



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Insufficient Veterans Crisis  
Line Management of Two  
Callers with Homicidal  
Ideation, and an Inadequate  
Primary Care Assessment at  
the Montana VA Health  
Care System in Fort Harrison



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## Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate allegations regarding delayed and insufficient Veterans Crisis Line (VCL) responses to a caller (caller 1) with homicidal ideation and a caller (caller 2) with suicidal and homicidal ideation. The inspection also evaluated OIG-identified concerns regarding the adequacy of care provided to caller 1 at the Montana VA Health Care System (facility) in Fort Harrison prior to contact with the VCL, and the VCL's quality management practices.

Caller 1 was a veteran who was 100 percent service-connected for schizophrenia and in their 70s at the time of the VCL call.<sup>1</sup> In early summer 2019, caller 1 and a family member (family member 1) attended a non-VA primary care appointment. The non-VA provider documented that caller 1 did "not feel" in need of "any psychiatric care, and [caller 1] does sound very stable. Advised to discuss further with the VA clinic."

The next month, caller 1 attended a primary care appointment at one of the facility's community-based outpatient clinics. Another family member (family member 2) was present at the appointment and reported that caller 1 had schizophrenia, which was "very frustrating." The primary care provider documented a review of psychiatric symptoms that noted caller 1's mood was "overall good" with no suicidal or homicidal ideations and that family member 2 reported caller 1 "has paranoia." The primary care provider documented that caller 1 had "appropriate affect," was "pleasant, cooperative," and was "well-groomed."

In fall 2019, a VCL responder transferred caller 1 from a chat to a telephone responder (responder).<sup>2</sup> The responder documented difficulty following the conversation with caller 1 "due to incongruence" and "over all lack of coherent presentation." Caller 1 reported being upset with family member 1 for "taking [caller 1's] medication away" and was not sure if police should be involved. Caller 1 reported living in a basement apartment in family member 1's house. The responder documented that caller 1 acknowledged "sitting with a gun" for protection and that caller 1 denied suicidal or homicidal ideation. The responder noted that caller 1 "was unable to develop a [safety] plan." Caller 1 requested that the responder reach out to family member 2 "for

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<sup>1</sup> Schizophrenia is a serious mental disorder that affects an individual's thoughts, behaviors, and emotions; and in which people may interpret reality abnormally. National Institute of Mental Health, accessed April 13, 2020, <https://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml>. Mayo Clinic, *Schizophrenia – Symptoms and causes*, accessed August 4, 2020, <https://www.mayoclinic.org/diseases-conditions/schizophrenia/symptoms-causes/syc-20354443>. The OIG uses the singular form of they (their) in this instance for the purpose of patient privacy.

<sup>2</sup> VCL Position Description, *Health Science Specialist*, January 8, 2019. Responders are staff who interact with individuals who contact the VCL through chats, calls, and texts.

further understanding of what happened with [caller 1's] medication." Caller 1 reported being alone in the home "without intention of shooting [family member 1], or anyone else, unless it is self-defense."

The responder ended the call and consulted with a supervisor (supervisor 1) "to ensure the plan was appropriate and clarify third party [family member 2] contact." After a failed attempt to reach caller 1, the responder telephoned family member 2 who reported contacting the police after caller 1 had "just called to state [caller 1] shot" family member 1.

The OIG substantiated that the responder's management of caller 1's call was insufficient and delayed. The OIG found that the responder documented and reported inadequate information regarding caller 1 and failed to take actions to prevent family member 1's death. Specifically, the OIG found that the responder failed to assess caller 1's homicidal risk factors, address lethal means restriction, and complete an adequate risk mitigation plan, as required by the VCL.<sup>3</sup> The OIG found that the responder did not communicate critical call information when consulting with supervisor 1 that likely would have resulted in an immediate emergency response. The OIG found that the responder inappropriately discontinued the call and risk mitigation efforts with caller 1.

Additionally, the responder delayed timely intervention by taking a personal break after supervisory consultation and before re-contacting caller 1 and initiating contact with family member 2. The OIG determined that the responder also failed to comply with VCL's duty to protect guidelines that advise responders to initiate a welfare check and attempt contact with the intended victim when there is a clear, substantial, and imminent threat made to a third party.<sup>4</sup> The OIG also determined that VCL leaders did not consider an administrative investigation board to review the responder's potential misconduct in the management of caller 1's contacts, because there was uncertainty about the authority of VCL leaders to initiate the process.<sup>5</sup> The OIG concluded that an administrative investigation board should have been considered to review the responder's potential misconduct in the management of caller 1's contacts.

In a review of care provided to caller 1 prior to the VCL contacts, the OIG determined that the facility primary care provider failed to include caller 1's mental health diagnosis in the assessment and plan of care.<sup>6</sup> However, the OIG was unable to determine if an assessment and plan of care related to caller 1's mental health condition would have prevented caller 1's actions that caused family member 1's death approximately two months after the primary care

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<sup>3</sup> VCL-S-ACT-217-1907, *Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation Planning*, July 10, 2019.

<sup>4</sup> VCL, *Health Science Specialist Training Participant Guide*, June 2019.

<sup>5</sup> An Administrative Investigation Board is the VA standard procedure "for collecting and analyzing evidence, ascertaining facts, and documenting complete and accurate information regarding matters of interest to VA." VA Handbook 0700, *Administrative Investigations*, July 31, 2002.

<sup>6</sup> The primary care provider was located at one of the facility's community-based outpatient clinics.

appointment. The primary care provider told the OIG that schizophrenia was not added to caller 1's problem list because caller 1's mental health diagnosis was not upfront and concerning, and caller 1 and family member 2 did not ask for mental health treatment. Family member 2 told the OIG that the visit with the primary care provider was primarily related to caller 1's medical diagnoses including high blood pressure and did not think that there were any unmet needs from the appointment.

The facility's Chief of Staff and Associate Chief of Staff of Primary Care told the OIG that they expect a primary care provider to include a new patient's schizophrenia diagnosis in the assessment and plan as part of establishing care. They also stated an expectation that the primary care provider documents if the patient did not require or declined mental health services. Consistent with this perspective, the OIG would expect the primary care provider to document a comprehensive medical history including details about caller 1's schizophrenia diagnosis, current or prior treatment for schizophrenia, and current symptoms.

The OIG team also found that the primary care provider did not submit caller 1's non-VA medical records for scanning into the electronic health record or document a review of the non-VA medical records, as expected by Veterans Health Administration (VHA) policy.<sup>7</sup> The primary care provider told the OIG that caller 1's non-VA medical records included basic encounters and did not include anything that required scanning into the electronic health record. The primary care provider also reported not typically documenting a summary review of non-VA medical records at the time of caller 1's visit but began including that information after attending workshops on better documentation. Because access to non-VA records allows providers to plan care consistently, minimize duplication of services, and recognize the patient's treatment needs, failure to comply with this VHA requirement may compromise care coordination for current and future providers.

The OIG found that VCL leaders did not fully adhere to VHA policies related to reporting and disclosure of adverse events because of leaders' uncertainty about the applicability of these processes to VCL. The OIG concluded that VCL leaders would benefit from written guidance on applicable quality management processes and expectations. In February 2020, the Deputy Director, Quality and Training, told the OIG that VCL was unable to prioritize patient safety-related trainings or to expand the patient safety risk management program because of operational demands. However, once quality management program requirements are established, VCL leaders could more clearly identify priorities and resource needs.

In fall 2019, a second caller (caller 2), a non-veteran, called the VCL anonymously at 10:45 p.m. Caller 2 reported suicidal ideation and homicidal ideation toward a family member to a

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<sup>7</sup> VHA Handbook 1907.07, *Management of Health Records File Room and Scanning*, May 12, 2016. Following an initial OIG interview, the primary care provider reported uploading the non-VA medical records to caller 1's electronic health record.

responder (responder 1) and then disconnected the call. Caller 2 called the VCL again within 15 minutes. The OIG substantiated that two social service assistants (SSAs) failed to dispatch local emergency services following responder 1's rescue request, as instructed by the VCL.<sup>8</sup> No action was taken on an emergency dispatch after approximately six and a half hours until a Lead SSA initiated one.<sup>9</sup> Inadequate communication between responders may have contributed to a failure to identify caller 2's location for the SSA's emergency dispatch efforts. The OIG determined that it was likely that the responder (responder 2) who answered caller 2's second call was not aware of responder 1's initiation of emergency rescue for caller 2. Further, the OIG was unable to determine if responder 1 communicated about caller 2's emergency dispatch status through instant messaging to responders because there was no recorded documentation of instant messages. If responder 2 had known about the emergency rescue initiation for caller 2, responder 2 may have followed up on the status of the welfare check as required and then may have asked caller 2 for a location to support the emergency dispatch effort.

The Assistant Deputy Director, Business Operations, stated that supervisory SSA positions were first approved in July 2018; however, there were hiring delays caused by multiple factors including union approval and posting more senior positions for hire prior to filling the supervisory positions. Given a VCL leader's report that five of seven supervisory SSA positions were hired as of April 2020 and VCL leaders continued recruiting efforts, the OIG did not make a recommendation regarding these positions.

The OIG also identified deficiencies in SSA oversight, including a failure to complete a thorough review of caller 2's rescue management by the team operations coordinator and supervisors.<sup>10</sup> In an email to a VCL leader, the team operations coordinator reported considering the review resolved based on a supervisor's discussion with one of the SSAs involved. The VCL team operations coordinator and supervisors' incomplete review of caller 2's rescue management may have resulted in supervisors' failure to identify performance and system deficiencies and actions to reduce the likelihood of similar unsuccessful rescue management.

The OIG made two recommendations to the Executive Director, Office of Mental Health and Suicide Prevention, related to the establishment of quality management processes and disclosure processes applicable to the VCL.

The OIG made seven recommendations to the VCL Director related to a review of the callers' contacts and consultation with Human Resources and General Counsel offices, leaders' understanding of administrative investigation board procedures, VCL leaders' expectations and

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<sup>8</sup> SSAs are responsible to facilitate emergency dispatch services to conduct a welfare check or develop a plan for the caller to go to a facility for immediate care. VCL, *Social Service Assistant Training Participant Guide*, July 2019.

<sup>9</sup> Lead SSAs serve in nonsupervisory roles to provide SSA consultation; collaborate with responders, VHA staff, and law enforcement; and facilitate emergency services, as needed. VCL Position Description, *Lead Social Services Assistant*, March 29, 2017.

<sup>10</sup> VCL team operations coordinators supervise supervisors.

benchmarks regarding silent monitored calls, root cause analyses, processes to promote responders' communication, and strengthening of supervisory oversight of SSAs.

The OIG made two recommendations to the Facility Director related to primary care providers' completion of assessment and care plans for patients with mental health conditions and compliance with VHA policy regarding documentation of patients' non-VA health records.

## Comments

The Under Secretary for Health concurred with recommendations 1, 2, 5, 6, and 8–11, concurred in principle with recommendation 7, and provided an acceptable action plan (see appendix A). Veterans Integrated Service Network 19 and Facility Directors concurred with recommendations 3–4 and provided an acceptable action plan (see appendixes B and C). The OIG will follow up on the planned actions until they are completed.



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## Abbreviations

CAPRI	Compensation and Pension Record Interchange
CARF	Commission on Accreditation of Rehabilitation Facilities
EHR	electronic health record
OIG	Office of Inspector General
SSA	social service assistant
VCL	Veterans Crisis Line
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review allegations regarding delayed and insufficient Veterans Crisis Line (VCL) responses to a caller (caller 1) with homicidal ideation and a caller (caller 2) with suicidal and homicidal ideation. The inspection also evaluated OIG-identified concerns regarding the adequacy of care provided to caller 1 at the Montana VA Health Care System (facility) in Fort Harrison prior to contact with the VCL, and the VCL's quality management practices.

## Background

In 2007, the Veterans Health Administration (VHA) established the National Veterans Suicide Prevention Hotline, now known as VCL, in response to the Joshua Omvig Veterans Suicide Prevention Act, Public Law 110-110.<sup>1</sup> The act mandated that VHA provide mental health services 24 hours per day, seven days per week, and a toll-free hotline for veterans.<sup>2</sup> Since established, VCL reports that staff have answered more than five million calls, engaged in more than 606,000 chats, and responded to more than 193,000 texts.<sup>3</sup> VCL staff refers individuals to local VHA mental health services, as appropriate.<sup>4</sup> VCL centers are located in three sites: Canandaigua, New York; Atlanta, Georgia; and Topeka, Kansas.<sup>5</sup> VCL, aligned under the Office of Mental Health and Suicide Prevention, is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).<sup>6</sup>

The facility is part of Veterans Integrated Service Network (VISN) 19 and provided services to over 38,000 patients for each of the last two years. The facility includes a 34-bed acute care unit

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<sup>1</sup> VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 31, 2017. The directive was rescinded and replaced by VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. The two policies contain the same or similar language related to the purpose and background of VCL.

<sup>2</sup> VHA Directive 1503.

