight of vet centers and all related provisions of readjustment counseling services.[3] Vet centers are community-based clinics at which readjustment counselors provide a wide range of psychosocial services to clients to support the transition from military to civilian life.[4] Vet centers offer "counseling interventions for psychological and psychosocial readjustment problems related to specific types of military service and deployment stressors."[5]

RCS requires each vet center to be aligned with a support VA medical facility.[6] The support VA medical facility director is required to assign a clinical liaison and external clinical consultant

[1] 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." VHA Directive 1500(4), *Readjustment Counseling Service*, January 26, 2021, amended November 21, 2023; To be consistent with vet center policy and terminology, the OIG refers to veterans receiving readjustment services as clients in this report; The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together. This footnote does not require an endnote.

[2] Readjustment Counseling Service is divided into five districts, with each district consisting of zones. VHA Directive 1500(4); The subject vet center is located in district 5, zone 1.

[3] VHA Directive 1500(4).

[4] VHA Directive 1500(4).

[5] VHA Directive 1500(4).

[6] VHA Directive 1500(4). Each vet center is aligned with a support VA medical facility to ensure access to clinical services and coordination of care for shared clients.

(external consultant).[7] The clinical liaison is responsible for assisting vet center staff in making referrals and coordinating services with the support VA medical facility.[8] The external consultant is a mental health professional who provides clinical consultation to vet center staff regarding mental health care for clients in need of services not offered by vet centers.[9]

Everett Vet Center

The Deputy District Director reported that the Everett Vet Center serves clients throughout three counties in Washington and the Naval Station Everett, Smokey Point Navy Complex, Armed Forces Building, and Snohomish Armory.[10] Further, the Deputy District Director reported that in fiscal year 2024, approximately 61,320 veterans resided in the service area and Everett Vet Center staff provided care to 460 unique clients.[11]

Everett Vet Center's support VA medical facility is the VA Puget Sound Health Care System (support facility). The support facility, part of Veterans Integrated Service Network (VISN) 20, offers a range of services including primary care and mental health, and substance use disorder treatment.

Prior OIG Reports

From September 2021 to September 2024, the OIG published 19 reports on deficiencies in vet center leaders' and staff's compliance with VHA requirements. The OIG determined that leaders failed to complete internal reviews regarding suicide attempts; establish written emergency and crisis plans; and ensure staff had access to critical event plans, including mental health crisis management.

The OIG identified that staff did not comply with RCS documentation standards or consult with vet center leaders and VA staff regarding clients with complex clinical needs and increased

[7] VHA Directive 1500(4). The support facility director is also required to assign an administrative liaison who assists vet center staff with organizational needs such as acquisition and transient benefits.

[8] VHA Directive 1500(4).

[9] VHA Directive 1500(4).

[10] The Deputy District Director discussed in this report was in the role at the time of the client's vet center visit. The District Director explained to the OIG that the Deputy District Director transitioned to another district role in October 2024.

[11] The fiscal year for the federal government is a 12-month period from October 1 through September 30 of any given year and is designated by the calendar year in which it ends. 49 C.F.R. § 1511.3 (2023).

suicide risk. Staff also failed to complete suicide risk assessments, safety plans for clients at intermediate or high risk for suicide, and crisis reporting (see appendix A).[12]

Allegations and Related Concerns

On April 9, 2024, the OIG received allegations that the VCD advised a counselor to allow the client to leave the clinic without notifying law enforcement authorities about the risk of harm the client posed to self and the public, referred to as duty to warn. Additionally, the complainant alleged that the VCD and counselor failed to consult with the external consultant, follow up with the support facility suicide prevention team, and complete crisis reporting following the client's report of opioid use with a plan to drive. The complainant also alleged that the Associate District Director for Counseling (ADDC) and VCD added to the client's Readjustment Counseling Service Net (RCSNet) clinical documentation (clinical record) to justify lack of action and altered notes to appear in compliance with practices.[13]

During evaluation of the allegations, the OIG identified additional concerns related to the

- adequacy of the counselor's risk assessment;
- delays in the counselor's documentation;
- failure to update the client's safety plan; and
- VCD's provision of clinical consultation to staff, despite the designation as a Title 5 employee.

Scope and Methodology

The OIG initiated the inspection on July 17, 2024, and conducted a site visit from August 13–14, 2024.

[12] A safety plan is a written list of coping strategies and sources of support for clients who are at high risk for suicide to use before or during a crisis. "RCS Suicide Prevention Safety Plan Procedural Guidance," RCS, accessed November 6, 2024, https://dvagov.sharepoint.com/sites/vharcs/shared%20documents/directive%201500/directive%201500%20support%20documents/rcs%20safety%20plan(2).pdf. (This site is not publicly accessible.) RCS defines intermediate acute suicide risk as suicidal ideation without intent or a suicide plan. Intermediate chronic suicide risk refers to "persistent suicidal ideation" without previous attempts. High acute suicide risk is defined as suicidal ideation with intent and plan and a history of previous attempts, with an "inability to maintain safety without external support." RCS considers high chronic suicide risk to be suicidal ideation with a "history of previous attempts," ongoing risk factors, and concurrent protective factors such as tools for coping and motivation to continue living. VHA Directive 1500(4).

[13] VHA Directive 1500(4). Vet center staff document client visits and client-related information in the web-based software system, RCSNet, which serves as the electronic client record and is independent from the electronic health record.

The OIG team interviewed RCS Central Office leaders, district leaders, the VCD, and Everett Vet Center and support facility staff knowledgeable about the client's care and relevant processes.

The OIG reviewed relevant VHA and RCS directives, handbooks, and memoranda; support facility policies; Everett Vet Center and support facility standard operating procedures and organizational charts; the client's clinical record and support facility's electronic health record (EHR) documentation; and relevant district and vet center leader and staff electronic communications.[14]

In the absence of current VA or VHA 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 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, as amended, 5 U.S.C. §§ 401–424. 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.

[14] As part of another OIG inspection, the OIG reviewed the client's clinical record on April 1, 2024. On June 3, 2024, the OIG team again accessed the client's clinical record and noted differences in documentation from the initial review.

Client Case Summary

The client, in their twenties at the time of the care under review, established care at the support facility in early fall 2020. The client's medical history included post-traumatic stress disorder (PTSD), major depressive disorder, attention deficit hyperactivity disorder, and substance use disorder to include opioid use disorder.[15]

The client first received psychiatric care at the facility in mid-fall 2020 and described thoughts of wanting "to sleep and not wake up," denied thoughts of suicide in the last month, and reported thoughts of harming others without intention to act on the thoughts. The client was prescribed medications to address depression and sleep concerns.

In late summer 2021, the client's care was transferred to another psychiatrist, who provided treatment for the client into 2024 for ongoing medication management.

In early 2024, the psychiatrist met with the client who reported worsening symptoms occurring over the prior week, including increased depression and PTSD, feelings of hopelessness, and passive suicidal ideation. The client reported holding an unloaded gun but denied suicidal intent or a plan, and agreed to take firearms from the home to a family member at another location later that day. The client reported taking opioids approximately three times a week over the prior year, but denied access at the time of the appointment and expressed a plan to abstain.

The psychiatrist documented that the client had an "elevated long-term risk for suicide" given the client's trauma history, mental health diagnoses, substance use, ongoing suicidal ideation, and access to firearms. The client declined hospitalization and agreed to present to an emergency department if feeling unsafe.

The same day, the psychiatrist completed a suicide prevention safety plan with the client, and submitted consults for outpatient substance use treatment, suicide prevention case management, and for consideration of a high risk for suicide patient record flag (high-risk flag). The psychiatrist completed a comprehensive suicide risk assessment with a plan to secure the client's firearm access and indicated the client had intermediate acute suicide risk and intermediate chronic suicide risk. The client agreed to follow up with the Everett Vet Center to pursue long-term individual therapy. The next day, a support facility social worker documented that the client did not meet criteria for a high-risk flag because the client endorsed passive suicidal ideation and the "event identified would not be considered a suicide attempt."

