



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Vet Center Inspection of
Southeast District 2 Zone 2
and Selected Vet Centers



MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

**Report suspected wrongdoing in VA programs and operations
to the VA OIG Hotline:**

www.va.gov/oig/hotline

1-800-488-8244



Figure 1. Southeast district 2 zone 2 vet centers inspected.
Source: VA Office of Inspector General inspection team virtual visit photographs.

Abbreviations

CDC	Centers for Disease Control and Prevention
OIG	Office of Inspector General
RCA	root cause analysis
RCS	Readjustment Counseling Service
VANTS	VA National Telecommunications System
VCD	Vet Center Director
VCIP	Vet Center Inspection Program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VVC	VA Video Connect



Report Overview

The VA Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) provides a focused evaluation of the quality of care delivered at vet centers. Vet centers are community-based clinics that provide a wide range of psychosocial services to clients, including eligible veterans, active duty service members, National Guard members, reservists, and their families, to support a successful transition from military to civilian life. The inspection focused on Southeast district 2 zone 2 and four selected vet centers: Clearwater, Ocala, and Sarasota in Florida; and Ponce in Puerto Rico.¹

VCIP inspections are one element of the OIG's oversight to ensure that the nation's veterans receive high-quality and timely mental health care and VA services. The inspections cover key clinical and administrative processes associated with promoting quality care. The OIG selects and evaluates specific areas of focus each year.

To examine risks or potential risks to clients, the OIG inspection focused on six review areas that influence the quality of client care and service delivery at vet centers:²

- Leadership and organizational risks
- Quality reviews
- COVID-19 response
- Suicide prevention
- Consultation, supervision, and training
- Environment of care

The findings presented in this report are a snapshot of the selected zone and vet center's performance within the identified review areas at the time of the OIG inspection. The OIG findings should help vet centers identify areas of vulnerability or conditions that, if addressed, could improve safety and quality of care.

¹ Veterans Health Administration, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010, was in effect during the OIG's inspection period. It was rescinded and replaced by VHA Directive 1500, *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021. Unless otherwise specified, the requirements in the 2021 directive contain the same or similar language as the rescinded November 2010 document. Readjustment Counseling Service is divided into five districts. Each district consists of two to four zones. Each zone consists of multiple vet centers, ranging from 18–25 vet centers per zone.

² VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. Vet centers provide counseling interventions for psychological and psychosocial readjustment problems related to specific types of military deployment stressors. Readjustment counseling services are "designed by law to be provided without a medical diagnosis." Therefore, those receiving readjustment services are not considered patients. To be consistent with vet center policy and terminology, the OIG refers to veterans receiving such services as clients in this report.

Leadership and Organizational Risks

The leadership and organizational risks review is specific to the district office and includes results from leadership questionnaires sent to all zone vet center directors.

District 2 zone 2’s leadership team consists of the District Director, Deputy District Director, Associate District Director for Counseling, and Associate District Director for Administration (see figure 2).³

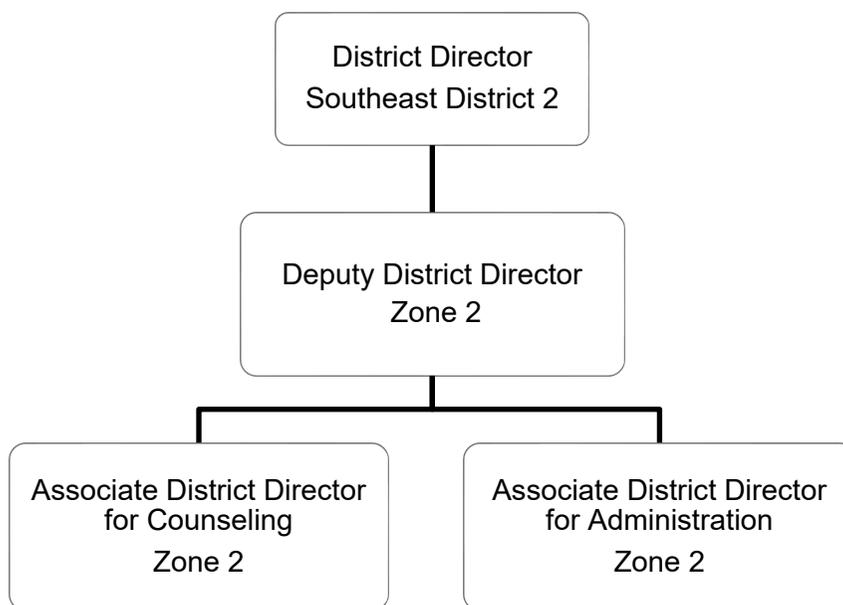


Figure 2. District 2 zone 2 leaders.
Source: VA OIG analysis of district organizational chart.

At the time of the inspection, three of the four district leaders had been working together as a group for more than three and a half years.⁴ The District Director was the most tenured leader, in the position since 2011. The Deputy District Director had been in the position since 2017, and the Associate District Director for Counseling since 2013. The Associate District Director for Administration position was vacant for 13 days at the time of inspection, with coverage provided by the individual holding the same position in district 2 zone 1.

Generally, district leaders had a good understanding of basic concepts of quality improvement and perceived their roles as important to driving and overseeing quality improvement activities.

³ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021. Readjustment Counseling Service is an organizational element within VHA with direct-line authority for community-based vet centers and is responsible for the provision of readjustment counseling.

⁴ For the purposes of this report, district leaders refer to district 2 Director, and district 2 zone 2 Deputy District Director, Associate District Director for Counseling, and Associate District Director for Administration.