<sup>3</sup> A chat is a discussion held over the Internet by sending messages back and forth, usually in a chat room. Merriam-Webster Dictionary, accessed February 21, 2020, <https://www.merriam-webster.com/dictionary/chat>. A text is a message sent electronically usually to or from a mobile cellular phone. Merriam-Webster Dictionary, accessed February 21, 2020, <https://www.merriam-webster.com/dictionary/text%20message>. VCL network website, accessed February 25, 2021, <https://www.veteranscrisisline.net/about/what-is-vcl>. VCL, *Health Science Specialist Training Participant Guide*, June 2019. A VCL responder is an employee who communicates and interacts with callers. Responders are also referred to as health science specialists by VCL. Veterans and Military Crisis Line, *VCL Orientation & Employee Handbook*, April 2018.

<sup>4</sup> VHA Directive 1503. The 2017 and 2020 directives contain the same or similar language related to the purpose and background of VCL.

<sup>5</sup> VCL, *Atlanta VCL Orientation & Employee Handbook*, October 2018.

<sup>6</sup> VHA Directive 1503. CARF is an independent, nonprofit accrediting body of health and human services that includes behavioral health. CARF International, *Who We Are*, accessed May 19, 2020, <http://www.carf.org/About/WhoWeAre/>, 2020.

and a 24-bed inpatient mental health unit located in the Fort Harrison Medical Center, a 30-bed community living center in Miles City, and 16 community-based outpatient clinics. The facility provides a range of inpatient and outpatient medical, surgical, and behavioral health services.

## Health Science Specialists

VCL health science specialists (responders) are staff who interact with individuals who contact VCL through calls, chats, and texts. Responders are expected to engage callers through active listening, motivational interviewing, problem-solving, and safety planning.<sup>7</sup> Responders receive training to identify a caller's level of risk for harm, and initiate dispatch of emergency services as indicated by the caller's risk of imminent harm.<sup>8</sup>

Responders should identify the caller's "situation properly and performs the tasks required to resolve the caller's questions/issues accurately and in a timely manner."<sup>9</sup> Responders are required to identify and address a caller's needs using available resources including supervisory consultation. Chat responders manage VCL's chat service and are required to transfer a chat to telephone management when the individual (1) is at imminent risk of harm and unable to establish a safety plan risk, (2) has technology challenges, or (3) would benefit from verbal communication.<sup>10</sup>

Supervisory health science specialists (supervisors) oversee "100 personnel when fully staffed" and responsibilities include providing "24/7 coverage," evaluating staff work performance, giving advice or instruction, and identifying staff training needs.<sup>11</sup> Supervisors told the OIG team that they oversee the work of responders and social service assistants (SSAs).

In addition to providing "clinical guidance and feedback to all employees on the shift," supervisors are responsible for assigned specific responders as direct supervisees.<sup>12</sup> The Deputy Director, Quality and Training, reported that responders and supervisors possess a bachelor's degree in a mental health-related field at a minimum and are not required to hold a professional license. VCL team operations coordinators supervise supervisors.

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<sup>7</sup> Active listening is a way of listening that involves full attention to what is said to obtain an accurate, thorough, and unbiased understanding of the speaker's communication. VCL, *Health Science Specialist Training Participant Guide*, June 2019. "Motivational interviewing (MI) is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."

<sup>8</sup> VHA Directive 1503.

<sup>9</sup> VCL Performance Appraisal, *Health Science Specialist*, October 1, 2019, through September 30, 2020.

<sup>10</sup> Veterans and Military Crisis Line, *New Media Orientation and Employee Handbook*, June 2017.

<sup>11</sup> VCL Position Description, *Supervisory Health Science Specialist*, March 21, 2016.

<sup>12</sup> Veterans and Military Crisis Line, *VCL Orientation & Employee Handbook*, April 2018.

## Social Services Assistants

SSAs are responsible to facilitate emergency dispatch services to conduct a welfare check or facility transport plan.<sup>13</sup> SSAs serve as the VCL point of contact for emergency dispatchers after rescue efforts have been initiated. In situations with an anonymous caller, VCL instructs SSAs to review VCL's internal electronic records for previous calls from the phone number and to conduct an internet search using available information. If these efforts do not produce identifying information, an SSA is expected to use the caller's area code to determine the closest dispatch center and enact a welfare check without delay.<sup>14</sup>

VCL does not have an education requirement for employment as an SSA.<sup>15</sup> Lead SSAs serve in nonsupervisory roles to provide SSA consultation; collaborate with responders, VHA staff, and law enforcement; and facilitate emergency services, as needed.<sup>16</sup> Supervisory SSAs are required to monitor SSA cases and ensure proper communication to relevant incoming staff and supervisors regarding rescue management.<sup>17</sup>

## Prior OIG Reports

In the 2017 report, *Healthcare Inspection—Evaluation of the Veterans Health Administration Veterans Crisis Line*, the OIG identified deficiencies similar to concerns reviewed in this inspection. These deficiencies were related to governance structure and oversight, procedural and clinical issues, and quality management. The OIG made 16 recommendations, all of which were closed as of March 28, 2018.<sup>18</sup>

In the 2020 report, *Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died*, the OIG reviewed VCL staff's management of a caller who died the same day as contacting the VCL. The OIG made eight recommendations. Two of the recommendations were relevant to the current inspection and were related to criteria for supervisor follow-up including

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<sup>13</sup> "A welfare check is a physical check on an individual's welfare by emergency services, prompted by a concerned person." "A Facility Transport Plan (FTP) is a collaboratively developed plan by a Responder and the Caller for the caller to present at a facility for immediate care." VCL, *Health Science Specialist Training Participant Guide*, June 2019.

<sup>14</sup> VCL, *Social Service Assistant Training Participant Guide*, July 2019.

<sup>15</sup> VCL Position Description, *Social Services Assistant*, December 4, 2018.

<sup>16</sup> VCL Position Description, *Lead Social Services Assistant*, March 29, 2017.

<sup>17</sup> VCL Position Description, *Supervisory Social Services Assistant*, undated. The VCL Assistant Deputy for Business Operations provided this document to the OIG on December 13, 2019. The Supervisory SSA positions were vacant at the time of the OIG inspection, as discussed later in the report.

<sup>18</sup> VA OIG, *Healthcare Inspection—Evaluation of the Veterans Health Administration Veterans Crisis Line*, Report No. 16-03985-181, March 20, 2017.

silent monitoring criteria, and the development of systems to identify caller contacts that warrant root cause analysis or other internal reviews and track the review process.<sup>19</sup>

## Allegations and Concerns

On October 16, 2019, the OIG received allegations about VCL staff's delayed responses to two callers and subsequently identified related concerns:

1. A responder's insufficient and delayed management of caller 1's homicidal ideation.
  - In addition to the allegation related to the VCL responder's management of caller 1's call, the OIG was concerned about a lack of
    - A primary care provider's follow-up on caller 1's mental health treatment needs, and
    - VHA guidance regarding VCL quality management oversight requirements.
2. SSAs' insufficient and delayed actions for caller 2's suicidal and homicidal ideation.

## Scope and Methodology

The OIG initiated the healthcare inspection on November 19, 2019, and conducted site visits on December 16–18, 2019, and January 29, 2020, at the VCL located in Atlanta, Georgia.

The OIG team reviewed applicable VHA directives, VCL policies and procedures regarding operations of VCL, caller 1's electronic health record (EHR), VCL staff's position descriptions and guides, Medora documentation, an issue brief, and audio recordings of subject callers' VCL telephonic contacts.<sup>20</sup> Other documents reviewed included American Association of Suicidology guidelines and CARF standards.

The OIG team interviewed the complainant, a family member of caller 1, five subject matter experts; and VCL staff members including the Acting Director of the VCL; Director, Suicide Prevention Program, Office of Mental Health and Suicide Prevention; Deputy Director, Quality and Training; Assistant Deputy Director of Quality and Training; Patient Safety, Risk Manager;

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<sup>19</sup> VA OIG, *Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died*, Report No. 19-08542-11, November 17, 2020. The root cause analysis process is a formal protected review with a multidisciplinary team approach that is used to identify systematic and procedural factors that contribute to adverse events. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. Adverse events are defined by VHA as "untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical facility, outpatient clinic, or other VHA facility."

<sup>20</sup> Medora is the computer-based application used by responders to document VCL contacts. Due to legal circumstances, the OIG was unable to obtain the medical examiner's autopsy report for caller 1's family member.

and VCL staff who interacted with callers 1 and 2.<sup>21</sup> The OIG team also interviewed facility leaders including the Chief of Staff; Associate Chief of Staff, Primary Care; and the primary care provider involved in caller 1's care.

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, Pub. L. No. 95-452, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leadership 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.

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<sup>21</sup> The Director of the Suicide Prevention Program served in an Acting Director role from July 2019 until appointment as Director on March 24, 2020. The Director also served as the Director of the VCL from July 2017 through July 2019. The five subject matter experts served on national crisis call center committees. Two subject matter experts had primary academic affiliations, and the three other subject matter experts served as crisis line organization leaders. Two of the three subject matter experts were from the same crisis line organization and participated in the OIG interview together.

## Case Summaries<sup>22</sup>

### Caller 1

Caller 1 was a veteran who was 100 percent service-connected for schizophrenia and in their 70s at the time of the VCL call.<sup>23</sup> On June 14, 2019, caller 1 and a family member (family member 1) attended a non-VA primary care appointment. The non-VA primary care provider documented that caller 1 did “not feel” in need of “any psychiatric care, and [caller 1] does sound very stable. Advised to discuss further with the VA clinic.”

In late summer 2019, caller 1 attended a primary care visit to establish care at a facility community-based outpatient clinic. A family member (family member 2) was present at the appointment and reported that caller 1 had schizophrenia which was “very frustrating.” The primary care provider documented a review of psychiatric symptoms that noted caller 1’s mood was “overall good” with no suicidal or homicidal ideations and that family member 2 reported caller 1 “has paranoia.” On physical exam, the primary care provider documented that caller 1 had “appropriate affect,” was “pleasant, cooperative,” and was “well-groomed.” The primary care provider’s treatment plan included high blood pressure management, a hearing exam, and colonoscopy scheduling.

Approximately two months later, caller 1 contacted the VCL chat service and communicated with a chat responder. The chat responder documented that caller 1 “made mention of wanting to shoot” family member 1 for taking caller 1’s medications. The chat responder also documented that caller 1 denied homicidal ideations, “was difficult to engage, and accepted a VCL phone transfer” to provide “more cohesive support.” At 5:32 p.m., a telephone responder (responder) initiated a call with caller 1. The responder documented difficulty following the conversation with caller 1 “due to incongruence” and “over all lack of coherent presentation.” Caller 1 reported being upset with family member 1 for “taking [caller 1’s] medication away” and was not sure if police should be involved. Caller 1 reported living in a basement apartment in family member 1’s house. The responder documented that caller 1 acknowledged “sitting with a gun” for protection and that caller 1 denied suicidal or homicidal ideation. The responder noted that caller 1 “was unable to develop a [safety] plan” and suggested caller 1 watch television, and caller 1 declined. Caller 1 requested that the responder reach out to family member 2 “for further

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<sup>22</sup> The summaries are based on relevant documentation from CAPRI, Medora, and the VCL crisis intervention tracker.

<sup>23</sup> Schizophrenia is a serious mental disorder that affects an individual’s thoughts, behaviors, and emotions; and in which people may interpret reality abnormally. National Institute of Mental Health, accessed April 13, 2020, <https://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml>. Mayo Clinic, *Schizophrenia – Symptoms and causes*, accessed August 4, 2020, <https://www.mayoclinic.org/diseases-conditions/schizophrenia/symptoms-causes/syc-20354443>. The OIG uses the singular form of they (their) in this instance for the purpose of patient privacy.

understanding of what happened with [caller 1's] medication." The responder agreed. Caller 1 reported being alone in the home "without intention of shooting [family member 1], or anyone else, unless it is self-defense."

The responder ended the call and consulted with a supervisor (supervisor 1) "to ensure the plan was appropriate and clarify third party [family member 2] contact." After a failed attempt to reach caller 1, the responder telephoned family member 2 who reported that caller 1 had "just called to state [caller 1] shot" family member 1. Additionally, family member 2 reported contacting the police. The responder then called caller 1 who reported "[family member 1] came in to talk about the medicine and I [*sic*] wanted to take my gun away." The responder remained on the call until police escorted caller 1 away. The next day, the facility's Suicide Prevention Coordinator documented that caller 1 "shot and killed" family member 1 and was incarcerated.

## **Caller 2**

Caller 2, a non-veteran, called VCL anonymously in fall 2019, at 10:45 p.m. Caller 2 reported suicidal ideation and homicidal ideation toward a family member to a responder (responder 1) and then disconnected the call. At 10:57 p.m., caller 2 called VCL again, spoke with another responder (responder 2), provided a first name only, and completed a safety plan. Responder 2 documented that the call ended normally. At approximately 11:00 p.m., responder 1 requested that an SSA initiate a rescue after caller 2 did not respond to telephone outreach efforts. Within 10 minutes, an SSA (SSA 1) accepted the request. The rescue continued until the following day at 9:46 a.m., subsequently involving another SSA (SSA 2) and a Lead SSA. After accepting the rescue, SSA 1 documented searching for caller 2's location through internet searches and that a supervisor used the approved non-VA database but neither produced caller 2's location. The rescue remained active, and the Lead SSA contacted police the day after the initial call, at 5:44 a.m. The Lead SSA requested that a responder (responder 3) call caller 2. Responder 3's outreach efforts were unsuccessful, and a supervisor discontinued the emergency dispatch.