The following week, the psychiatrist met with the client who reported ongoing depressive and PTSD symptoms with improvement since the prior visit. The client continued to experience intermittent passive suicidal ideation but denied active suicidal ideation, plans, or intent, and

[15] The OIG uses the singular form of they, "their" in this instance, for privacy purposes. The client case summary is based on the client's clinical record documentation present on April 1, 2024.

confirmed that firearms were secured in a safe to which a family member held the key. The client denied opioid access and homicidal ideation and confirmed having a printed copy of the safety plan. The psychiatrist completed medication reconciliation and scheduled a follow-up appointment with the client for three weeks later.

Client's Care at the Everett Vet Center

The next day (day 1), the client presented to the Everett Vet Center for an individual visit and reported depression, anxiety, and suicidal ideation within the last four days to the readjustment counselor (counselor). The counselor completed a risk assessment and documented the client's suicide risk level as "Intermediate Acute/Intermediate Chronic." The counselor documented that the client described experiencing suicidal thoughts since separation from the military in 2020, including thoughts of suicide by hanging, and being "more prone to entertain a plan for taking opioids." The client recalled two past episodes of preparatory behavior, including loading and unloading a firearm in 2016, and aborting use of a hanging apparatus in 2017. The client also reported a history of opioid overdose in 2021.

The client denied intention of self-harm and completed a safety plan with the counselor that identified coping strategies and social supports, a plan to secure firearms, and family members to contact when experiencing "drug cravings." The counselor scheduled a one-week follow-up visit due to the client's "higher acuity." The following day the counselor documented the client's intake assessment and noted that the psychiatrist referred the client to the Everett Vet Center.

At the next scheduled visit, approximately one week later (day 9), the client reported being "high and not stable" after relapsing the previous night and reported taking 11 hydrocodone pills "before" the appointment, with a plan to obtain and take more pills after the appointment. The counselor documented the client had "passive suicidal ideations," denied suicidal intent or a plan, and stated, "I just want out of the pain, I don"t [*sic*] care what happens to me, I just want to get high." Additionally, the client admitted to "fantasies of torturing people" during periods of anger but denied having a specific person in mind.

The counselor completed the intake assessment and documented speaking with the client about ways to stay safe. The client declined the counselor's suggestion to "allow anyone close with [the client]" to accompany the client to an emergency department but agreed to the counselor attempting contact with the support facility suicide prevention team (suicide prevention team).

With the client's approval, the VCD joined the appointment and explained the process of presenting to an emergency department in response to the client's inquiry. The counselor documented speaking with a support facility "emergency psychiatric services" nurse who advised the client to go to the support facility emergency department for screening, encouraged the client to attend a scheduled outpatient substance use treatment appointment at the support facility, and explained that the client would not be admitted unless the client presented as a

danger to self or others. The VCD documented that the client "responded by saying, 'People like me have to say we are suicidal in order to get help.'"

The counselor further documented that the client continued to discuss a plan to take more opioids prior to presenting to an emergency department. The counselor suggested the client go to a closer emergency department in case the client could not drive to the support facility. The client declined the counselor's suggestion to contact someone for a ride to an emergency department. The counselor documented that the client was alert and oriented, with coherent speech, and that the client agreed to present to an emergency department but declined to do so prior to taking more opioids. The VCD also documented that the client declined suggestions to abstain from further opioid use prior to going to the emergency department and strategies to reduce potential harm from substance use such as decreasing the amount taken.

The client agreed to call 911 or the Veterans Crisis Line should suicidal thoughts increase.[16] The counselor documented paging the suicide prevention team and not receiving a return call and the client was scheduled to meet with the counselor four days later.[17] The VCD noted that the counselor discussed calling 911 following the client's departure from the Everett Vet Center, but "we decided that this did not warrant police attention at this point."

The VCD documented that the counselor reported contacting the support facility external consultant (external consultant), who agreed that the client did not "seem to meet criteria for police involvement." The VCD also documented leaving the appointment, that the counselor and client changed the plan, and that the client would present to a non-VA emergency department in closer proximity, "which the client did."

On day 13, the counselor documented consultation with the VCD regarding the client's non-VA hospital admission following a review of the client's support facility EHR documentation. The client's non-VA EHR documentation included that the client presented to a non-VA emergency department on day 9 and reported ingesting 21 opioid pills and suicidal ideations. The client was subsequently transferred to another non-VA facility, on day 10, for an inpatient mental health unit admission.

The counselor further documented discussing a plan with the VCD to increase the client's suicide risk to high and completed a risk assessment documenting the client's acute and chronic risk levels as high. The counselor suggested to the VCD that all the client's care be transferred to the support facility due to the client's "high acuity risk factors for suicide and active drug use

[16] The National 911 Program coordinates police, fire department, and medical assistance for individuals in emergency situations. "Calling 911," 911.gov, accessed November 20, 2024, https://www.911.gov/calling-911/; The Veterans Crisis Line is a confidential hotline, chat, and text service that connects veterans in crisis with VA responders. "Mental Health," VHA, accessed November 19, 2024, https://mentalhealth.va.gov/get-help/index.asp.

[17] On day 13, the counselor documented that the lack of response from the suicide prevention team may have been due to a phone issue at the Everett Vet Center.

with chronic suicidal behavior," and that the client could return for care at the Everett Vet Center when stabilized. Also on day 13, the counselor notified the psychiatrist about the client's vet center visit on day 9.

The next day, on day 14, the counselor documented consultation with the external consultant and provided an update of the "events that lead [*sic*] up to [the client's] current hospitalization." The external consultant reviewed "when calling 911 is necessary and when it's not necessary." In an addendum note on this day, the counselor further documented concurrence from the external consultant that calling 911 for the client on day 9 was not warranted "for someone who wants to go out and get high."

Two days later (day 16), the VCD documented a discussion with the ADDC regarding the counselor's progress notes and risk assessment for this client that were "not entered in a manner that is appropriate or in line with RCS standards." The VCD further documented, "We are in the process of correcting the notes and rewriting a risk assessment to ensure they are clear, accurate, meet the RCS normal standard and are in line with policy."

On day 24, the client was discharged from the non-VA inpatient mental health unit. Following discharge, the client engaged in post-discharge follow-up treatment with medication management and psychotherapy providers at the support facility, as well as substance use disorder groups.

Inspection Results

1. Deficiencies in Crisis Management and Reporting

The OIG substantiated that Everett Vet Center staff and leaders inadequately managed the client's crisis, including that the VCD advised the counselor to allow the client to leave the clinic without notifying law enforcement authorities. The OIG found that the VCD and counselor failed to fully consider duty-to-warn obligations in response to the client's plan to drive following opioid use because the VCD lacked knowledge of duty-to-warn requirements, and the counselor deferred to the VCD.

Further, the OIG was unable to determine if the client's circumstances necessitated vet center staff to fulfill duty-to-warn obligations because vet center staff did not obtain adequate information from the client to assess the imminent risk the client posed to self and the public while driving after using opioids and reporting the intent to take more as discussed below.

The OIG also substantiated that the VCD and counselor failed to immediately seek consultation from the external consultant or follow up with the support facility suicide prevention team, as

required by RCS.[18] Further, the OIG found that the counselor completed a crisis report for the client approximately two weeks after the client's appointment, not on the day of the client's visit, as required, based on guidance from the VCD.[19]

Deficiencies in Consideration of Duty to Warn

Since 2000, mental health providers in Washington state have had a "duty to warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims."[20] In 2016, the requirements in Washington state expanded to include the addition of duty to warn to "foreseeable" victims.[21]

When a client poses a threat to self or others, RCS staff may have a duty to notify law enforcement authorities under Tarasoff law.[22] RCS leaders reported an expectation that counselors remain aware of relevant state laws pertaining to duty to warn and consult with the VCD and ADDC; and consider consulting with the Office of General Counsel and external consultants to inform any necessary action.[23]

In response to the client's report of taking 11 hydrocodone pills and intent to take additional opioids after leaving the appointment, the counselor consulted with the VCD regarding the client's safety. The counselor documented and confirmed with the OIG that the client's judgment was "poor." However, the VCD noted that the client was "reasoning seemingly with ease."

The counselor and VCD documented discussing the following options with the client to mitigate risk:

- traveling directly to an emergency department without obtaining additional opioids,

[18] VHA Directive 1500(4). The directive notes that VHA requires that the support medical facility director and VCD assign support facility staff in the roles of clinical liaison and external clinical consultant to the vet center. The clinical liaison assists the vet center with coordination of VA services and suicide prevention activities. The external clinical consultant is an independently licensed mental health professional who provides a minimum of four hours of consultation monthly to vet center counseling staff regarding mental health care and services and clinically complex concerns.