## Inspection Results

### 1. Insufficient and Delayed Response to Caller 1

The OIG substantiated that the responder's management of caller 1's call was insufficient and delayed. The OIG found that the responder documented and reported inadequate information regarding caller 1 and failed to take actions to prevent family member 1's death. Specifically, the OIG found that the responder failed to assess caller 1's homicidal risk factors, address lethal means restriction, and complete an adequate risk mitigation plan, as required by VCL standard operating procedure.<sup>24</sup> The OIG found that the responder did not communicate critical call information when consulting with supervisor 1 that likely would have resulted in an immediate emergency response. Additionally, the responder delayed timely intervention by taking a personal break after supervisory consultation and before re-contacting caller 1. The OIG determined that the responder also failed to comply with VCL's duty to protect guidelines. The OIG determined that VCL leaders did not consider an administrative investigation board to review the responder's potential misconduct in the management of caller 1's contacts. Further, VCL leaders expressed uncertainty about their authority to initiate administrative investigation board process that may have contributed to inadequate and delayed management of administrative actions.

#### Risk Assessment

VHA policy and VCL guidelines require that responders make every effort to conduct a thorough risk assessment on every caller including identifying risk factors, such as the caller's current suicidal, assaultive, or homicidal ideation or plans including whether there is an identified target, details of the extent of the plan, timeline, and whether the caller has the ability to carry out the plan.<sup>25</sup> Responders are expected to use active listening to adequately evaluate the caller's crisis situation and risk.<sup>26</sup>

CARF requires responders to demonstrate knowledge and skills in the identification of risk indicators and assessment, active engagement with callers, and decide the appropriate action to

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<sup>24</sup> VCL-S-ACT-217-1907, *Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation Planning*, July 10, 2019.

<sup>25</sup> VCL, *Health Science Specialist Training Participant Guide*, June 2019. VCL-S-ACT-220-1908, *Standard Operating Procedure for Positive Violent Behavior Risk Screening*, August 1, 2019. VCL defines risk factors as "sex, ethnicity, age, criminality, combat exposure, presence/absence of mental illness/substance disorders, history of violent behavior (outside of military behavior); ... relationship status, job, situational events, current substance use;... and hopelessness, helplessness, or feeling trapped." VCL defines protective factors as "immediate support, social supports, future orientation, engagement with helper, core values/beliefs, ambivalence, sense of purpose, stable employment, stable housing, healthy sleeping pattern, minimal physical pain." VHA Directive 1503.

<sup>26</sup> VCL, *Health Science Specialist Training Participant Guide*, June 2019.

stabilize a crisis as soon as possible.<sup>27</sup> The American Association of Suicidology requires that crisis center workers conduct assessments for callers who may be at risk of self-harm and identify active engagement as a main component of crisis management including active listening and collaboration with callers.<sup>28</sup>

The OIG determined that the chat responder appropriately transferred caller 1 to telephone management in accordance with VCL guidelines.<sup>29</sup> The chat responder documented the “chatter was difficult to engage,” and “accepted a VCL phone transfer” to provide caller 1 with more support. When interviewed by the OIG team, the chat responder described difficulty assessing caller 1 and was concerned that caller 1 was having delusions and therefore initiated a transfer to telephone management.<sup>30</sup> Caller 1 “accepted a VCL phone transfer,” and the chat responder provided a “Warm Transfer to Hotline.”

The OIG substantiated that the responder’s management of caller 1’s call was insufficient and delayed. The OIG found that the responder documented and reported inadequate information regarding caller 1 and failed to take actions to prevent family member 1’s death. After family member 2’s report to the responder that caller 1 shot family member 1, VCL supervisors initiated a review of VCL staff’s contacts with caller 1. A shift supervisor who listened to the audio recordings of the responder’s contacts with caller 1 identified several concerns related to the responder’s performance including that the responder misidentified family member 1 as another relative “on several occasions” during the first call with caller 1. The responder’s direct supervisor (supervisor 2) found that the responder repeatedly misidentified family member 1 as another relative during the consultation with the shift supervisor. A shift supervisor also found that during the call, caller 1 “has a pistol” and “will shoot anyone that comes into [caller 1’s] apartment” and that the responder did not adequately engage in “risk mitigation over [caller’s] pistol done during the call,” or conduct a safety plan with caller 1. Consistent with the shift supervisor’s findings, the OIG found that the responder did not ask questions to understand if caller 1 was having homicidal ideation, as expected by VHA, VCL, CARF, and the American

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<sup>27</sup> CARF, *Behavioral Health Standards Manual 2018*, July 1, 2018–June 30, 2019. CARF refers to risk assessments as lethality assessments. Merriam-Webster Dictionary, *Lethal*, accessed April 15, 2020, <https://www.merriam-webster.com/dictionary/lethal#medicalDictionary>. Lethality is defined as related to or causing death.

<sup>28</sup> American Association of Suicidology, *Organization Accreditation Standards Manual Thirteenth Edition*, January 2012. The American Association of Suicidology is a nonprofit accrediting organization that applies nationally recognized standards to crisis intervention programs. The American Association of Suicidology refers to risk assessments as lethality assessments.

<sup>29</sup> VCL, *New Media Orientation and Employee Handbook*, June 2017.

<sup>30</sup> Delusions are “false beliefs that are not based in reality” and “occur in most people with schizophrenia.” Mayo Clinic, *Schizophrenia – Symptoms and causes*, accessed August 4, 2020, <https://www.mayoclinic.org/diseases-conditions/schizophrenia/symptoms-causes/syc-20354443>.

Association of Suicidology risk assessment requirements and guidelines.<sup>31</sup> The OIG also found that caller 1 informed the responder that family member 1 lived in the same residence, but the responder did not document this information.

The OIG concluded that the responder's failure to fully engage in active listening contributed to the responder's inability to gather pertinent information from caller 1 to adequately assess risk. The OIG further concluded that completion of a thorough assessment, including caller 1's risk severity and plan to harm self or others may have revealed additional information regarding caller 1's risk and protective factors that may have warranted further action with caller 1 and changed the course of events.

### **Safety Plan and Lethal Means Restriction**

VCL instructs responders to develop a safety plan when a caller endorses suicidal or homicidal ideation.<sup>32</sup> VCL requires the three-item safety plan to include lethal "means reduction, coping skills/avoiding triggers, and future plans" that the caller can take to decrease suicidal or homicidal risk.<sup>33</sup> Lethal means reduction (restriction) involves a responder's collaboration with a caller to diminish the caller's access to means that could be used to carry out self-directed or violent behaviors, such as firearms.<sup>34</sup> Examples of lethal means restriction include disabling a firearm or asking a third party to take possession of the lethal means.<sup>35</sup> If the responder's assessment indicates a potential for imminent risk, a welfare check or an emergency dispatch is initiated.<sup>36</sup>

The OIG consulted with five subject matter experts who noted that responders should address lethal means restriction with a caller with suicidal or homicidal ideation who has accessible lethal means. One of the subject matter experts provided written guidance from a crisis line organization regarding collaborative safety planning to disable a caller's plan for harm of self or others, including third-party involvement whenever possible, such as a three-way call with a family member or friend. When presented with a scenario similar to caller 1, all five subject matter experts recommended that a responder should immediately dispatch emergency services if

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<sup>31</sup> VHA Directive 1503. VCL, *Health Science Specialist Training Participant Guide*, June 2019. VCL-S-ACT-220-1908, *Standard Operating Procedure for Positive Violent Behavior Risk Screening*, August 1, 2019. CARF, *Behavioral Health Standards Manual 2018*, July 1, 2018–June 30, 2019. American Association of Suicidology, *Organization Accreditation Standards Manual Thirteenth Edition*, January 2012.

<sup>32</sup> VCL, *Health Science Specialist Training Participant Guide*, June 2019. VCL also refers to safety planning as a risk mitigation plan; for the purposes of this report, the OIG used safety plan. VCL-S-ACT-217-1907, *Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation Planning*, July 10, 2019.

<sup>33</sup> VCL, *Health Science Specialist Training Participant Guide*, June 2019. VCL-P-ACT-229-1906, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, July 8, 2019.

<sup>34</sup> VCL, *Health Science Specialist Training Participant Guide*, June 2019.

<sup>35</sup> VCL, *Health Science Specialist Training Participant Guide*, June 2019.

<sup>36</sup> VCL-S-ACT-214-1910, *Standard Operating Procedure for Emergency Dispatch*, October 2, 2019.

a caller has access to lethal means, has an identified target, and the target is in the same location as the caller.

The responder documented that caller 1 was unable to independently develop a safety plan and declined the responder's suggestion to watch television. When the responder asked caller 1, "what can you do to make sure that you are going to be able to keep your [family member 1] and everybody else safe today? Can you, are you going to sit here?" Caller 1 responded, "I'm not going to do anything, except sit here." The responder did not discuss lethal means restriction after learning that caller 1 possessed a firearm. During the second call, caller 1 informed the responder of having shot family member 1. Despite this information, the responder failed to assess caller 1's continued access to lethal means to mitigate further risk of harm to self or others. While on the call, police arrived and caller 1 disclosed access to "two pistols over there."

The OIG concluded that the responder failed to complete an adequate safety plan and address lethal means restriction with caller 1. The OIG would have expected the responder to further pursue safety planning efforts given that the caller was unable to independently develop a safety plan and declined the responder's only suggestion. Further, the OIG would have expected the responder to examine options for lethal means restriction to reduce risk of harm to self and others given that caller 1 reported firearm possession and homicidal ideation during the first call, and harm to family member 1 by firearm during the second call.

## **Duty to Protect**

VCL's duty to protect guidelines advise responders to initiate a welfare check and attempt contact with the intended victim when there is a clear, substantial, and imminent threat made to a third party.<sup>37</sup> When interviewed by the OIG, the responder confirmed awareness of the guidelines and reported not having family member 1's location or contact information to conduct duty to protect. However, the OIG team found that caller 1 informed the responder of family member 1's location during the first call. After family member 2 informed the responder about contacting emergency services, the responder initiated an emergency services request and the police department confirmed emergency services had already been dispatched. Consistent with subject matter experts, the OIG would have expected the initiation of emergency services based on the responder's inability to complete a safety plan, caller 1's access to lethal means, and the presence of an identified target in the same location as caller 1.

## **Supervisory Consultation**

Responders are required to identify and address a caller's needs in an appropriate manner using available resources, such as supervisory consultation.<sup>38</sup> Responders are instructed to consult with

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<sup>37</sup> VCL, *Health Science Specialist Training Participant Guide*, June 2019.

<sup>38</sup> VCL Performance Appraisal, *Health Science Specialist*, from October 1, 2019, through September 30, 2020.

a supervisor regarding potential outreach to a specified person who may be at imminent risk of harm by a caller, such that “harm is likely before Emergency services may arrive.”<sup>39</sup> VCL supervisors are expected to provide direct guidance and advice to responders regarding suicide, mental illness, and crisis intervention.<sup>40</sup>

The responder discontinued the first telephone call with caller 1, documented a plan to call family member 2, and then consulted a supervisor (supervisor 1) regarding the appropriateness of contact with family member 2. The responder told supervisor 1 that caller 1 was “possibly delusional” and that caller 1 reported concerns related to family member 1 taking caller 1’s medications. Additionally, the responder told supervisor 1 that during the chat, caller 1 stated “[caller 1] was going to shoot the [family member 1].” When supervisor 1 asked if caller 1 was suicidal, the responder replied “No, [caller 1’s] not suicidal, I asked if [caller 1] was safe and [caller 1] said I got a gun right here and I’ll shoot anyone that comes in my house.” The OIG found that supervisor 1 did not inquire further about caller 1’s statement that reflected homicidal ideation or about lethal means restriction efforts. Additionally, although caller 1 reported to the responder “I rent an apartment below [family member 1],” the responder told supervisor 1 “[caller 1] doesn’t know where [family member 1] is, they don’t live in the same house.” Supervisor 1 instructed the responder to contact caller 1 to request a third-party conference call with family member 2 and to assist with a welfare check if necessary.<sup>41</sup>

When interviewed by the OIG, supervisor 1 told the OIG that supervisors rely on responders’ call summaries and reported being unaware that caller 1 had potential homicidal ideation during the supervisory consultation. Further, supervisor 1 told the OIG that the responder focused on caller 1 being “delusional.” Supervisor 1 told the OIG that, after the responder consulted with the supervisor, the responder attempted to telephone caller 1 but was unsuccessful and then took a personal break, as discussed below. Supervisor 1 told the OIG that, after the responder returned from the break, the responder then contacted caller 1’s family member 2. Supervisor 1 told the OIG that if the responder had communicated caller 1’s homicidal risk, supervisor 1 may have instructed the responder to remain on the call or have another responder contact caller 1.