[19] VHA Directive 1500(4).

[20] "Mental Health Professionals' Duty to Warn," National Conference of State Legislatures, accessed June 20, 2024, https://www.ncsl.org/health/mental-health-professionals-duty-to-warn.

[21] "Guidance on New Duty to Warn or Protect Standard," Washington State Medical Association, accessed June 25, 2024, https://www.wsha.org/wp-content/uploads/Volk-recs-FINAL.pdf. The Supreme Court ruled in Volk v. DeMeerleer, 386 P.3d 254, 187 Wn.2d 241 (2016) that it is the "duty of health care providers to warn or protect potential victims of violence" and the duty to warn "extends to all individuals who may be 'foreseeably' endangered by a patient," even if there is no specific target identified.

[22] VHA Directive 1500(4).

[23] The Office of General Counsel's mission is to, "identify and meet the legal needs of the Department of Veterans Affairs (VA)." "Office of General Counsel," VA Office of General Counsel, accessed June 2, 2025, https://www.va.gov/OGC/.

- having a family member or friend transport the client to the emergency department, and
- asking the client to "cut the dosage [the client] planned to take" of opioids.

The client declined assistance with transportation to an emergency department and agreed to call 911 if experiencing suicidal ideation.

The counselor told the OIG about considering calling 911 due to concern and uncertainty about what would occur when the client left the Everett Vet Center; however, reported not calling 911 based on direction from the VCD. The VCD documented that after the client left the Everett Vet Center, the counselor discussed calling 911, "but we decided that this did not warrant police attention at this point."

The counselor reported discussing safety concerns with the VCD related to the client's report of passive suicidal ideation and plan to drive alone to an emergency department after presenting "high." The VCD reported considering the possibility that the client might pose a risk to others by driving in an impaired state but also noted the client did not appear to be under the influence of drugs. The VCD asserted that at the time of the client's appointment, 911 should not have been called.

In interviews with the OIG, RCS Central Office and district leaders reported that the VCD and licensed counselors are responsible for understanding state requirements.[24] Although the VCD acknowledged that vet center staff rely on "leadership" rather than state law for guidance on duty-to-warn requirements, the VCD reported being unaware of Washington state duty-to-warn requirements or how to become aware of these requirements. In interviews, five counselors described referring to a vet center crisis reference guide or consulting with the VCD if a duty-to-warn situation arose.[25]

The ADDC explained that counselors are expected to call 911 when the counselor or VCD determines that duty to warn is warranted. The ADDC reported that based on a documentation review, the ADDC would have contacted the police if the client reported a plan to drive after recent opioid use and intention to consume additional pills.

The OIG found inadequacies in staff knowledge and timely consultation related to the consideration of duty to warn. The OIG found that the counselor relied on the VCD's guidance when deciding not to contact 911 to warn authorities of the client's potential risk to others. However, the VCD told the OIG about not being aware of state guidelines pertaining to duty to warn, nor how to access the information.

[24] The counselor who saw the client was licensed.

[25] The crisis reference guide provided general instruction to contact 911 when a client or others are "in immediate danger" or if a client needs hospitalization and is not willing to go voluntarily.

The OIG found that the VCD's limited knowledge and advice may have contributed to the counselor's decision to not call 911 or consult with the ADDC on the day of the client's appointment. The OIG concluded that this lack of knowledge likely contributed to the VCD's and counselor's failure to engage in sufficient decision-making to determine the applicability of duty to warn.

Deficiencies in Consultation with the External Consultant

RCS requires that a counselor seek immediate consultation from the external consultant when a serious mental health condition is suspected or the counselor detects evidence of serious mental health conditions.[26] Five days after the client's visit, on day 14, the counselor documented contacting the external consultant to ask if 911 should have been called after the client presented to the vet center on day 9 "'high' on hydrocodone" with a plan to take more and "escape the pain." The counselor documented that the external consultant reported "calling 911 is not indicated for someone who wants to go out and get high" and that if a client reported suicidal ideation or threats, then contacting 911 is warranted.

The external consultant told the OIG that consultation with the counselor occurred once, when the counselor sought input on whether the client's report of intended substance use "warranted a welfare check."[27] The external consultant confirmed telling the counselor that contacting 911 was not necessary unless the client was at risk for suicide. The counselor did not document informing the external consultant about the client's intent to operate the vehicle, although reported to the OIG the belief that information had been shared. However, the external consultant did not recall being informed about the client's intent to operate a vehicle by the counselor.

Due to the counselor's lack of documentation, the OIG was unable to determine if the counselor fully informed the external consultant about the potential risk of harm related to the client's opioid use and plan to drive. The external consultant told the OIG that had the counselor provided information about the client's reported intent to drive after opioid use, the external consultant may have recommended preventing the client from driving but may not have considered a duty to warn. Furthermore, the counselor's failure to consult with the external consultant at the time of the client's visit may have contributed to the external consultant's incomplete knowledge of the situation and therefore may have compromised the guidance provided to the counselor regarding duty to warn.

[26] VHA Directive 1500(4).

[27] A welfare check is a physical check of an individual's welfare by emergency services, prompted by a concerned person. "What is a welfare check," The Law Dictionary, accessed February 27, 2025, https://thelawdictionary.org/article/what-is-a-police-welfare-check/.

Failure to Follow Up with the Suicide Prevention Coordinator

The OIG substantiated that the VCD and counselor failed to follow up with the suicide prevention team about the client's increased suicide risk level on day 9 after lack of response to a page, or on day 13 when the risk assessment was completed, as required by RCS.[28] Counselors must report clients considered "acute high-risk" for suicide to the suicide prevention coordinator at the support VA medical facility.[29]

On day 9, when the client reported taking 11 hydrocodone pills and passive suicidal ideation, the counselor paged the suicide prevention team, providing the counselor's direct office phone number and did not receive a response. That same day, in a secure instant message, a suicide prevention team member informed the suicide prevention team of receiving a page from the Everett Vet Center and getting a "busy signal" when calling the provided number.

On day 13, the counselor documented that another counselor clarified that when paging the suicide prevention team, staff should "provide the main number to our Vet Center because the phones have not yet been transferred over to our direct lines when we send a page; hence why I did not hear back from suicide prevention when I paged them on [day 9]."

The counselor reported not contacting the suicide prevention team on day 13 based on having already emailed the psychiatrist, consultation with the VCD, and the client's hospitalization. The VCD reported awareness of the counselor's page to the facility suicide prevention team on day 9. The VCD also noted that the client presented for help with substance use and was not suicidal; therefore, the VCD thought there was "some margin for question and consultation and figuring out what would be appropriate given the situation that [the client] is not suicidal."

The OIG determined that the counselor's failure to follow up with the suicide prevention team may have contributed to a missed opportunity to reconsider if the client met criteria for a high-risk flag. Approximately one week prior to the client's initial vet center visit, the suicide prevention coordinator documented that the client did not meet criteria for a high-risk flag. The director, suicide prevention told the OIG that notification of the client's increased risk level would have prompted the suicide prevention team to conduct a review and reconsider placement of a high-risk flag.

The VCD's and counselor's failure to follow up with the suicide prevention team about the client's increase in risk level prevented the suicide prevention team's reconsideration of a high-risk flag placement that may have prompted additional outreach to the patient.

[28] VHA Directive 1500(4).

[29] VHA Directive 1500(4).

Crisis Reporting Deficiencies

The OIG substantiated that the counselor delayed crisis reporting because the counselor and VCD were uncertain about whether the client's circumstances met the criteria for reporting the event. The OIG also found that RCS leaders did not establish clear written guidance regarding crisis reporting criteria and monitoring responsibilities.