The OIG found that the responder did not communicate critical information to supervisor 1, such as caller 1 resided in the basement apartment of family member 1’s house and that family member 1 came into caller 1’s basement apartment earlier that day. Additionally, the OIG would have expected supervisor 1 to ask the responder questions related to homicidal risk and lethal means access restriction when informed of caller 1’s statements via chat and telephone about thoughts of shooting family member 1 and having a gun. The communication of accurate, critical

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<sup>39</sup> VCL-S-ACT-220-1908, *Standard Operating Procedures for Positive Violent Behavior Risk Screening*, August 1, 2019.

<sup>40</sup> VCL Position Description, *Supervisory Health Science Specialist*, March 21, 2016.

<sup>41</sup> A conference call is a telephone call that allows a caller to simultaneously converse with several callers. Merriam-Webster Dictionary, accessed April 15, 2020, <https://www.merriam-webster.com/dictionary/conference%20call>.

information related to caller 1's homicidal risk, and supervisory determination of lethality risk may have resulted in an immediate emergency response, potentially preventing family member 1's death.

## **Delayed Responder's Response**

The OIG found that the responder inappropriately discontinued the call and risk mitigation efforts with caller 1. Additionally, the responder took a personal break for approximately six minutes following consultation with supervisor 1 and before initiating contact with family member 2.

### *Call Disconnection and Delay*

The American Association of Suicidology standards indicate that crisis responders should conduct active rescue without disengaging from a caller.<sup>42</sup> When the OIG team asked about a responder remaining on a call while dispatching emergency services or consulting with a supervisor, all five subject matter experts described the priority for a responder to maintain telephone connection with a caller.

VCL allows employees one 30-minute lunch and two 15-minute breaks during a daily work shift.<sup>43</sup> VCL allows infrequent, unscheduled personal breaks for urgent instances when the responder is unable to wait for a scheduled break. A team operations coordinator (team operations coordinator 1) told the OIG that a responder should wait until after a call and documentation completion before taking a break. Further, when interviewed by the OIG, supervisor 1 reported expecting a responder to request another responder to assist with call management when needing a break during an active call. VCL employees are permitted intermittent personal internet use at lunch and on breaks if it does not interfere with the employee's or others' work duties. VCL requires responders to maintain access to EHR systems including Compensation and Pension Record Interchange (CAPRI) and CRISTAL.<sup>44</sup> CRISTAL serves as VCL's "primary medical record resource for verifying Veteran information and to assist with the risk assessment process."<sup>45</sup>

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<sup>42</sup> American Association of Suicidology, *Organization Accreditation Standards Manual Thirteenth Edition*, January 2012.

<sup>43</sup> VCL, *Atlanta VCL Orientation & Employee Handbook*, October 2018.

<sup>44</sup> CAPRI is a system used to access patients' EHRs. CAPRI, *System Administration and Technical Guide*, November 2019, accessed September 10, 2020, [https://www.va.gov/vdl/documents/Financial\\_Admin/CAPRI/DVBA\\_27\\_215\\_sys\\_adm.pdf](https://www.va.gov/vdl/documents/Financial_Admin/CAPRI/DVBA_27_215_sys_adm.pdf). CRISTAL was developed for VCL in September 2017. VCL, *Health Science Specialist Training Participant Guide*, June 2019. VCL Position Description, *Health Science Specialist*, January 8, 2019.

<sup>45</sup> VCL, *Health Science Specialist Training Participant Guide*, June 2019.

The OIG found that the responder did not maintain the call connection, despite caller 1's situation warranting further risk mitigation. The Deputy Director, Quality and Training, told the OIG that the responder should have maintained call connection until caller 1's homicidal risk was fully assessed and safety planning occurred. The OIG would have expected further risk mitigation since caller 1 reported homicidal ideation toward family member 1, firearm possession, and residing in the same location as family member 1. The responder did not immediately contact caller 1 back following the consultation with supervisor 1. From approximately 5:58 p.m. to 6:04 p.m., the responder's work activity log noted a 6-minute personal break.<sup>46</sup> The responder told the OIG about taking a personal break to go to the restroom. However, the Deputy Director, Quality and Training, informed the OIG that during the personal break, the responder accessed a YouTube video.<sup>47</sup>

The OIG also found that the responder failed to maintain CAPRI access, as required by VCL.<sup>48</sup> The responder told the OIG about asking another responder to access caller 1's EHR. In the telephone consultation, the responder reported to supervisor 1 having "checked [caller 1's] CAPRI, and there's no information." The responder told the OIG team about not having access to EHRs since May 2019. According to information provided by a VCL leader, the responder's CAPRI access had been disabled since May 2019 due to inactivity, but the responder had access to CRISTAL (VCL's primary source for EHR information) and could have checked for caller 1's information.

## Administrative Actions

Under the VA Accountability and Whistleblower Protection Act of 2017, the VCL is required to provide evidence to support performance-based action taken against an employee.<sup>49</sup> Performance deficiencies typically involve either one or a combination of

- The failure of critical elements in an employee's performance plan,
- "A reasonable belief" that the performance deficiency cannot be improved,
- The deficiency "poses a clear danger to the employee or others," or
- Presents a risk to veterans' services.<sup>50</sup>

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<sup>46</sup> Responders record time engaged in various duties such as calls, texts, chats, meetings, breaks, and trainings.

<sup>47</sup> YouTube is a website for sharing videos, accessed July 1, 2020, <https://www.britannica.com/topic/YouTube>.

<sup>48</sup> VCL Position Description, *Health Science Specialist*, January 8, 2019.

<sup>49</sup> Office of Personnel Management Handbook TS-107, *The Classifier's Handbook*, August 1991. "Title 5, United States Code, governs the classification of positions in the Federal service." <https://www.opm.gov/policy-data-oversight/classification-qualifications/classifying-general-schedule-positions/classifierhandbook.pdf>. (The website was accessed July 21, 2020.) Human Resources Management Letter No. 05-17-06, *Adverse Action Procedures*, August 24, 2017.

<sup>50</sup> Human Resources Management Letter No. 05-17-06.

Misconduct deficiencies may include neglect of duty, such as failure of an employee to maintain control over matters that the employee is assigned.<sup>51</sup> In situations that involve alleged misconduct, VCL is required to “promptly and thoroughly” review and, as necessary, investigate “using appropriate processes, such as fact-finding inquiries or administrative investigation boards.”<sup>52</sup>

In early October 2019, a supervisor (supervisor 3) completed an issue brief regarding caller 1, and a VCL leader reportedly then sent the issue brief to the Office of Mental Health and Suicide Prevention leadership.<sup>53</sup> The issue brief noted that a root cause analysis would be conducted, and the responder would be temporarily removed from active call management. Later that month, supervisor 2 and a team operations coordinator (team operations coordinator 2) consulted with a human resources specialist regarding administrative actions related to the responder. When interviewed by the OIG team, the human resource specialist reported recommending that VCL supervisors pursue conduct-related rather than performance-related administrative actions.

Following consultation with the human resources specialist, supervisor 2 took steps to improve the responder’s job performance. When interviewed by the OIG team, supervisor 2 reported completing a review of the responder’s audio recordings, computer screen recordings, and Medora documentation related to caller 1. The responder would be required to successfully complete three calls, monitored by a supervisor, and demonstrate the ability to meet standards. Additionally, during this time, a preceptor would be with the responder to monitor calls for safety.

Approximately a month later, VCL team operations coordinator 2 informed the human resources specialist that after consulting supervisor 1, the responder viewed a YouTube video before contacting family member 2. The human resources specialist advised team operations coordinator 2 to ask the responder specific questions regarding the potential conduct issue. In an email three days later, the human resources specialist told supervisor 2 not to pursue questioning with the responder because of pending consultation “with our leadership to see if we should pursue questioning at this time since [the] OIG is involved.” In early 2020, supervisor 2 reported to the OIG team that the responder had not completed the requirements listed in the notification to return to independent work.

In early February 2020, the Office of General Counsel advised that management “should wait until OIG has completed their investigation.” The human resources specialist told the OIG that

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<sup>51</sup> Human Resources Management Letter No. 05-17-06.

<sup>52</sup> Human Resources Management Letter No. 05-17-06. An Administrative Investigation Board is the VA standard procedure “for collecting and analyzing evidence, ascertaining facts, and documenting complete and accurate information regarding matters of interest to VA.” VA Handbook 0700, *Administrative Investigations*, July 31, 2002.

<sup>53</sup> Deputy Secretary for Health for Operations and Management, *10N Guide to VHA Issue Briefs*, June 20, 2017. VHA uses an issue brief to communicate detailed information regarding a critical situation, event, or issue to appropriate leadership within the organization.

the understanding was that the OIG was conducting a criminal investigation and not a healthcare inspection, and therefore it would be appropriate to cease internal review.<sup>54</sup> On February 19, supervisor 2 contacted the OIG “wondering if the investigation is still underway.” Supervisor 2 asked the OIG team if the inspection was complete so that VCL could proceed with the internal review. The OIG team explained that the ongoing healthcare inspection should not interfere with VCL internal reviews and encouraged immediate administrative follow-up.<sup>55</sup> On March 3, the Chief of Staff informed the OIG team that the responder had a period of extended leave that delayed retraining. As of May 14, the responder had completed the three core calls successfully and returned to independent duty.

When the OIG team asked about consideration of an administrative investigation board to review the responder’s actions, the VCL Acting Director said that VCL did formal fact-finding for potential staff disciplinary situations but was uncertain if they conduct formal administrative investigation boards. The former VCL Director and Deputy Director, Quality and Training, both told the OIG that the Office of Human Resources could initiate an administrative investigation board.

The OIG determined that VCL leaders did not consider an administrative investigation board to review the responder’s potential misconduct in the management of caller 1’s contacts, because there was uncertainty about the authority of VCL leaders to initiate the process.<sup>56</sup> The OIG concluded that an administrative investigation board should have been considered to review the responder’s potential misconduct in the management of caller 1’s contacts.

### **Related Concern: Primary Care Provider’s Inadequate Response to Caller 1’s Mental Health Care Needs**

The OIG determined that a facility primary care provider failed to include caller 1’s mental health diagnosis in the assessment and plan of care. However, the OIG was unable to determine if an assessment and plan of care related to caller 1’s mental health condition would have prevented caller 1’s actions that caused family member 1’s death approximately two months after the primary care appointment. The OIG team also found that the primary care provider did not submit caller 1’s non-VA medical records for scanning into the EHR or document a review of the non-VA medical records, as expected by VHA policy.

VHA EHR documentation must “record pertinent facts, findings, and observations about an individual’s health history, including past and present illnesses, tests, treatments, and

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<sup>54</sup> VA Handbook 0700.

<sup>55</sup> In early March 2020, the OIG communicated with a VCL leader and the Office of General Counsel and emphasized that OIG healthcare inspections do not affect administrative actions.

<sup>56</sup> VA Handbook 0700, *Administrative Investigations*, July 31, 2002. An Administrative Investigation Board is the VA standard procedure “for collecting and analyzing evidence, ascertaining facts, and documenting complete and accurate information regarding matters of interest to VA.”

outcomes.”<sup>57</sup> Facility policy requires providers to document, as appropriate, an “assessment, clinical impression, or diagnosis plan for care.”<sup>58</sup> Additionally, VHA requires practitioners to review non-VA health records and either document a summary in the patient’s EHR or submit the non-VA health records for scanning.<sup>59</sup> The Joint Commission requires that medical records for each patient include diagnostic impressions, conclusions from a review of the patient’s medical history, and the plan of care.<sup>60</sup>

Primary care providers regularly care for patients who have both medical and mental health diagnoses with the goal of stabilization of both physical and mental health to support optimal health outcomes. VHA requires primary care providers to conduct preventative healthcare services including patient evaluations that may lead to “recognition of symptoms of mental disorder” and to engage Primary Care-Mental Health Integration or behavioral health providers when appropriate.<sup>61</sup> VHA policy notes that primary care staff “collaborates with Mental Health Treatment Coordinator and designated mental health providers when caring for Veterans with serious mental illness,” such as schizophrenia.<sup>62</sup> Facility rules and bylaws direct providers to include a summary of a patient’s psychological needs in the medical assessment, when pertinent.<sup>63</sup>

In late summer 2019, caller 1 and family member 2 met with the primary care provider for an initial appointment to establish care. The primary care provider documented caller 1’s schizophrenia diagnosis, that caller 1’s mood was “overall good” with no suicidal or homicidal ideation, and that family member 2 reported caller 1 “has paranoia” and that caller 1’s schizophrenia was “very frustrating.” The primary care provider told the OIG that family

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<sup>57</sup> VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

<sup>58</sup> Facility Policy 11-19-232, *Documentation Standards for Licensed Independent Providers (LIP)*, August 1, 2016, expired August 2019. In February 2020, the facility Risk Manager told the OIG that a policy rescission request was submitted due to the requirements already identified in The Joint Commission Standards and the facility’s *Bylaws and Rules of the Medical Staff*, June 2019.