According to RCS policy, a counseling crisis event (crisis event) occurs when a client presents with "suicide ideation (with inability to maintain safety)," a suicide attempt, or dies by suicide.[30] VCDs are responsible to ensure that a report of a crisis event (crisis report) is entered into the "Log-a-Crisis" software program prior to close of business on the day of notification of the crisis event.[31] A crisis report entry generates an email alert of the crisis event to the RCS Deputy Chief Officer and district directors.[32] The ADDC explained that the purpose of the email notification is to "increase awareness so that we can offer assistance to the vet center if needed." VCDs must also ensure that the assigned counselor completes a "Clinical Crisis Report of Contact" (report of contact) within two business days of notification of the crisis event.[33]

On day 9, the VCD, counselor, and client established a plan for the client to go to an emergency department to address the client's reported passive suicidal ideation and opioid use. The VCD reported that, because of the referral to an emergency department, a crisis report should have been entered. The VCD explained that the criteria for crisis reporting were unclear unless a client is "suicidal" and that this lack of clarity may cause a delay in the crisis report entry. The VCD and ADDC told the OIG that counselors are able to complete a crisis report without leaders' consultation; however, the counselor reported deferring to the VCD for guidance on next steps following the client's visit.

In an email on day 19, the VCD instructed the counselor to plan on working "on the crisis report, ROC [report of contact] and the notes" with the VCD the next day. The VCD noted "consulting with [the ADDC] along the way so we can ensure to get this on track." On day 20, the counselor documented meeting with the VCD and ADDC to "discuss policy and procedures for documenting this high risk" client and entered the crisis report. The VCD told the OIG that although the client was not considered suicidal in the consultation with the ADDC, it was determined that a crisis report was warranted for the client because the VCD and counselor referred the client to an emergency department.

[30] VHA Directive 1500(4).
[31] VHA Directive 1500(4).
[32] VHA Directive 1500(4).
[33] VHA Directive 1500(4).

Although not identified in RCS written guidance, the Deputy District Director told the OIG that the ADDC is responsible for tracking delayed crisis report entries. In an interview with the OIG, the ADDC reported being unaware of any crisis report timeliness monitoring.

The OIG concluded that the lack of clarity regarding criteria to prompt the entry of a crisis report contributed to the delay in crisis report entry for the client. Vet center leaders' and staff's uncertainty regarding crisis reporting requirements is likely to contribute to inconsistency in reporting within and across vet centers. The failure to complete crisis reports and monitor entry timeliness may impede leaders' ability to most effectively assist staff and provide guidance in client care.

2. Deficiencies in Clinical Record Documentation Practices

The OIG substantiated that the VCD backdated a progress note in the client's clinical record and found that the backdating occurred because of the VCD's lack of awareness of RCS documentation requirements. The OIG did not substantiate that the ADDC added or altered documentation or advised the VCD to add or alter documentation in the client's clinical record to justify "not calling the authorities" and appear in compliance with RCS practices. However, the OIG found that the counselor added late documentation in the client's clinical record, as advised by the VCD. Additionally, the OIG substantiated that the ADDC deleted progress notes in the client's clinical record; however, at the time, RCS allowed ADDCs to delete non-visit progress notes without oversight.

VCD Noncompliance with Documentation Entry Requirements

The OIG substantiated that on day 16, the VCD entered documentation, dated day 9, with information about meeting with the client on day 9 and the counselor's consultation with the external consultant on day 14.

RCS differentiates visit and non-visit progress notes.[34] Vet center staff must document client-related administrative and consultative information, such as internal and external consultation, in non-visit progress notes.[35] Vet center staff must document progress notes in the clinical record "within two working days from the date of the visit."[36] Although RCS policy does not specify a time frame for entering non-visit progress notes, the Deputy Chief Officer, RCS told the OIG that the two-day requirement was applicable to both visit and non-visit progress notes.

[34] VHA Directive 1500(4).

[35] VHA Directive 1500(4). The RCS National Service Support (NSS) Officer "is responsible for maintenance and oversight of the RCS System of Records and all service data collection and management."

[36] VHA Directive 1500(4). The Deputy Chief Officer, RCS confirmed to the OIG that this requirement applied to both visit and non-visit progress notes.

The OIG found that on day 16, the VCD entered into the client's record a non-visit progress note dated day 9 detailing events that occurred on days 9 and 14. Specifically, the VCD documented information about meeting with the counselor and the client on day 9 and the counselor's day 14 consultation with the external consultant. The VCD told the OIG that a non-visit progress note can be dated differently from the date it is documented and that the note in the client's record was likely dated for day 9 based on what the VCD thought was "appropriate." Inconsistent with RCS policy, the VCD reported it was "common practice" to enter notes under a different date as the counselor deems appropriate.

Backdated notes and inclusion of information that occurred after the progress note entry date may contribute to an inaccurate understanding of the client's care and timeline of related events.

Documentation Deficiencies and Modifications to the Client's Clinical Record

The OIG did not substantiate that the ADDC added or altered documentation or advised the VCD to add or alter documentation in the client's clinical record to justify "not calling the authorities" and appear in compliance with RCS practices. The OIG found that after consultation with the ADDC, consistent with RCS practice at that time, the VCD directed the counselor to add new progress notes in the client's record after the client's visit to provide more detail to existing documentation.

Counselors are "responsible for accurately entering basic visit information into the individual record in the order in which the visits occurred to preserve an accurate chronological record of services provided."[37]

Approximately one week after the client's visit, on day 15, the VCD emailed the counselor requesting to meet regarding the client; however, the counselor was unable to meet due to being out of the office. The next day, the VCD documented in the client's clinical record that the ADDC and VCD

> … discussed how the [non-visit] progress notes and Risk Assessment entered into [the clinical record] for this client are not entered in a manner that is appropriate or in line with RCS standards. We are in the process of correcting the notes and rewriting a risk assessment to ensure they are clear, accurate, meet the RCS normal standard and are in line with policy.

In an interview with the OIG, the VCD reported that during consultation with the ADDC, the VCD and ADDC determined that the counselor's documentation was "unprofessional and not meeting the standards." The counselor told the OIG that the VCD asked the counselor to rewrite notes in the client's clinical record to address incorrect formatting, improper copying and pasting

[37] VHA Directive 1500(4).

from the client's support facility EHR, and lack of clarity regarding consultation about the client's care. The VCD reported having no prior concerns with the counselor's documentation and attributed the deficient documentation in the client's clinical record to the counselor's emotional state related to another client situation.

On day 17, the counselor sent the VCD a revised non-visit progress note and requested the VCD's review prior to adding to the client's clinical record. Two days later, the VCD met with the counselor and instructed the counselor to add non-visit progress notes for each consultation that occurred about the client's care and another to summarize the counselor's "clinical judgement."

From days 19 to 21, the VCD reviewed and requested edits to the counselor's revised versions of progress notes. The VCD and counselor corresponded with the ADDC regarding note revisions. On day 22, the VCD emailed the counselor that the progress notes "reads [*sic*] much better." On day 27, almost three weeks after the client's visit, the counselor added 19 non-visit progress notes to the client's clinical record for days 9, 13, 14, and 15 that included changes such as more detail about consultation and the client's hospitalization, summarization of previously documented information, and removal of copy and paste information included from the client's EHR.

Due to the need for staff to manually enter dates in RCSNet and an absence of RCS policy for staff to document actual entry date of a non-visit progress note, the OIG found that the client's clinical record was nonsequential and failed to preserve an accurate chronological record of the client's care. Further, the OIG found that the manual date entry prevented identification within the clinical record of notes entered at a later date.

The counselor's visit progress note, entered on day 9, described the client as presenting with "organized and goal directed" thinking, "coherent and unimpaired" speech, and "poor" judgment. However, in an added non-visit progress note about paging the support facility suicide prevention team, the counselor described the client as a "danger to [self] and to others because [the client] was intoxicated, under the influence of narcotics and [the counselor] was concerned [the client's] behavior was suicidal in nature."

The OIG did not identify any negative outcomes for the client from the counselor's different reports. However, unreconciled contradictory information in a client's clinical record may contribute to an inaccurate understanding of the client's risks and treatment needs.

The OIG determined that although the VCD provided reasonable justification for instructing the counselor to add notes to the client's record, the delayed entry of clinical information may prevent other vet center staff from accessing valuable data about a client's care in real time. The addition of late-entry notes to the client's record without identification of the actual date of note entry prevents transparency regarding clinical documentation modifications. Further, by

documenting clinical information at a later date, it may be difficult to identify an accurate timeline of care provided to a client.

Progress Note Deletions and RCS Central Office Leaders' Actions

The OIG found that approximately two months after the client's visit, on day 69, the ADDC removed five of the counselor's non-visit progress notes from the client's clinical record. RCS requires that "the original text of the progress note is" the client's "official record and must not be altered or destroyed"; however, staff and leaders had the capability to delete notes and did so under certain circumstances.[38]

Approximately six weeks after the client's vet center visit, on day 60, the ADDC requested to meet with the VCD to "sit down and go through [the client's clinical record] together to delete" notes. Four days later, the ADDC emailed the counselor not to close the client's case in order "to clean up the record" and the ADDC would meet with the VCD to "complete all the edits." Almost a week later, on day 69, the ADDC sent an instant message to the VCD that the counselor's notes were "not in compliance with RCS standards and need to be removed." Five days later, the ADDC and the VCD removed five non-visit progress notes from the client's clinical record.

In August 2024, the ADDC told the OIG that ADDCs had the ability to delete progress notes from clinical records, including at the time of the client's visit. The ADDC explained that a clinical record might be altered or modified if staff enter information in an incorrect record, document inaccurate or confusing information, or include the client's support facility EHR documentation. The ADDC further reported that RCS leaders did not provide guidance regarding progress note deletion. RCS Central Office leaders confirmed that written guidance had not been issued about criteria for progress note deletion.

In August 2024, the Deputy Chief Officer, RCS alerted a VA OIG leader that an internal RCS review had been initiated in response to reports of documentation concerns at two other vet centers. The Chief Officer, RCS told the OIG about directing a National Service Support (NSS) program analyst to remove the delete function for district leaders after learning of the ADDCs' capability to delete progress notes from the clinical record in September 2024. Additionally, the Chief Officer, RCS reported a plan to establish a process for progress note review and deletion.

The NSS program analyst demonstrated to the OIG that deleted progress notes were maintained digitally and accessible to NSS staff. The NSS program analyst reported disabling of the delete function three days after the Chief Officer, RCS request in September 2024. Another NSS program analyst emailed RCS employees to inform them of the disabled delete function and

[38] VHA Directive 1500(4).

outlined a progress note deletion process that required approvals by the ADDC; District Director; and National Privacy Officer, RCS; prior to NSS staff deleting a note.

The lack of written guidance and oversight of progress note deletion likely contributed to the ADDC's deletion of progress notes without documented justification. The absence of established procedures to guide progress note deletion may result in inaccurate and misleading clinical records that fail to represent clients' treatment needs and care. Further, the ability to delete progress notes without oversight can increase the risk of clinical record inaccuracies and result in unwarranted or fraudulent deletions.

3. Inadequate Risk Assessment, Delayed Documentation, and Safety Plan Update

The OIG found that the counselor did not document a required risk assessment with the client on day 9 when the client's risk level increased as a result of the client's reported opioid use and passive suicidal ideation.[39] The OIG also found that the counselor did not update the client's safety plan as required when the client presented with increased risk on day 9.[40] Although the OIG did not identify that the VCD's and counselor's delayed risk assessment documentation and failure to update the safety plan resulted in negative outcomes for this client, staff's failure to adhere to safety protocols may hinder the provision of appropriate interventions in the care of high-risk clients.

Inadequate Risk Assessment and Delays in Documentation

Counselors are required to conduct risk assessments with clients at the initial visit to a vet center and subsequently as clinically indicated.[41] Counselors should conduct risk assessments in person "whenever possible" and must document the risk assessment in the client's clinical record.[42] When a counselor determines a client's risk level to be intermediate or high, consultation must occur with the VCD or ADDC. As of January 2025, RCS leaders had not established written guidance regarding time requirements for the completion of risk assessment documentation in clients' clinical records.[43]

RCS acknowledges that substance use frequently co-occurs for individuals diagnosed with PTSD and therefore, requires counselors to assess clients for substance use. Opioid use increases a

[39] VHA Directive 1500(4). The directive notes that risk assessments are conducted to evaluate a client's suicidal ideation, intent, preparatory behavior, and previous suicide attempts and to identify the client's suicide risk level as acute or chronic and low, intermediate, or high.

[40] VHA Directive 1500(4).

[41] VHA Directive 1500(4).

[42] VHA Directive 1500(4).

[43] VHA Directive 1500(4).

person's risk for unintentional overdose and death by suicide.[44] These risks are further increased when opioid use occurs concurrently with other mental health concerns.[45] Hydrocodone, the opioid reportedly taken by the client, may cause a life-threatening reaction, drowsiness, fainting, or dizziness, and using too much can result in an overdose and possible death.[46]

As required on day 1, the counselor completed a risk assessment and documented the client's risk level as intermediate acute and intermediate chronic. Approximately a week later on day 9, the counselor consulted with the VCD after the client reported taking 11 hydrocodone pills earlier that day and passive suicidal ideation.

The OIG found that the counselor did not document a risk assessment on day 9, as expected based on clinical indication of increased risk due to opioid use. The counselor told the OIG that the information documented in the client's clinical record was based on the client's report rather than a "formal assessment" and explained not completing the client's risk assessment on day 9 because of being "exhausted" with a plan to complete "the next business day."

The OIG also found that although the counselor documented that the client had taken 11 hydrocodone pills before the appointment, the counselor and VCD did not ask the client for more information about the time frame of pill ingestion. In an interview with the OIG, the VCD reported that the client "generally had indicated that it had been awhile" since taking the pills, and acknowledged that "it was probably a mistake" not to ask the client when the pills were taken. The failure to obtain information about the time frame of the client's opioid use limited the Everett Vet Center staff's understanding of the potential effects to the client.

The counselor documented in the clinical record that the client was coherent, and the VCD described the client as coherent and "reasoning seemingly with ease." Further, the counselor reported that the client did not present with signs of intoxication, such as stumbling, slurring speech, or nodding out.[47] However, the OIG would have expected the counselor and VCD to attempt to gain more information about the timing of the client's opioid use to determine if the client was at risk for onset of opioid effects, especially since the client planned to drive. The lack of information about the client's use pattern may have affected the counselor's and VCD's decision not to contact 911, as discussed below.

Four days later (day 13), the counselor reviewed the support facility EHR and learned that the client had been hospitalized at a non-VA facility since day 10 because the client "was feeling

[44] Amy S. B. Bohnert and Mark A. Ilgen, "Understanding Links among Opioid Use, Overdose, and Suicide," *The New England Journal of Medicine*, no. 380 (January 3, 2019): 71–79, https://www.nejm.org/doi/10.1056/NEJMra1802148.

[45] Bohnert and Ilgen, "Understanding Links among Opioid Use, Overdose, and Suicide."

[46] Mayo Clinic, "Hydrocodone (oral route)," accessed November 18, 2024, https://www.mayoclinic.org/drugs-supplements/hydrocodone-oral-route/description/drg-20084881.

[47] Opioid use can cause nodding out, a semi-conscious state that is characterized by sudden lapses into drowsiness or sleep.

suicidal with intentional overdose." The counselor then documented a risk assessment without the client present and assessed the client's acute and chronic risk levels as "High." The VCD explained to the OIG that the risk assessment should be documented at the time of the assessment and that the counselor's later completion "did not meet the criteria."

Given the client's increased suicide risk due to opioid use and the RCS requirement to complete a risk assessment when clinically indicated, the OIG would have expected the counselor to complete and document a thorough risk assessment at the time of the client's day 9 visit. Although the OIG did not identify negative outcomes as a result of the counselor's incomplete assessment and delayed documentation, failure to thoroughly assess and document risk factors timely may have contributed to staff's incomplete understanding of the client's mental health treatment and safety needs and inadequate coordination of care.

Failure to Update the Client's Safety Plan

The OIG found that the counselor did not update the client's safety plan as required when the client presented with increased risk on day 9.[48] Counselors must complete a safety plan with a client to include the client's "specific stressors and plans for maintaining safety" and provide a copy to the client following a determination of intermediate or high suicide risk.[49] The counselor told the OIG about not reviewing the safety plan with the client on day 9 because the focus was to encourage the client to go to an emergency department and the client had a copy of the safety plan completed during the previous visit. The VCD told the OIG that a safety plan was not reviewed because the client was in crisis and a "verbal safety plan" had been discussed with the client. Given that the counselor and VCD identified the client as in crisis but deemed appropriate to leave the Everett Vet Center, the OIG would have expected the counselor to have provided the client with a written safety plan to ensure the client's awareness of resources to maximize safety.