<sup>59</sup> VHA Handbook 1907.07, *Management of Health Records File Room and Scanning*, May 12, 2016.

<sup>60</sup> VHA Directive 1100, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. The Joint Commission is a nationally recognized accreditation organization that provides external quality reviews to evaluate if a VHA facility meets quality and safety standards. The Joint Commission, *Record of Care, Treatment, and Services*, July 1, 2019. The January 2019 standard contained the same or similar language concerning medical records. The Joint Commission, *Performance Measurement*. accessed October 23, 2020, <https://www.jointcommission.org/measurement/#:~:text=The%20Joint%20Commission%20is%20a%20nationally%20recognized%20leader,considered%20the%20%22gold%20standard%22%20in%20health%20care%20today.>

<sup>61</sup> Primary Care-Mental Health Integration includes behavioral health providers who are co-located in primary care and collaborate with primary care staff for patients with mental health disorders. VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017.

<sup>62</sup> An individual identified as having a serious mental illness meets diagnostic criteria for a severe psychiatric disorder, such as schizophrenia that impacts a person’s functioning or affects their daily living activities or both. VHA Handbook 1101.10(1).

<sup>63</sup> Facility’s *Bylaws and Rules of the Medical Staff*, June 2019.

member 2 said the frustration was because caller 1 would not leave the house. However, the primary care provider did not conduct further assessment of caller 1's mental health diagnosis or psychological needs, or refer caller 1 to Primary Care-Mental Health Integration or other behavioral health providers.

The primary care provider told the OIG that schizophrenia was not added to caller 1's problem list because caller 1's mental health diagnosis was not upfront and concerning, and caller 1 and family member 2 did not ask for mental health treatment. Family member 2 told the OIG that the visit with the primary care provider was primarily related to caller 1's medical diagnoses including high blood pressure and did not think that there were any unmet needs from the appointment.

The facility's Chief of Staff and Associate Chief of Staff of Primary Care told the OIG that they would expect a primary care provider to include a new patient's schizophrenia diagnosis in the assessment and plan as part of establishing care. They also stated an expectation that the primary care provider documents if the patient did not require or declines mental health services. Consistent with this perspective, the OIG would expect the primary care provider to document a comprehensive medical history including details about caller 1's schizophrenia diagnosis, current or prior treatment for schizophrenia, and current symptoms, including delusions or hallucinations.<sup>64</sup> Although the primary care provider might not have determined if caller 1's schizophrenia should be treated, the primary care provider should have gathered information to ascertain caller 1's level of independent functioning and ability to understand current medical issues to make informed decisions. Further, the OIG would expect the primary care provider to assess whether caller 1's high blood pressure medication noncompliance may have been related to schizophrenia given that patients with schizophrenia may lack insight into their healthcare needs, suffer from poor functioning, and neglect self-care.

When interviewed by the OIG, the primary care provider reported reviewing caller 1's non-VA medical records and having them available at the visit or right after. In a June 2019 note, the non-VA medical provider listed caller 1's schizophrenia diagnosis and noted "No current symptoms. No recent symptoms. Has never required medication. Unclear when and who made diagnosis." The non-VA provider also noted that caller 1 did not feel in need of psychiatric care, sounded "very stable," and advised caller 1 "to discuss further with the VA clinic." The primary care provider stated that caller 1 and family member 2 did not say they needed psychiatric care, notes indicated caller 1 was stable, and it did not seem as if caller 1's mental health was in need of attention at that time. However, given caller 1's documented serious mental illness diagnosis, the OIG would have expected the primary care provider to offer a referral to Primary Care-Mental

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<sup>64</sup> Hallucinations "usually involve seeing or hearing things that [do not] exist" and for a "person with schizophrenia, they have the full force and impact of a normal experience." Mayo Clinic, *Schizophrenia – Symptoms and cause*, accessed August 4, 2020, <https://www.mayoclinic.org/diseases-conditions/schizophrenia/symptoms-causes/syc-20354443>.

Health Integration or another behavioral health provider, as required by VHA.<sup>65</sup> The primary care provider told the OIG that Primary Care-Mental Health Integration providers are readily accessible and that caller 1 was not referred because caller 1 and family member 2 did not ask for help.

The OIG was unable to determine if an assessment and plan of care related to caller 1's mental health condition would have prevented caller 1's actions that caused family member 1's death. However, completion of a mental health assessment, including further evaluation of family member 2's observations and initiation of a collaborative plan of care, may have addressed symptoms that contributed to caller 1's behaviors approximately two months after the primary care appointment.<sup>66</sup>

Further, the primary care provider acknowledged not documenting a review of the non-VA records or submitting the non-VA records to be scanned into caller 1's EHR, as required by VHA policy.<sup>67</sup> The primary care provider told the OIG that caller 1's non-VA medical records included basic encounters and did not include anything that required scanning into the EHR. The primary care provider also reported not typically documenting a summary review of non-VA medical records at the time of caller 1's visit but began including that information after attending workshops on better documentation. Because access to non-VA records allows providers to plan care consistently, minimize duplication of services, and recognize the patient's treatment needs, failure to comply with this VHA requirement may compromise care coordination for current and future providers.

### **Related Concern: Quality Management Practices**

In August 2013, VHA defined leadership roles for the oversight of patient care quality and safety and required an integration of "the functions of quality, safety, and high reliability" at each organizational level.<sup>68</sup> On October 24, 2019, VHA rescinded the directive "so that it doesn't conflict with modernization efforts as they are being rolled out as part of the new VHA governance process." VHA supporting program offices, such as the National Center for Patient Safety and Risk Management, continued to provide guidance for quality and safety oversight.<sup>69</sup>

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<sup>65</sup> VHA Handbook 1101.10(1).

<sup>66</sup> A collaborative plan of care includes the patient, family members, Primary Care-Mental Health Integration, and other behavioral health providers, as appropriate, in decision-making and planning.

<sup>67</sup> VHA Handbook 1907.07. Following an initial OIG interview, the primary care provider reported uploading the non-VA medical records to caller 1's EHR.

<sup>68</sup> VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

<sup>69</sup> VHA Notice 2019-21, Rescission of VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, October 24, 2019.

VCL's activities are categorized into three areas of specialization: business operations, clinical operations, and quality management.<sup>70</sup> Quality management is focused on the assessment and management of the quality of service delivered to callers through quality assurance activities, such as silent monitoring.<sup>71</sup> VCL leaders reported establishing the Patient Safety, Risk Manager position in 2018 and initiating a root cause analysis program the following year. The Patient Safety, Risk Manager reported completing a National Center for Patient Safety training in March 2019 and incorporating root cause analyses since May 2019.

The OIG found that VCL leaders did not fully adhere to VHA policies related to reporting and disclosure of adverse events because of leaders' uncertainty about the applicability of these processes to VCL. The OIG concluded that VCL leaders would benefit from written guidance on applicable quality management processes and expectations. In February 2020, the Deputy Director, Quality and Training, told the OIG that VCL was unable to prioritize patient safety-related trainings or to expand the patient safety risk management program because of operational demands. However, once quality management program requirements are established, VCL leaders could more clearly identify priorities and resource needs.

### *Silent Monitoring*

The OIG found that monitor specialists did not complete the expected number of silent monitored calls for the responder for caller 1. VHA requires VCL leaders to implement silent monitoring to oversee the quality of responders' work.<sup>72</sup>

Silent monitor social science program specialists (monitor specialists) are staff specifically trained to listen to active calls, assess calls, and provide coaching for identified areas in need of improvement immediately following monitored calls.<sup>73</sup> VCL leaders developed a silent monitoring protocol that outlines the evaluation criteria for responder and SSA call management and guides monitor specialists' coaching for unmet criteria. Monitor specialists evaluate responders' calls using VCL-established critical and noncritical criteria. Critical criteria include the responder's completion of a suicide risk assessment, offering a suicide prevention team consult, developing a plan to reduce current risk, and ending a call appropriately. Noncritical

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<sup>70</sup> Veterans and Military Crisis Line, *VCL Orientation & Employee Handbook*, April 2018. VCL, *Atlanta VCL Orientation & Employee Handbook*, October 2018. Business operations oversee management of VCL services to callers and evaluates the effectiveness of services including staffing patterns and timekeeping. Clinical operations oversee the delivery of services to callers.

<sup>71</sup> Veterans and Military Crisis Line, *VCL Orientation & Employee Handbook*, April 2018. VCL, *Atlanta VCL Orientation & Employee Handbook*, October 2018.

<sup>72</sup> VHA Directive 1503. The 2017 and 2020 directives contain the same or similar language related to silent monitoring.

<sup>73</sup> Veterans and Military Crisis Line, *VCL Orientation & Employee Handbook*, April 2018. VCL, *Atlanta VCL Orientation & Employee Handbook*, October 2018. Responders are not aware that silent monitoring occurs until after the call. VCL-P-ACT-231-1901, *Policy for Veterans Crisis Line Quality Assurance Monitoring of Social Services Assistants*, February 6, 2019.

criteria include the responder's active call management, such as focusing on the present and current concerns, defining the problem, accurately documenting the call, and assessing a caller's homicidality.<sup>74</sup>

The Deputy Director, Quality and Training, told the OIG team that silent monitoring of telephone calls started in April 2016, and the goal was 80 percent of staff receive at least one monitoring every two weeks. Although there is not written guidance about frequency of monitoring for each responder, a supervisory program analyst in quality assurance told the OIG that the goal is for each responder to have 26 silent monitoring reports in a 12-month period.

For the responder who managed caller 1's calls, the OIG found that monitor specialists completed 15 of 22 expected silent monitored calls from October 2018 through September 2019.<sup>75</sup> Of the 15 silent monitored calls, the responder received coaching regarding two calls, each with two failed elements that included a critical element related to risk assessment history or past attempts and three noncritical elements related to writing a clear, concise, and accurate synopsis and greeting properly. These concerns were directly relevant to the responder's deficiencies in caller 1's call management. However, silent monitors did not complete nearly one-third of the expected calls for the responder.

Silent monitors completed nearly all of the expected silent monitored calls for the two responders who managed caller 2's calls during the time period reviewed. The OIG found that the coaching provided did not directly relate to either responder's actions with caller 2.

In February 2019, VCL leaders implemented silent monitoring of SSA staff's internal and external communications, such as emergency dispatch and documentation.<sup>76</sup> VCL policy outlines the evaluation criteria for SSAs' management of an emergency dispatch request or a facility transportation plan.<sup>77</sup> VCL policy requires SSA silent monitoring to occur a "minimum of three times per quarter, per SSA."<sup>78</sup> The OIG found that monitor specialists completed silent monitored calls as required for SSA 1 and approximately half of what was expected for SSA 2.<sup>79</sup>

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<sup>74</sup> VCL, *Silent Monitoring Quality Improvement Protocols*, February 18, 2016, updated August 10, 2017. This protocol was in effect during some of the time frame of the relevant silent monitoring data analysis used in this report. The protocol was rescinded and replaced by VCL-P-ACT-229-1906, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, July 8, 2019. The updated protocol and new policy included similar language regarding criteria for silent monitoring noncritical criteria.

<sup>75</sup> The OIG analysis included consideration of the responder's leave.

<sup>76</sup> VCL-P-ACT-231-1901.

<sup>77</sup> VCL-P-ACT-231-1901.

<sup>78</sup> VCL-P-ACT-231-1901.

<sup>79</sup> Based on SSA 1's period of employment, a monitor specialist completed the two expected silent monitored calls for SSA 1 in September and October 2019 and no coaching was indicated. From March through October 2019, SSA 2 had five silent monitored calls and no coaching occurred. For the two full quarters following policy implementation, SSA 2 only had three of the expected six silent monitored calls. A VCL leader told the OIG that Lead SSAs are not subject to silent monitoring.

The Deputy Director, Quality and Training, acknowledged that monitor specialists were not meeting the required frequency and had plans to troubleshoot to increase SSA silent monitored calls.

The OIG found that monitor specialists did not complete silent monitored calls as expected for the responder for caller 1's call or SSA 2 for caller 2's management. VCL leaders' failure to ensure that sufficient silent monitored calls were conducted for all staff may lead to an inadequate representation and unidentified deficiencies in staff performance.

### *Root Cause Analysis*

The OIG identified deficiencies in VCL's root cause analysis review that was initiated after VCL received notification of the death of caller 1's family member.

VHA requires that facility staff report adverse events to the patient safety manager so that a review of the adverse events occurs to identify potential underlying causes. Following an adverse event, a root cause analysis team may be appointed to determine root causes and establish action plans to avoid recurrence.<sup>80</sup> The root cause analysis process is a formal protected review with a multidisciplinary team approach that is used to identify systematic and procedural factors that contribute to adverse events.<sup>81</sup> Additionally, root cause analyses require a charter memorandum specific to that event or incident that includes purpose, focus, and assigned team member roles. VHA requires facility leaders to complete a root cause analysis within 45 days of awareness of the need for the review.<sup>82</sup>

In October 2019, VCL leaders planned to initiate a root cause analysis regarding caller 1's events on October 8, 2019, although the VCL Director did not establish a charter. The Deputy Director, Quality and Training, informed the OIG that on October 16, 2019, the root cause analysis team was convened and the Patient Safety, Risk Manager told the OIG team that the information was entered into WebSPOT.<sup>83</sup> On November 4, 2019, the Patient Safety, Risk Manager sent a notification email that dismissed the root cause analysis team, due to leaders' decision to proceed with an administrative personnel review of the responder's actions. The Deputy Director, Quality and Training, told the OIG that the root cause analysis would resume after completion of the administrative review. On January 10, 2020, a root cause analysis was chartered and resumed the

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<sup>80</sup> VHA Handbook 1050.01.

<sup>81</sup> VHA Handbook 1050.01. Adverse events are defined by VHA as "untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical facility, outpatient clinic, or other VHA facility."

<sup>82</sup> VHA Handbook 1050.01.

<sup>83</sup> WebSPOT is a software application which is used by facility safety managers to report all adverse events in the VHA Patient Safety Information System. VHA Handbook 1050.01.

week of February 24, 2020. On April 9, 2020, 90 days later, the root cause analysis was finalized, and the team did not identify any system issues.

VHA requires aggregated reviews for incidents of falls, adverse drug events, and missing patients, and also allows for “wild card aggregated reviews,” which are adverse events other than the three required.<sup>84</sup> The Patient Safety, Risk Manager told the OIG team that aggregated reviews of root cause analyses are required for VCL but none have been completed yet. Further, the Deputy Director, Quality and Training, told the OIG team that VCL plans to perform aggregated reviews, but had not completed reviews as of February 2020.

The OIG found that VCL leaders failed to adhere to VHA policy regarding root cause analysis requirements. Additionally, the OIG found that VCL leaders failed to complete the root cause analysis in the required time frame potentially delaying actions that ensure safety. The OIG team concluded that the VCL leaders’ failure to implement aggregated root cause analysis reviews may contribute to a delay in identification of process deficiencies and associated improvements.

### *Reporting and Disclosure of Adverse Events*

The OIG found that VCL leaders did not fully adhere to VHA policies related to reporting and disclosure of adverse events because of leaders’ lack of certainty about the applicability of these processes to VCL.

VHA requires employees to report adverse events and close calls within a medical center to the patient safety manager.<sup>85</sup> CARF recommends that an “organization implements written procedures regarding critical incidents that include: a. prevention, b. reporting, c. documentation, d. remedial action, [and] e. timely debriefings conducted following critical incidents.”<sup>86</sup>

In April 2018, CARF surveyors recommended to VCL that “a written analysis of all critical incidents be provided to or conducted by the leadership at least annually.” As required, VCL leaders established a Quality Improvement Plan that included corrective actions in response to the CARF recommendations.<sup>87</sup> As of August 2020, VCL leaders reported developing a standard operating procedure for supervisors to report critical incidents. A VCL leader confirmed that VCL did not have a system to report all types of critical incidents. A crisis line subject matter

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<sup>84</sup> VHA Handbook 1050.01.

<sup>85</sup> VHA Handbook 1050.01. Adverse events include untoward diagnostic or therapeutic incidents or other occurrences of harm directly associated with care or services delivered by VA providers. “A close call is an event or situation that could have resulted in an adverse event, but did not, either by chance or through timely intervention.”

<sup>86</sup> CARF, *Behavioral Health Standards Manual*, 2019, July 1, 2019–June 30, 2020.

<sup>87</sup> CARF requires submission of a Quality Improvement Plan for the facility’s action plans to address recommendations within 90 days of a facility receiving notification of an accreditation outcome report. CARF, *Behavioral Health Standards Manual*, 2018, July 1, 2018–June 30, 2019. This is the same language found in CARF, *Behavioral Health Standards Manual*, 2019, July 1, 2019–June 30, 2020, and CARF, *Behavioral Health Standards Manual*, 2020, July 1, 2020–June 30, 2021.

expert told the OIG that another crisis line’s adverse event and incident reporting process included any type of adverse occurrence, including both suicides and homicides committed by clients.

The Patient Safety, Risk Manager told the OIG that family member 1’s death was considered an adverse event. VCL leaders established procedures for frontline staff to report adverse events and close calls through a “Report of Death by Suicide” and the disruptive behavior reporting system.<sup>88</sup>

VCL leaders told the OIG that the National Patient Safety Improvement Handbook includes requirements, such as reporting all adverse events and close calls that apply specifically to VA medical centers, and therefore have been challenging to incorporate within VCL. The Deputy Director, Quality and Training, and the Patient Safety, Risk Manager told the OIG that VCL did not collect reports of close calls. The Deputy Director, Quality and Training, noted that it would be difficult to determine what would constitute a close call within the responsibility of VCL. The Patient Safety, Risk Manager also noted learning of incidents through various ways, including a submitted complaint, email, death by suicide report, or a medical center issue brief.

In January 2020, a National Center for Patient Safety program analyst informed the Patient Safety, Risk Manager that Joint Patient Safety Reporting “is only mandated for VA hospitals and health care systems. VCL does not meet this criteria.”<sup>89</sup> The OIG found that VCL did not have a structured process for staff to report adverse events and close calls. The Deputy Director, Quality and Training told the OIG that supervisors submit reports of concerns and complaints through email. The OIG determined that VCL currently did not have a formal tracking system to review, track, and trend root cause analyses or adverse events. In February 2020, the Patient Safety, Risk Manager told the OIG team that a SharePoint tracking system for root cause analyses was being developed.

Without a formal tracking system to identify adverse event trends or patterns of causal and contributing factors, VCL leaders may not be effectively identifying factors and recommendations for policy and operations to reduce the likelihood of negative outcomes.

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<sup>88</sup> A “Report of Death by Suicide” is to be completed by a responder and includes “a summary of the interaction, known details of the death by suicide, and name of involved” supervisor. VCL-P-ACT-210-1807, *Policy for Veterans Crisis Line for Reporting of Death by Suicide*, August 30, 2018. A Disruptive Behavior Report System submission is a communication tool to alert the Disruptive Behavior Review team of a caller’s disruptive or violent behavior. VCL-S-ACT-233-1903, *Standard Operating Procedure for Disruptive Behavior Reporting System Submissions*, March 18, 2019.

<sup>89</sup> The Joint Patient Safety Reporting system is a standardized reporting method for VHA employees to inform patient safety managers of safety concerns or incidents.

## Disclosure

The OIG found that VCL leaders did not fully adhere to VHA policies related to reporting and disclosure of adverse events because of leaders' lack of certainty about the applicability of these processes to VCL.

VHA policy requires medical center leaders to disclose harmful or potentially harmful adverse events to patients or their personal representatives. An adverse event may warrant institutional disclosure, which is a formal process for VA medical center leaders and clinicians to "inform the patient or patient's personal representative that an adverse event" occurred and includes "specific information about the patient's rights and recourse."<sup>90</sup>

When asked by the OIG in December 2019, the Acting Director and Deputy Director, Quality and Training, were unaware of the institutional disclosure process. In February 2020, the Director, Suicide Prevention Program, Office of Mental Health and Suicide Prevention, was unsure if it was applicable, because VCL does not operate with the same patient care function and structure as a medical facility. In February 2020, the Deputy Director, Quality and Training, told the OIG team about pursuing a National Center for Ethics in Healthcare consultation to determine if the institutional disclosure process is applicable to VCL.

The OIG finds it understandable that VCL leaders did not consider making an institutional disclosure given the questionable applicability of this process to VCL. However, a VCL leader found that the responder made "egregious" errors and "violated documented policies," in the management of caller 1's contact. Given VCL and OIG-identified deficits in call management; Suicide Prevention Program, Office of Mental Health and Suicide Prevention, and VCL leaders must determine whether a process currently exists that addresses VCL accountability and the need to disclose the events involving the responder. If no current process exists, VHA leaders should consider whether accountability dictates amending a current policy or drafting a new policy to cover disclosures of events, such as those involving caller 1 and the responder.

## 2. Insufficient and Delayed Responses to Caller 2

The OIG substantiated that two SSAs failed to dispatch local emergency services following responder 1's rescue request, as instructed by VCL.<sup>91</sup> No emergency dispatch action was taken after approximately six and a half hours until a Lead SSA initiated one. Inadequate communication between responders may have contributed to a failure to identify caller 2's location for the SSA's emergency dispatch efforts. The OIG also identified deficiencies in SSA oversight, including a failure to complete a thorough review of caller 2's rescue management.

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<sup>90</sup> VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

<sup>91</sup> VCL, *Social Service Assistant Training Participant Guide*, July 2019.

## Deficiencies in SSA Emergency Dispatch Management

VCL instructs SSAs to use approved resources to locate a caller, which may include online search resources or contacting law enforcement in the area where a caller is thought to be located. SSAs serve as the VCL point of contact for emergency dispatchers after rescue efforts have been initiated. In situations with an anonymous caller, VCL instructs SSAs to review Medora for previous calls from the phone number and to conduct an internet search using available information. VCL instructs the SSA to determine the closest dispatch center and quickly initiate a welfare check.<sup>92</sup>

After the welfare check has been initiated, the SSA can resume search efforts and consult with a supervisor for additional resources if needed. Resources include an approved non-VA database that provides additional information about the caller, including address history, phone numbers, and relatives.<sup>93</sup>

VCL allows an SSA managing an active rescue to carry over, or hand off, rescue responsibility to another SSA at the end of a shift. VCL instructs SSAs to document both successful and unsuccessful status updates on the crisis intervention form and tracker during rescue management and at the time of carry over to another SSA.<sup>94</sup> VCL supervisors told the OIG that supervisors can authorize discontinuation of emergency dispatch efforts after a rescue is initiated.<sup>95</sup>

After accepting responder 1's rescue, SSA 1 documented unsuccessfully searching for caller 2's location through internet searches. SSA 1 also documented that a supervisor searched the approved non-VA database but did not identify caller 2's location. SSA 1 documented the carry over to SSA 2. The OIG reviewed SSA 1's telephone call records from the time of receiving the rescue to work shift end. The OIG found that when search efforts did not produce additional identifying information, SSA 1 did not place any outgoing calls that matched a call to an emergency dispatch with caller 2's telephone area code or corresponding city, as advised by VCL.<sup>96</sup> Further, the OIG found that SSA 1 did not document contacting emergency dispatch for the welfare check. The next day, a Lead SSA informed supervisory staff that SSA 1 had logged off 30 minutes after receiving responder 1's request for a rescue and SSA 1 did not initiate the emergency dispatch.

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<sup>92</sup> VCL, *Social Service Assistant Training Participant Guide*, July 2019.

<sup>93</sup> VCL, *Social Service Assistant Training Participant Guide*, July 2019.

<sup>94</sup> VCL-S-ACT-205-1910, *Standard Operating Procedure for Crisis Intervention/ Facility Transportation Plan Tracker*, October 2, 2019. VCL, *Social Service Assistant Training Participant Guide*, July 2019.

<sup>95</sup> VCL, *Standard Work for Closing Failed Welfare Check & FTPs [Facility Transport Plans]*, Undated. Provided to the OIG on May 22, 2020.

<sup>96</sup> VCL, *Social Service Assistant Training Participant Guide*, July 2019.

SSA 2 accepted the carryover from SSA 1 and managed the rescue for approximately six hours. During an interview with the OIG team, SSA 2 reported multiple inaccuracies regarding caller 2's rescue management, including that SSA 2 reported re-contacting emergency dispatch throughout the night after SSA 1 initiated an emergency dispatch.<sup>97</sup> SSA 2 told the OIG that the police took a long time. The OIG reviewed outgoing telephone call records and did not find evidence that SSA 2 called any phone numbers matching caller 2's telephone area code or corresponding city to contact local emergency dispatch during the shift.<sup>98</sup>

SSA 2 documented being notified by a responder "that all attempts has [*sic*] been unsuccessful." When interviewed by the OIG, SSA 2 reported speaking to a supervisor who reported responders were attempting contact with caller 2. SSA 2 told the OIG that responder outreach continued until approximately 4:30 a.m. when staff learned that another responder completed a safety plan with caller 2. SSA 2 did not document actions to complete the rescue for caller 2 and did not document a carry over with another SSA at the end of the shift. The next day, a Lead SSA informed supervisory staff that SSA 2 did not take any actions for caller 2's rescue.

Although SSA 2 did not document a carry over, a Lead SSA documented receiving the rescue carry over at 5:26 a.m. Within approximately 20 minutes of the carry over, the Lead SSA documented contacting the local emergency dispatch who reported that a rescue could not be completed without caller 2's address. The Lead SSA requested a ping of caller 2's cellular telephone number, which the dispatcher stated was not possible due to caller 2 not directly contacting the local emergency dispatch.<sup>99</sup> The Lead SSA documented that caller 2 used a voice-over-internet protocol to call VCL.<sup>100</sup> Team operations coordinator 3 told the OIG that anonymous callers who use voice-over-internet protocol are more difficult to locate and may require local police to obtain identifying information. Team operations coordinator 2 also told the OIG that VCL staff cannot call back a voice-over internet protocol number. At 6:00 a.m., the Lead SSA documented that caller 2 was assessed as safe according to responder 2's call. At 7:00 a.m., the Lead SSA requested that another responder (responder 3) "reach out" to caller 2. Approximately two and a half hours later, responder 3 documented three unsuccessful contact attempts for caller 2 and shortly after, the Lead SSA documented that a supervisor discontinued the rescue.