4. Inconsistent VCD Position Descriptions

The OIG received conflicting information from RCS leaders and district leaders regarding the Everett VCD's position description. The OIG found that after the client's visit, the Everett VCD may have been provided with a position description that included higher-level clinical responsibilities such as the provision of clinical consultation to staff, inconsistent with the limitations identified in the position description issued by RCS Central Office approximately three years prior. The OIG also found that conflicting information provided to the Everett VCD about the scope of the VCD's clinical responsibilities may have contributed to the VCD's failure to consult immediately with the ADDC on day 9 as required by an applicable 2021 VCD position description.

[48] VHA Directive 1500(4).

[49] VHA Directive 1500(4).

In 2017, VHA initiated a conversion of staff positions from Title 5 to Hybrid Title 38 to align with staff's assigned duties and qualification standards.[50] VHA Human Resources Information Service staff identified positions and employees considered for conversion to Hybrid Title 38 based on education, experience, or credentials needed for the positions, including licensed professional mental health counselors, psychologists, and social workers.[51] Title 5 positions do not require "clinical knowledge, skills, and abilities" and include program analysts, human resources specialists, and program support assistants.[52] The District Director indicated that Title 5 positions are typically administrative roles and not clinical.

The Chief Officer, RCS and Deputy Chief Officer, RCS told the OIG that Title 5 VCDs should not provide clinical consultation and were required to consult with an ADDC on clinical matters. Consistently, the Deputy District Director reported that staff's clinical consultation with Title 5 staff and leaders was not appropriate and should occur with Hybrid Title 38 staff.[53] However, the District Director noted that a Title 5 VCD can provide consultation but staff should immediately consult with the ADDC or external consultant during "complicated" clinical concerns, and that the VCD and the counselor should have contacted the ADDC for consultation on the same day as the client's visit.

The Chief Officer, RCS informed the OIG that in 2021, RCS Central Office leaders advised district leaders that Title 5 employees "must cease performing clinical counseling and/or clinical based assessments immediately." The Chief Officer, RCS also reported that at that time, district leaders received training on "how to manage the new scope of work" and that Title 5 VCDs received the updated position description requiring clinical consultation with the ADDC. District leaders provided the Everett VCD the updated position description in March 2021.[54]

District leaders told the OIG about conducting a "Zone 1 VCD Sequester" in July 2024 and providing the Title 5 VCDs with a position description.[55] The OIG found that the 2021 and 2024 position descriptions included different information regarding the Title 5 VCD's scope of work. Specifically, the 2021 position description stated that the VCD is "responsible for making non-

[50] "Qualification standards establish basic requirements which are predictive of successful performance." VHA Handbook 5005/92, *Staffing,* November 22, 2017.

[51] VHA Handbook 5005/92.

[52] VHA Handbook 5005/161, *Staffing*, January 29, 2024; VA, *Job Search Guide*, accessed December 10, 2024, https://www.va.gov/OAA/docs/Job_Search_Guide_for_VHA_Health_Professions_Trainees.pdf.

[53] VHA Directive 1500(4).

[54] The Deputy Chief Officer, RCS explained to the OIG that the 2021 position description needed to be reformatted in 2023 to align with new documentation requirements. In December 2023, the District Director issued a memorandum to RCS Operations confirming that Title 5 VCDs in the district "received their new position description." The OIG compared the 2021 and 2023 position descriptions and did not identify changes to the clinical care and consultation responsibilities of Title 5 VCDs.

[55] In October 2024, District 5 leaders provided the OIG with a copy of the position description that the VCD reportedly received at the "Zone 1 VCD sequester."

clinical recommendations to the interdisciplinary treatment team," can provide assistance with "less complicated cases without prior approval," and must refer staff to appropriate resources for "difficult and complex cases."

In contrast, the 2024 position description included expectations that the VCD provide crisis intervention and "highly skilled readjustment counseling services to clients with difficult and complex problems of social, emotional and vocational adjustment." Responsibilities also included "the clinical supervision of and consultation to a multidisciplinary staff in the development of treatment plans and the resultant therapy."[56]

In March 2025, RCS leaders and the District Director informed the OIG that the expectations for "highly skilled" counseling services and "clinical supervision … and consultation" were not included in the position description for Title 5 VCDs. RCS leaders and the District Director reported that the VCD was formally assigned to the 2021 position description through December 2024.[57]

Consistent with RCS leaders' and the District Director's expectations, at the time of the client's visit on day 9, the VCD should have been abiding by the 2021 position description, which required consultation regarding the client's clinical needs. The VCD described receiving conflicting information about the scope of the VCD's clinical responsibilities. The VCD reported being told, approximately three months after the client's visit, about being unable to see complex clients. A month later, the VCD initiated transfer of clients to an Everett Vet Center counseling staff member.

The conflicting information provided to the OIG, including the lack of clarity regarding VCD responsibilities and scope of work as reflected in the distribution of inconsistent position descriptions, may have resulted in the Everett VCD's lack of awareness of the need to consult with the ADDC regarding the client's condition on day 9. The VCD's report of seeing complex clients until three months after the client's visit provides further support of the lack of clarity regarding the Title 5 VCD responsibilities. The absence of consultation may have contributed to an incomplete understanding of the client's clinical condition, potential risks, and relevant factors in the consideration of the duty to warn.

Conclusion

The OIG substantiated that the VCD advised the counselor to allow the client to leave the clinic without notifying law enforcement authorities. The VCD's limited knowledge of duty-to-warn requirements and advice may have contributed to the counselor's decision to not call 911 or

[56] In December 2024, the OIG did not receive a response from District 5 leaders to review the position description provided to the OIG in October 2024 to confirm that this was the position description provided to VCDs at the July 2024 "Zone 1 VCD Sequester."

[57] The Chief Officer, RCS informed the OIG that the VCD separated from employment in December 2024.

consult with the ADDC on the day of the client's appointment and likely contributed to the VCD's and counselor's failure to engage in sufficient decision-making to determine the applicability of duty to warn.

The OIG substantiated that the VCD and counselor failed to immediately seek consultation from the external consultant or follow up with the support facility suicide prevention team, as required by RCS. The counselor's failure to consult with the external consultant at the time of the client's visit may have contributed to the external consultant's incomplete knowledge of the situation and therefore compromised the guidance provided to the counselor regarding duty to warn. The VCD's and counselor's failure to follow up with the suicide prevention team about the client's increase in risk level prevented the suicide prevention team's reconsideration of a high-risk flag placement that may have prompted additional outreach to the patient.

The OIG substantiated that the counselor delayed crisis reporting because the counselor and VCD were uncertain about whether the client's circumstances met the criteria for reporting the event. RCS leaders did not establish clear written guidance regarding crisis reporting criteria and monitoring responsibilities. Vet center leaders' and staff's uncertainty regarding crisis reporting requirements is likely to contribute to inconsistency in reporting within and across vet centers. The failure to complete crisis reports and monitor entry timeliness may impede leaders' ability to most effectively assist staff and provide guidance in client care.

The OIG substantiated that the VCD backdated a progress note in the client's clinical record and found that the backdating occurred because of the VCD's lack of awareness of RCS documentation requirements. Backdated notes and inclusion of information that occurred after the progress note entry date may contribute to an inaccurate understanding of the client's care and timeline of related events.

The OIG did not substantiate that the ADDC added or altered documentation or advised the VCD to add or alter documentation in the client's clinical record to justify "not calling the authorities" and appear in compliance with RCS practices. Although the VCD provided reasonable justification for instructing the counselor to add notes to the client's record, the delayed entry of clinical information may prevent other vet center staff from accessing valuable data about a client's care in real time. The addition of late-entry notes to the client's record without identification of the actual date of note entry prevents transparency regarding clinical documentation modifications. Further, by documenting clinical information at a later date, it may be difficult to identify an accurate timeline of care provided to a client.