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<sup>97</sup> The OIG confirmed that SSA 2 had accessed caller 2's rescue management documentation for this interview.

<sup>98</sup> The OIG found three outgoing calls made to another city in the same state as caller 2. The OIG reviewed the audio recordings of the three calls and found that none were related to the rescue or emergency dispatch request for caller 2.

<sup>99</sup> A ping is a signal sent to a cellular phone that may assist in locating the phone, accessed October 26, 2020, Merriam-Webster Dictionary. <https://www.merriam-webster.com/dictionary/ping>.

<sup>100</sup> Voice-over-internet protocol is any of various technologies that support telephony using the Internet for transmission rather than traditional telephone lines. Merriam-Webster Dictionary, accessed October 26, 2020, <https://www.merriam-webster.com/dictionary/Voice%20over%20Internet%20Protocol>.

Although an earlier initiation of emergency dispatch may not have resulted in a successful rescue for caller 2, the SSAs' ongoing failure to initiate emergency dispatch management could hinder identification of future callers' locations as well as the deployment of rescue efforts to ensure safety for the caller and others at risk for harm.

## **Inadequate Responder Communication**

VCL requires that responders conduct risk mitigation and initiate a rescue if needed for non-veteran callers experiencing suicidal ideation or thoughts of violent behavior.<sup>101</sup> VCL instructs responders to use instant messaging (text) to communicate with staff about active welfare checks and facility transport plan statuses.<sup>102</sup> Additionally, when a call is received from a caller who already has an active rescue in progress, responders are instructed to check the welfare check status as documented in the crisis intervention tracker.<sup>103</sup>

After endorsing suicidal ideation and homicidal ideation toward a family member, caller 2 abruptly disconnected from the call with responder 1, who had not yet completed risk assessments or safety planning (see table 1). Responder 1 unsuccessfully attempted to call back caller 2 and then requested emergency dispatch due to caller 2's self-reporting of suicidal and homicidal ideation. SSA 1 accepted the request.<sup>104</sup> Caller 2 contacted VCL again and spoke with another responder (responder 2). Responder 1 reported sometimes notifying other responders via instant message when a caller disconnects but could not recall the specifics of this call.<sup>105</sup> When interviewed by the OIG, responder 2 did not recall being aware that a rescue had been initiated for caller 2 and stated that may have been due to responder 1's call documentation not yet being entered in Medora. Responder 2 conducted a suicide risk assessment that included lethal means restriction and ended the call with caller 2 with a safety plan in place. Based on the report of the absence of responder 1's documentation, the OIG determined that it was likely that responder 2 was not aware of responder 1's initiation of emergency rescue for caller 2. Further, the OIG was unable to determine if responder 1 communicated about caller 2's emergency dispatch status through instant messaging to responders, because there was no recorded documentation of instant messages. If responder 2 had known about the emergency rescue initiation for caller 2,

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<sup>101</sup> VCL-P-ACT-229-1906, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, July 8, 2019.

<sup>102</sup> VCL, *Health Science Specialist Training Participant Guide*, June 2019.

<sup>103</sup> "The Crisis Intervention Tracker is a tool within the VCL SharePoint site for tracking Welfare Checks and Facility Transport Plans." VCL, *Health Science Specialist Training Participant Guide*, June 2019.

<sup>104</sup> An emergency services dispatch request form (or crisis intervention form) is located on the VCL SharePoint and is completed by a responder whenever a welfare check is requested. The form should include information specific to the caller and nature of the crisis for an SSA to initiate a dispatch to the appropriate law enforcement. VCL, *Health Science Specialist Training Participant Guide*, June 2019.

<sup>105</sup> VA's software application during the time frame for this inspection did not retain instant messages. Therefore, the OIG could not evaluate instant message communications.

responder 2 may have followed up on the status of the welfare check as required and then may have asked caller 2 for a location to support the emergency dispatch effort.

**Table 1. Responder and SSA Activity Timeline for Caller 2**

Date/Time	Responder Action	SSA Action
October 13, 2019, 10:45 p.m.	Caller 2 called VCL and responder 1 initiated call management.	
10:53 p.m.	Caller 2 disconnected the call.	
10:56 p.m.	Caller 2 called VCL again and responder 2 initiated call management and completed a safety plan.	
11:10 p.m.	Responder 1 requested a rescue.	SSA 1 accepted the rescue from responder 1 and initiated management of rescue.
11:14 p.m.		SSA 1 searched for caller 2's location through internet searches and requested the supervisor search an approved non-VA database.
11:26 p.m.		SSA 1 carried over the rescue to SSA 2, and SSA 2 initiated management of the rescue.
11:37 p.m.		SSA 1 documented that a non-VA database did not produce an address.
October 14, 2019, 12:03 a.m.	Responder 2 documented that the call ended normally.	
12:30 a.m.		SSA 2 documented that responder 1 called back and could not reach caller 2.
5:26 a.m.		The Lead SSA initiated management of the rescue.
5:44 a.m.		The Lead SSA contacted local emergency dispatch who reported inability to ping caller 2's cell phone.
6:00 a.m.		The Lead SSA documented that caller 2 was assessed as safe according to responder 2's call.
7:00 a.m.		The Lead SSA requested that responder 3 conduct additional outreach to caller 2.
9:39 a.m.	Responder 3 documented three unsuccessful outreach calls.	
9:46 a.m.		The Lead SSA documented that a supervisor discontinued the rescue.

*Source: OIG analysis of Medora and crisis intervention documentation*

## SSA Supervisory Oversight

Supervisory SSAs are required to monitor SSA activities and ensure carry overs are communicated properly to relevant incoming staff and supervisors.<sup>106</sup> The Assistant Deputy Director, Business Operations, stated that supervisory SSA positions were first approved in July 2018; however, there were hiring delays caused by multiple factors including union approval and posting more senior positions for hire prior to filling the supervisory positions. VCL's July 2019 organizational chart reflected seven supervisory SSA positions. A team operations coordinator told the OIG team that until supervisory SSA positions were filled, supervisors had oversight of responders and SSAs. The OIG found that the supervisor position description did not include SSA oversight of rescues and carry overs as a position responsibility. Another team operations coordinator said that as of January 2020, the supervisory SSA positions remained vacant. In April 2020, a supervisory management analyst informed the OIG that five of seven supervisory SSAs had been hired.

In interviews with the OIG, VCL's eight team operations coordinators presented five different and inconsistent understandings regarding supervisor responsibility of SSA rescue progress and carry over procedures (see table 2).<sup>107</sup>

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<sup>106</sup> VCL Position Description, *Supervisory Social Services Assistant*, Undated.

<sup>107</sup> Seven of the team operations coordinators supervised supervisory responders and included team operations coordinators 1 and 2. One of the team operations coordinators was detailed to a position overseeing supervisory SSAs that was vacant at the time of the January 2020 OIG interviews.

**Table 2. Team Operations Coordinators’ Understanding of SSA Supervision**

Team Operations Coordinator	SSA Rescue Oversight <sup>108</sup>	Carry Over Activities Oversight	Additional Oversight Noted
1	Lead SSA and Supervisor	Lead SSA and Supervisor	
2	Lead SSA and Supervisor	Lead SSA and Supervisor	
3	Lead SSA and Supervisor	Lead SSA and Supervisor	
4	Lead SSA	Lead SSA	Lead SSA notifies Supervisor if needed
5	Supervisor	Supervisor	
6	Lead SSA and Supervisor	Lead SSA	
7	Lead SSA and Supervisor	Lead SSA	
8	SSA	SSA	SSA notifies Supervisor if needed

Source: *OIG Interviews*

The OIG concluded that the delay in hiring supervisory SSAs and inconsistent team operations coordinators’ understanding of SSA oversight responsibilities may have contributed to the lack of supervisory intervention in caller 2’s rescue management. Given a VCL leader’s report that five of seven supervisory SSA positions were hired as of April 2020 and VCL leaders continued recruiting efforts, the OIG did not make a recommendation regarding these positions.

### **Inadequate Review of Delayed SSA Response**

VCL requires that supervisors manage staff “to facilitate safe, effective, and efficient care” and are responsible for evaluating staff work performance.<sup>109</sup> On October 21, 2019, a team operations coordinator (team operations coordinator 4) emailed SSAs 1 and 2’s supervisors (supervisor 4 and supervisor 5, respectively), and requested that the supervisors conduct a review of caller 2’s rescue management. Following a discussion with SSA 2 about the rescue, supervisor 5 reported to team operations coordinator 4 that SSA 2 did not take further action after learning that caller 2 had “reconnected with another responder and eventually committed to a risk mitigation plan.” Further, SSA 2 reported forgetting to document the rescue closure due to confusion related to a

<sup>108</sup> As discussed above, Lead SSAs serve in nonsupervisory roles.

<sup>109</sup> VCL Position Description, *Supervisory Health Science Specialist*, March 21, 2016.

planned VCL location power outage. Supervisor 5 reported discussing the importance of timely rescue documentation with SSA 2.

Team operations coordinator 4 told the OIG that preparation for the power outage may have resulted in SSA 2 hurriedly completing tasks. However, the OIG found that the power outage was not scheduled to begin until October 14, 2019, at 5:00 a.m., near the end of SSA 2's work shift.

Supervisor 4 did not email a response to team operations coordinator 4 and explained to the OIG that supervisor 5 agreed to look into the matter. In an email to a VCL leader, team operations coordinator 4 reported considering the review resolved based on supervisor 5's discussion with SSA 2.

The OIG concluded that the VCL team operations coordinator and supervisors' incomplete review of caller 2's rescue management may have resulted in supervisors' failure to identify performance and system deficiencies and actions to reduce the likelihood of similar unsuccessful rescue management.

## Conclusion

The OIG substantiated that the responder's management of caller 1's call was insufficient and delayed. The responder documented and reported inadequate information regarding caller 1 and failed to take actions to prevent family member 1's death. Specifically, the responder failed to assess caller 1's homicidal risk factors, address lethal means restriction, and complete an adequate risk mitigation plan, as required by VCL.<sup>110</sup> The responder did not communicate critical call information when consulting with supervisor 1 that likely would have resulted in an immediate emergency response. Additionally, the responder delayed timely intervention by taking a personal break after supervisory consultation and before re-contacting caller 1. The responder also failed to comply with VCL's duty to protect guidelines. VCL leaders did not consider an administrative investigation board to review the responder's potential misconduct in the management of caller 1's contacts, because there was uncertainty about the authority of VCL leaders to initiate the process. The OIG concluded that an administrative investigation board should have been considered to review the responder's potential misconduct in the management of caller 1's contacts.

A facility primary care provider failed to include caller 1's mental health diagnosis in the assessment and plan of care.<sup>111</sup> However, the OIG was unable to determine if an assessment and plan of care related to caller 1's mental health condition would have prevented caller 1's actions

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<sup>110</sup> VCL-S-ACT-217-1907, *Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation Planning*, July 10, 2019.

<sup>111</sup> The primary care provider was located at a facility community-based outpatient clinic.

that caused family member 1's death approximately two months after the primary care appointment. The primary care provider did not submit caller 1's non-VA medical records for scanning into the EHR or document a review of the non-VA medical records, as expected by VHA policy.

VCL leaders did not fully adhere to VHA policies related to reporting and disclosure of adverse events because of leaders' uncertainty about the applicability of these processes to VCL. The OIG concluded that VCL leaders would benefit from written guidance on applicable quality management processes and expectations.

Inadequate communication between responders may have contributed to a failure to identify caller 2's location for the SSA's emergency dispatch efforts. The OIG substantiated that two SSAs failed to dispatch local emergency services following responder 1's rescue request, as instructed by VCL.<sup>112</sup> No action was taken on the emergency dispatch after approximately six and a half hours, until a Lead SSA initiated one. The OIG also identified deficiencies in SSA oversight, including a failure to complete a thorough review of caller 2's rescue management.

The Assistant Deputy Director, Business Operations, stated that supervisory SSA positions were first approved in July 2018; however, there were hiring delays caused by multiple factors including union approval and posting more senior positions for hire prior to filling the supervisory positions. Given a VCL leader's report that five of seven supervisory SSA positions were hired as of April 2020, and VCL leaders continued recruiting efforts, the OIG did not make a recommendation regarding these positions.

The OIG determined that it was likely that responder 2 was not aware of responder 1's initiation of emergency rescue for caller 2. Further, the OIG was unable to determine if responder 1 communicated about caller 2's emergency dispatch status through instant messaging to responders because there was no recorded documentation of instant messages. If responder 2 had known about the emergency rescue initiation for caller 2, responder 2 may have followed up on the status of the welfare check as required and then may have asked caller 2 for a location to support the emergency dispatch effort.

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<sup>112</sup> VCL, *Social Service Assistant Training Participant Guide*, July 2019.