The OIG substantiated that the ADDC deleted progress notes in the client's clinical record; however, at the time, RCS allowed ADDCs to delete non-visit progress notes without oversight. The absence of established procedures to guide progress note deletion may result in inaccurate and misleading clinical records that fail to represent clients' treatment needs and care. Further, the ability to delete progress notes without oversight can increase risk of clinical record inaccuracies and result in unwarranted or fraudulent deletions.

The counselor did not document a required risk assessment with the client when the client's risk level increased as a result of the client's reported opioid use and passive suicidal ideation. Although the OIG did not identify negative outcomes as a result of the counselor's incomplete assessment and delayed documentation, failure to thoroughly assess and document risk factors timely may have contributed to staff's incomplete understanding of the client's mental health treatment and safety needs and inadequate coordination of care.

The counselor did not update the client's safety plan as required when the client presented with increased risk. Given that the counselor and VCD identified the client as in crisis but deemed appropriate to leave the Everett Vet Center, the counselor should have provided the client with a written safety plan to ensure the client's awareness of resources to maximize safety.

After the client's visit, the Everett VCD may have been provided with a Title 5 position description that included higher-level clinical responsibilities such as the provision of clinical consultation to staff, inconsistent with the limitations identified in the position description issued by RCS Central Office approximately three years prior. The lack of clarity regarding VCD responsibilities and scope of work as reflected in the distribution of inconsistent position descriptions may have resulted in the Everett VCD's lack of awareness of the need to consult with the ADDC regarding the client's condition on day 9. The absence of consultation may have contributed to an incomplete understanding of the client's clinical condition, potential risks, and relevant factors in the consideration of the duty to warn.

Recommendations 1–9

1. The District 5 Director conducts a full review of care provided to the client by the Everett Vet Center Director and counselor, consults with Human Resources and General Counsel Offices, and takes action as needed.
2. The District 5 Director ensures vet center leaders and staff are knowledgeable about applicable state laws pertaining to duty to warn.
3. The District 5 Director makes certain that the Everett Vet Center Director and staff adhere to requirements for consultation with support facility external consultants and suicide prevention coordinators when indicated, and monitors compliance.
4. The Chief Officer, Readjustment Counseling Service provides written guidance to clarify crisis reporting criteria and monitoring responsibilities.
5. The Chief Officer, Readjustment Counseling Service establishes written policy that clarifies clinical record documentation requirements regarding entry dates; non-visit progress note completion time frames; and progress note deletion and addition, and monitors compliance.

6. The Chief Officer, Readjustment Counseling Service establishes written guidance regarding time requirements for the completion of risk assessment documentation in clients' clinical records.
7. The District 5 Director ensures readjustment counselors' compliance with updating and reviewing safety plans as required by Readjustment Counseling Service policy.
8. The Chief Officer, Readjustment Counseling Service ensures that vet center directors are issued the correct position description and are performing duties within the identified scope of work.
9. The District 5 Director conducts a review of the care provided to complex clients by the Everett Vet Center Director since March 2021 and addresses identified clinical needs.

Appendix A: September 2021 to September 2024 OIG Reports Identifying Related Vet Center Deficiencies

VA OIG Published Healthcare Inspection Reports	Publication Date
Vet Center Inspection of Continental District 4 Zone 2 and Select Vet Centers	September 30, 2021
Vet Center Inspection of Pacific District 5 Zone 1 and Selected Vet Centers	September 30, 2021
Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers	September 30, 2021
Vet Center Inspection of Continental District 4 Zone 1 and Selected Vet Centers	December 2, 2021
Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers	December 20, 2021
Vet Center Inspection of Midwest District 3 Zone 3 and Selected Vet Centers	January 12, 2023
Deficiencies in Suicide Risk Assessments, Continuity of Care, and Leadership at the South Bend Vet Center in Indiana	January 19, 2023
Vet Center Inspection of Midwest District 3 Zone 1 and Selected Vet Centers	January 19, 2023
Vet Center Inspection of North Atlantic District 1 Zone 3 and Selected Vet Centers	May 25, 2023
Vet Center Inspection of North Atlantic District 1 Zone 4 and Selected Vet Centers	May 25, 2023
Inspection of Select Vet Centers in Southeast District 2 Zone 1	April 18, 2024
Inspection of Select Vet Centers in Southeast District 2 Zone 2	April 18, 2024
Inspection of Southeast District 2 Vet Center Operations	April 18, 2024
Inspection of Continental District 4 Vet Center Operations	August 27, 2024
Inspection of Select Vet Centers in Continental District 4 Zone 1	August 27, 2024
Inspection of Select Vet Centers in Continental District 4 Zone 2	August 27, 2024
Inspection of Select Vet Centers in Pacific District 5 Zone 1	September 30, 2024
Inspection of Select Vet Centers in Pacific District 5 Zone 2	September 30, 2024
Inspection of Select Vet Centers in Pacific District 5 Zone 3	September 30, 2024

Source: OIG analysis of prior OIG publications.

Appendix B: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: May 28, 2025

From: Acting Under Secretary for Health (10)

Subj: Healthcare Inspection—Deficiencies in Crisis Management of a Client, Crisis Reporting, and Documentation Practices Inadequate Crisis Management at the Everett Vet Center in Washington (VIEWS 13160786)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report. The Veterans Health Administration concurs with the recommendations made to the Chief Officer and District 5 Director of the Readjustment Counseling Service. The action plan to address the recommendations is attached.

2. Comments regarding the contents of this memorandum may be directed to the Readjustment Counseling Service.

(Original signed by:)

Steven L. Lieberman, M.D., MBA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on June 5, 2025.]

Appendix C: Chief Officer, Readjustment Counseling Service Memorandum

Department of Veterans Affairs Memorandum

Date: May 15, 2025

From: Chief Officer, Readjustment Counseling Service (10RCS)

Subj: Deficiencies in Crisis Management of a Client, Crisis Reporting, and Documentation Practices at the Everett Vet Center in Washington (VIEWS 13160786)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Deficiencies in Crisis Management of a Client, Crisis Reporting, and Documentation Practices at the Everett Vet Center in Washington. I have reviewed the recommendations and submitted action plans to address all findings in the report.

2. Should you require any additional information, please contact Readjustment Counseling Service.

(Original signed by:)

Michael Fisher

[OIG comment: The OIG received the above memorandum from VHA on June 5, 2025.]

Chief Officer, Readjustment Counseling Service Response

Recommendation 4

The Chief Officer, Readjustment Counseling Service provides written guidance to clarify crisis reporting criteria and monitoring responsibilities.

Enter text here

_X _Concur

____Nonconcur

Target date for completion: January 2026

Chief Officer Response

Readjustment Counseling Service established guidance on crisis reporting criteria for suicide ideation (with inability to maintain safety), suicide attempt, and suicide completion. The Chief Readjustment Counseling Officer will ensure that written guidance clarifying reporting criteria for all clinical crises and monitoring responsibilities is developed and distributed.

Recommendation 5

The Chief Officer, Readjustment Counseling Service establishes written policy that clarifies clinical record documentation requirements regarding entry dates; non-visit progress note completion time frames; and progress note deletion and addition, and monitors compliance.

Enter text here

_X _Concur

____Nonconcur

Target date for completion: January 2026

Chief Officer Response

In September 2024, the Chief Readjustment Counseling Officer directed Readjustment Counseling Service (RCS) staff to disable the delete function for encounters and progress notes in the electronic health record system, RCSNet, pending a review and remediation of all identified issues. In October 2024, RCS developed a process to track the deletion and retraction requests for encounters and notes. In December 2024, RCS collaborated with VHA partner offices to review and consult on the proposed modification process. The Chief Readjustment Counseling Officer will ensure that written guidance is developed to clarify counseling record

documentation requirements regarding entry dates, non-visit progress note completion time frames, and progress note deletion and addition.

Recommendation 6

The Chief Officer, Readjustment Counseling Service establishes written guidance regarding time requirements for the completion of risk assessment documentation in clients' clinical records.

Enter text here

_X _Concur

____Nonconcur

Target date for completion: January 2026

Chief Officer Response

Readjustment Counseling Service has established guidance on the time requirements for completing risk assessment documentation in client records on the first counseling visit. The Chief Readjustment Counseling Officer will ensure written guidance outlining the time requirements for completing risk assessments in client records on subsequent visits when there is any change in risk factors is developed and distributed.

Recommendation 8

The Chief Officer, Readjustment Counseling Service ensures that vet center directors are issued the correct position description and are performing duties within the identified scope of work.

Enter text here

_X _Concur

____Nonconcur

Target date for completion: November 2025

Chief Officer Response

In 2021 and 2023, Title 5 Vet Center Director position descriptions (PD) were updated as part of a larger organizational PD/Functional Statement (FS) standardization project to ensure appropriate scope of work and compliance with updated document formatting requirements respectively. Once completed, the updated Title 5 Vet Center Director PD was sent to each RCS District Director for issuance and associated training. It required an attestation that 100% of Title 5 Vet Center Directors received their updated, standardized PD and performance standards. The Chief Readjustment Counseling Officer will ensure that all Hybrid Title 38 and Title 5 Vet Center Directors have been issued the correct PD or FS. RCS will work with the Human

Resources Operations Office to conduct an evaluation to validate that Vet Center Directors are on the correct PD/FS and operating within the identified scope of work.

Appendix D: Readjustment Counseling Service District 5 Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 14, 2025

From: District 5 Director, Pacific Region (RCS5)

Subj: Healthcare Inspection—Deficiencies in Crisis Management of a Client, Crisis Reporting, and Documentation Practices at the Everett Vet Center in Washington at the Everett Vet Center in Washington (VIEWS 13160786)

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) report, Deficiencies in Crisis Management of a Client, Crisis Reporting, and Documentation Practices at the Everett Vet Center in Washington.

2. I have reviewed the report and concur with all recommendations. District 5 leadership has developed a response plan and has initiated steps to implement improvements throughout the District and the Everett Vet Center.

3. Should you require any additional information please contact Readjustment Counseling Service.1.

(*Original signed by:*)

Debra Moreno

[OIG comment: The OIG received the above memorandum from VHA on June 5, 2025.]

Readjustment Counseling Service District 5 Director Response

Recommendation 1

The District 5 Director conducts a full review of care provided to the client by the Everett Vet Center Director and counselor, consults with Human Resources and General Counsel Offices, and takes action as needed.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

The District 5 Director will ensure that a comprehensive review of the care provided to the client will be conducted. Based on the outcomes and recommendations of that review, District 5 leadership will seek consultation with Human Resources and the Office of General Counsel and take action as needed.

Recommendation 2

The District 5 Director ensures vet center leaders and staff are knowledgeable about applicable state laws pertaining to duty to warn.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

During both FY 2024 and FY 2025, District 5 leadership provided training to Vet Center Directors on duty to warn, mandatory reporting, limits of confidentiality, and applicable state laws. District 5 held in-person trainings in 2024 for Vet Center Directors on June 10-14, 2024 (Zone 2), June 24-28, 2024 (Zone 3), and July 15-19, 2024 (Zone 1). District 5 held a virtual Vet Center Director Summit on April 8-10, 2025. District 5 leadership will provide this training to all counseling staff on a recurring basis.

Recommendation 3

The District 5 Director makes certain that the Everett Vet Center Director and staff adhere to requirements for consultation with support facility external consultants and suicide prevention coordinators when indicated, and monitors compliance.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

During both FY 2024 and FY 2025, District 5 leadership provided training to Vet Center Directors, including the former Everett Vet Center Director, on consultation and documentation of consultation requirements within VHA Directive 1500(4). District 5 held in-person trainings in 2024 for Vet Center Directors on June 10-14, 2024 (Zone 2), June 24-28, 2024 (Zone 3), and July 15-19, 2024 (Zone 1). In 2025, District 5 held a virtual Vet Center Director Summit on April 8-10, 2025. District 5 leadership will provide this training to all counseling staff. District 5 leadership will conduct monitoring until there is sufficient evidence to demonstrate that staff adhere to requirements for consultation with support facility external consultants and suicide prevention coordinators.

Recommendation 7

The District 5 Director ensures readjustment counselors' compliance with updating and reviewing safety plans as required by Readjustment Counseling Service policy.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

During both FY 2024 and FY 2025, District 5 leadership provided training to Vet Center Directors on compliance with VHA Directive 1500(4) and the Safety Plan Protocol. District 5 leadership also developed a tracker to monitor compliance with the Directive and Protocol. District 5 held in-person trainings in 2024 for Vet Center Directors on June 10-14, 2024 (Zone 2), June 24-28, 2024 (Zone 3), and July 15-19, 2024 (Zone 1). In 2025, District 5 held a virtual Vet Center Director Summit on April 8-10, 2025. District 5 leadership will provide this training to all counseling staff.

Recommendation 9

The District 5 Director conducts a review of the care provided to complex clients by the Everett Vet Center Director since March 2021 and addresses identified clinical needs.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

District 5 Leadership will identify and review all records for complex clients treated by the former Everett Vet Center Director since March 2021 to address any remaining clinical needs or concerns.

Glossary

To go back, press "alt" and "left arrow" keys.

attention deficit hyperactivity disorder. A mental health disorder with persistent symptoms that may include inattention, hyperactivity, and impulsivity and can lead to problems such as relationship instability, issues at school or work, and decreased self-esteem.[1]

high risk for suicide patient record flag. An alert in a patient's EHR to "communicate to VA staff that a veteran is at high risk for suicide" that must be used "only for the duration of the increased risk for suicide."[2]

hydrocodone. An opioid medication used to relieve severe pain that when used for a long time may cause mental or physiological dependence.[3]

major depressive disorder. An episode of at least two weeks during which the person experiences depressed mood or loss of interest or pleasure in usual activities, and other symptoms such as changes in appetite, sleep disturbance, loss of energy, feelings of worthlessness or guilt, thoughts of death, and suicidal ideation.[4]

opioid. A type of narcotic drug occurring naturally or developed synthetically in a laboratory and prescribed by healthcare providers to manage pain.[5]

opioid use disorder. A mental health condition that involves a "problematic pattern of opioid misuse" that causes distress and impairs daily life.[6]

passive suicidal ideation. A "desire to die" without a specific plan or intent for self-harm.[7]

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[1] Mayo Clinic, "Adult attention-deficit/hyperactivity disorder (ADHD)," accessed November 14, 2024, https://www.mayoclinic.org/diseases-conditions/adult-adhd/symptoms-causes/syc-20350878.

[2] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008; VHA Directive 2010-053, Patient Record Flags, December 3, 2010; Deputy Under Secretary for Health for Operations and Management (10N), "Update to High Risk for Suicide Patient Record Flag Changes," memorandum, January 16, 2020; VHA Directive 1166, Patient Record Flags, November 6, 2023; The 2023 directive rescinds and replaces the 2010 directive. Unless otherwise specified, the 2023 directive contains the same or similar language regarding high-risk flags as the 2010 directive.

[3] Mayo Clinic, "Hydrocodone (oral route)," accessed November 18, 2024, https://www.mayoclinic.org/drugs-supplements/hydrocodone-oral-route/description/drg-20084881.

[4] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition – Text Revision* (DSM-5-TR), "Depressive Disorders," accessed February 27, 2025, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x04_Depressive_Disorders.

[5] Cleveland Clinic, "Opioids," accessed November 21, 2024, https://my.clevelandclinic.org/health/drugs/21127-opioids.

[6] Cleveland Clinic, "Opioid Use Disorder," accessed February 27, 2025, https://my.clevelandclinic.org/health/diseases/24257-opioid-use-disorder-oud.

[7] Christine N. May et al., "Passive suicidal ideation: A clinically relevant risk factor for suicide in treatment-seeking veterans," *Illness, Crisis, & Loss* 23, no. 3 (July 2015): 261–277, https://doi.org/10.1177/1054137315585422.

post-traumatic stress disorder. A mental health condition triggered by experiencing or witnessing a terrifying event and characterized by flashbacks, nightmares, severe anxiety, and uncontrollable thoughts of the event.[8]

substance use disorder. A mental health condition that involves a "problematic pattern of substance use" that impacts "health and well-being."[9]

[8] Mayo Clinic, "Post-traumatic stress disorder (PTSD)," accessed January 31, 2024, https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967.

[9] Cleveland Clinic, "Substance Use Disorder (SUD)," accessed November 18, 2024, https://my.clevelandclinic.org/health/diseases/16652-drug-addiction-substance-use-disorder-sud.

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