## Recommendations 1–11

1. The Veterans Crisis Line Director conducts a full review of the Veterans Crisis Line staff's management of caller 1's contacts, including the responder's conduct, consults with Human Resources and General Counsel Offices, and takes action as warranted.
2. The Veterans Crisis Line Director ensures leaders' awareness and understanding of administrative investigation board policy and procedures as applicable to the Veterans Crisis Line.
3. The Montana VA Health Care System Director ensures that primary care providers include and document assessment and care plans for patients with mental health conditions.
4. The Montana VA Health Care System Director makes certain that primary care providers comply with Veterans Health Administration policy regarding the electronic health record documentation of patients' non-VA health records.
5. The Executive Director, Office of Mental Health and Suicide Prevention, consults with relevant Veterans Health Administration program offices, including the National Center for Patient Safety, to establish applicable quality management processes and expectations including staff reporting of adverse events and close calls.
6. The Veterans Crisis Line Director evaluates Veterans Crisis Line leaders' expectations regarding the percentage of silent monitored calls completed and establishes benchmarks for individual staff requirements.
7. The Veterans Crisis Line Director makes certain that root cause analyses are conducted as required by Veterans Health Administration policy.
8. The Executive Director, Office of Mental Health and Suicide Prevention, determines if Veterans Health Administration disclosure policies apply to the Veterans Crisis Line and establishes procedures as appropriate.
9. The Veterans Crisis Line Director ensures processes are developed to promote responders' communication regarding emergency dispatch for disconnected callers.
10. The Veterans Crisis Line Director conducts a full review of Veterans Crisis Line staff members' contacts and rescue management with caller 2, consults with the Human Resources and General Counsel Offices, and takes action as warranted.
11. The Veterans Crisis Line Director strengthens supervisory oversight of social service assistants and clearly communicates expectations to all supervisory levels.

## Appendix A: Office of the Under Secretary for Health Memorandum

### Department of Veterans Affairs Memorandum

Date: February 18, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, Healthcare Inspection—Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation, and an Inadequate Primary Care Assessment at the Montana VA Health Care System (VIEWS 04269459)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the Office of the Inspector General (OIG) draft report on Veterans Crisis Line (VCL) care at the Montana VA Health Care System. We appreciate the Inspector General's (OIG) inspection of the call center's actions and take the report's findings very seriously. VA deeply regrets the losses of lives described in the report.
2. The Veterans Health Administration (VHA) values the difficult and heartfelt work of our crisis line responders. The emotional toll they pay to work with people in dire circumstances deserves our respect and gratitude.
3. As a highly reliable organization we want to learn from OIG's findings and improve our ability to help people in crisis. To foster a learning environment, VHA works to increase transparency and increase willingness of individuals to report challenges to their work, near misses and errors. In this way VHA builds a just culture where employees are safe to bring up problems and help build solutions.
4. We are committed to engaging in ongoing process improvements, learning from past experiences while continuing to monitor our key performance indicators (KPIs) as part of our commitment to the Quadruple Aim. In fiscal year (FY) 2020, VCL answered on average 1756 calls/day, answering 95% of calls in 20 seconds or less with an average speed of 9 seconds, with an abandonment rate of 3.8% and rollover rate to our backup center at 0.1%. In FY20, VCL also dispatched emergency services to callers at immediate risk approximately 79 times/day while placing 371 average referrals/day to local VA prevention team members to ensure continuity of care.

S.2661, *the National Suicide Hotline Designation Act*, was signed into law on October 17, 2020, requiring the full 1-800-273-8255 hotline number to be changed to 988 by no later than July 16, 2022. T-Mobile, Verizon, and UScellular have all already initiated 988 independently. As of January 31, 2021 with this early 988 implementation by these three carriers beginning in November, VCL is denoting a 17.5% dialing increase in average call volume. VCL remains fully committed to meeting its KPIs while continuing ongoing quality improvement as we answer the call.

5. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at [VHA10BGOALACTION@va.gov](mailto:VHA10BGOALACTION@va.gov).

*(Original signed by:)*  
Richard A. Stone, M.D.

## Acting Under Secretary for Health's Response

### Recommendation 1

The Veterans Crisis Line Director conducts a full review of the Veterans Crisis Line staff's management of caller 1's contacts, including the responder's conduct, consults with Human Resources and General Counsel Offices, and takes action as warranted.

Concur.

Status: In Progress                      Target Completion Date: 90 days after initiation of evidentiary review

### Acting Under Secretary for Health Comments

Veterans Crisis Line (VCL) leadership consulted VHA's Workforce Management and Consulting (WMC) subject matter experts with regard to responder 1 as outlined in the Inspector General's draft report. VCL will seek further consultation through WMC to determine if the Offices of Human Resources and General Counsel advise that further action is warranted.

### Recommendation 2

The Veterans Crisis Line Director ensures leaders' awareness and understanding of administrative investigation board policy and procedures as applicable to the Veterans Crisis Line.

Concur.

Status: In Progress                      Target Completion Date: April 2021

### Acting Under Secretary for Health Comments

It's common practice for Veterans Crisis Line (VCL) leadership to consult with VHA Workforce Management and Consulting (WMC) prior to convening an administrative investigation board (AIB). Current VCL supervisory training on employee relations/labor relations outlines AIB policy. The VCL Director will ensure consultation with WMC Human Resources Operations Office to prepare and conduct AIB training for supervisors. VCL will ensure participation and completion through the Talent Management System. This training will also be fully consistent with and reflective of principles and practices of a learning organization within the framework of a High Reliability Organization and will not promote a culture of blame.

### Recommendation 5

The Executive Director, Office of Mental Health and Suicide Prevention, consults with relevant Veterans Health Administration program offices, including the National Center for Patient

Safety, to establish applicable quality management processes and expectations including staff reporting of adverse events and close calls.

Concur.

Status: In Progress

Target Completion Date: August 2021

### **Acting Under Secretary for Health Comments**

The Office of Mental Health and Suicide Prevention will consult with relevant VHA program offices, including the National Center for Patient Safety, to review and refine the Veterans Crisis Line quality management processes to ensure actions and oversight for quality control. VCL will also review quality management guidance to enhance identification and reporting of adverse event and close-call reporting applicable to non-patient care settings. This guidance will address expectations of VCL staff to identify and evaluate adverse events and close calls, with the important distinction that VCL staff are neither licensed independent providers nor credentialed and privileged to provide health care.

### **Recommendation 6**

The Veterans Crisis Line Director evaluates Veterans Crisis Line leaders' expectations regarding the percentage of silent monitored calls completed and establishes benchmarks for individual staff requirements.

Concur.

Status: In process

Target Completion Date: August 2021

### **Acting Under Secretary for Health Comments**

The Veterans Crisis Line (VCL) will review and clarify individual staff monitoring requirements including percentage of silent monitored calls completed as stated in current policies for interaction and silent monitoring. VCL quality assurance team members will implement quarterly reporting on silent monitoring standards to ensure targets are met.

### **Recommendation 7**

The Veterans Crisis Line Director makes certain that root cause analyses are conducted as required by Veterans Health Administration policy.

Concur in principle.

Status: In process

Target Completion Date: August 2021

## **Acting Under Secretary for Health Comments**

VHA concurs in principle with the Inspector General's recommendation because VHA root cause analysis (RCA) policy only applies to the delivery of health care by health care providers. The Veterans Crisis Line (VCL) is not designed to deliver health care and VCL responders are not health care providers.

VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, establishes the requirements for a RCA to be performed when an enrolled Veteran dies by suicide while receiving inpatient care or within 72 hours of discharge from an inpatient acute care unit or 7 days from discharge from an inpatient mental health unit. The applicable facility Medical Center Director charters the RCA team and signs off on the final report. The facility Patient Safety Manager facilitates the RCA process and may include an investigation of VCL contact depending on the event circumstances. VHA Handbook 1050.01 applies to health care delivery by health care providers only; VCL is not a health care delivery setting nor are responders health care providers. Rather, the VCL will enhance and refine quality management guidance to ensure actions and oversight for quality control, in collaboration with the National Center for Patient Safety (see recommendation 5 above). VCL will include the requirement to perform, on an annual basis, a Common Cause Analysis for all identified VCL callers that died by suicide before the caller received contact with emergency services and where VCL was the last point of contact.

### **Recommendation 8**

The Executive Director, Office of Mental Health and Suicide Prevention, determines if Veterans Health Administration disclosure policies apply to the Veterans Crisis Line and establishes procedures as appropriate.

Concur.

Status: In Progress

Target Completion Date: May 2021

## **Acting Under Secretary for Health Comments**

The Office of Mental Health and Suicide Prevention will review Veterans Crisis Line policies related to adverse events disclosure and update policies as needed.

### **Recommendation 9**

The Veterans Crisis Line Director ensures processes are developed to promote responders' communication regarding emergency dispatch for disconnected callers.

Concur.

Status: In progress

Target Completion Date: May 2021

## **Acting Under Secretary for Health Comments**

The Veterans Crisis Line (VCL) will review the current Emergency Dispatch Standard Operating Procedure (SOP) to identify any additions to strengthen communication regarding emergency dispatch for disconnected callers as indicated. VCL will ensure staff are trained on any SOP revisions.

### **Recommendation 10**

The Veterans Crisis Line Director conducts a full review of Veterans Crisis Line staff members' contacts and rescue management with caller 2, consults with the Human Resources and General Counsel Offices, and takes action as warranted.

Concur.

Status: In progress                      Target Completion Date: 90 days after initiation of evidentiary review

## **Acting Under Secretary for Health Comments**

The Veterans Crisis Line (VCL) Director through consultation with VHA's Workforce Management and Consulting Human Resources Operations Office and General Counsel, will review VCL staff members' contacts and rescue management to determine whether administrative action is warranted.

### **Recommendation 11**

The Veterans Crisis Line Director strengthens supervisory oversight of social service assistants and clearly communicates expectations to all supervisory levels.

Concur.

Status: In progress                      Target Completion Date: May 2021

## **Acting Under Secretary for Health Comments**

The Veterans Crisis Line (VCL) recently implemented the use of Supervisory Social Services Assistants to increase oversight of Social Service Assistant (SSA) performance metrics. VCL will refine and finalize an SSA dashboard job aid to assist with ensuring appropriate staff are trained and appropriately implementing this newly developed guidance. VCL will also refine standard operating procedures which delineate roles and responsibilities for all levels of SSA supervisory staff.

## Appendix B: VISN Director Memorandum

### Department of Veterans Affairs Memorandum

Date: January 4, 2021

From: Network Director, Rocky Mountain Network (10N19)

Subj: Healthcare Inspection—Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation, and an Inadequate Primary Care Assessment at the Montana VA Health Care System

To: Director, Office of Healthcare Inspections (54MH00)  
Director, GAO/OIG Accountability Liaison (GOAL) Office (10E1D)

1. I have reviewed the findings, recommendations, and action plan of the Montana VA Health Care System. I am in agreeance with the above.

*(Original signed by:)*

Ralph Gigliotti  
Network Director, VISN 19

## Appendix C: Facility Director Memorandum

### Department of Veterans Affairs Memorandum

Date: December 29, 2020

From: Director, Montana VA Health Care System (436/00)

Subj: Healthcare Inspection—Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation, and an Inadequate Primary Care Assessment at the Montana VA Health Care System

To: Director, VA Rocky Mountain Network (10N19)

1. We appreciate the opportunity to work with the Office of Inspector General as we continuously strive to improve the quality of healthcare for America's Veterans.
2. I have reviewed and concur with the findings for Recommendation 3 and Recommendation 4.
3. Please find attached our response to each recommendation provided in this report.

*(Original signed by:)*

Judy Hayman, PhD.

Executive Director, Montana VA Health Care System

## Facility Director's Response

### Recommendation 3

The Montana VA Health Care System Director ensures that primary care providers include and document assessment and care plans for patients with mental health conditions.

Concur.

Target date for completion: February 28, 2021

#### Director Comments

The Associate Chief of Staff for Behavioral Health will conduct education for primary care providers, at the monthly state-wide primary care meeting, on how to document mental health assessments and care plans for patients with metal [mental] health conditions. This training will include how to use the template for SIGECAPS (Sleep, Interest, Guilt, Energy, Concentration, Appetite, Psychomotor, Suicidal Ideation), CAGE (Cut down, Annoyed, Guilty, Eye opener), and a check box for documenting a warm hand off to Primary Care Mental Health Integration (PCMHI) in the progress note. Attendance will be documented, and the Power Point presentation will be assigned to those not in attendance.

#### OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

### Recommendation 4

The Montana VA Health Care System Director makes certain that primary care providers comply with Veterans Health Administration policy regarding the electronic health record documentation of patients' non-VA health records.

Concur.

Target date for completion: February 28, 2021

#### Director Comments

The Health Information Management Service (HIMS) Chief will conduct education for primary care providers, at the monthly state-wide primary care meeting, regarding the electronic health record documentation of patients' non-VA health records. Attendance will be documented, and the Power Point presentation will be assigned to those not in attendance.

## **OIG Comment**

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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