The majority of district leaders reported spending 10 or more hours a week engaged in quality improvement activities across the zone. District leaders also indicated they did not have a dedicated district quality department and relied on vet center directors for quality improvement activities. Vet center directors cited ways they achieved psychological safety in the workplace including individual supervision, weekly team meetings, staff engagement, transparency, and an open-door policy allowing for good communication.

The VA All Employee Survey is an annual, voluntary, census survey of VA workforce experiences.⁵ District leaders identified the top three fiscal year 2019 VA All Employee Survey priorities as communication, growth, and workload.⁶

The OIG reviewed Vet Center Service Customer Feedback survey results and found that district 2 zone 2 exceeded national scores and clients indicated overall satisfaction with appointment availability, staff courtesy, and vet center services. District leaders reported the culture of customer service fostered from the top down had a positive impact on Vet Center Service Feedback scores. Results for the leadership and organizational risks review generally do not rise to the level of findings.

Quality Reviews

The OIG conducted an analysis of vet center clinical and administrative quality reviews, and critical incident quality reviews. Vet centers are required to have an annual clinical and administrative quality review completed to ensure compliance with policy and procedures.⁷ The Readjustment Counseling Service requires critical incident quality reviews for client safety events (events not primarily related to the natural course of the client's illness or underlying condition) including clients with serious suicide or homicide attempts, death by suicide, or homicide.⁸

The OIG identified deficiencies with clinical and administrative quality review remediation plans including the lack of the deputy district director's approval, a date of approval, and documentation showing resolution of the issues. The OIG identified deficiencies with completion of critical incident quality reviews for a death by suicide and active clients with serious suicide

⁵ "VA All Employee Survey," VA National Center for Organization Development, accessed September 10, 2019, <https://www.va.gov/ncod/vaworkforcesurveys.asp>.

⁶ The OIG defines fiscal year 2019 as October 1, 2018, through September 30, 2019.

⁷ VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010, was in effect during the OIG's inspection period. It was rescinded and replaced by VHA Directive 1500, *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021. Unless otherwise specified, the requirements in the 2021 directive contain the same or similar language as the rescinded November 2010 document.

⁸ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

attempts. The OIG issued four recommendations for clinical and administrative quality reviews and two recommendations for critical incident quality reviews.⁹

COVID-19 Response

The COVID-19 response review results were gathered through a zone-wide questionnaire to staff and interviews with district leaders and vet center directors from the four selected vet centers. This review is designed primarily to gather information from leaders and staff within the zone and to draw general conclusions.

The OIG interviewed district leaders and vet center directors of the four selected vet centers in the following areas: emergency planning, supplies and infrastructure, access and client care—telework and telehealth, and client screening including referral. District leaders were also interviewed about communication and field guidance. The OIG sent a voluntary COVID-19 questionnaire to 140 employees at the 24 zone 2 vet centers.¹⁰

In general, district leaders reported feeling ill-prepared for the pandemic despite the issuance of Readjustment Counseling Service (RCS) Central Office field guidance within weeks of the pandemic onset. Although initially feeling ill-equipped, district leaders enacted emergency plan procedures and vet centers remained operational. The four vet center directors reported following COVID-19 safe practice guidelines and taking appropriate steps to protect the safety of employees and clients. Overall, employees' responses to the COVID-19 questionnaire indicated communication, telework, telehealth, and response to the pandemic were managed well by district leaders and vet center directors. Employees reported thoughtful preparation was provided by district leaders and vet center directors. Results for the COVID-19 response review generally do not rise to the level of findings.

Suicide Prevention

The suicide prevention review included a zone-wide evaluation of electronic client records with results and recommendations specific to the district office, and a focused review of the four selected vet centers with results and recommendations to the district office and the four vet center sites.

⁹ RCS policy does not define a serious suicide attempt; in the absence of an RCS definition of a serious suicide attempt, the OIG considered the client being transferred to the hospital an indicator of a serious suicide attempt that would have met the criteria for completion of a critical incident quality review.

¹⁰ A questionnaire was sent to 140 employees at the 24 vet centers. One employee received two surveys to provide responses for each of the vet centers the employee represented creating a total of 141 voluntary questionnaires.

Vet centers are required to complete a psychosocial assessment including an intake and military history.¹¹ The OIG found noncompliance across the zone with clinicians not completing psychosocial assessments, military histories, and timely completion of lethality risk assessments.

Vet centers are required to have a written crisis plan addressing how staff respond to crisis situations.¹² The four selected vet centers inspected had crisis plans but were unable to provide policy or guidance that ensured required participation by a vet center staff member on the mental health council of the support VA medical facility.¹³ One of the four selected vet centers was not compliant with required availability of nontraditional hours for appointments. The four selected vet centers did not provide evidence of receiving the required Office of Mental Health and Suicide Prevention lists of clients with increased predictive risk for suicide and high risk for suicide.¹⁴ The four selected vet centers did not have a standardized communication process to collaborate with the support VA medical facility suicide prevention coordinators.

The OIG issued 10 recommendations—four specific to the zone-wide evaluation of electronic client records and six specific to the selected vet centers' suicide prevention and intervention processes.¹⁵

Consultation, Supervision, and Training

The consultation, supervision, and training review evaluated the four selected vet centers with results and recommendations specific only to those sites. The four vet centers inspected complied with requirements for having a clinical liaison and external clinical consultant from the VA medical facility mental health or social work service. The external clinical consultants were appropriately licensed as were the required mental health professionals on staff at each vet

¹¹ RCS-CLI-003, Revised Clinical Site Visit (CSV) Protocol, January 25, 2019; VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Client Records*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

¹² VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

¹³ VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), 2021. The 2010 handbook required participation by a vet center staff member; the 2021 directive requires participation by “a licensed Vet Center staff member.” VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. Mental health councils at “Each VA medical center must establish and maintain a Mental Health Executive Council that includes representation from core mental health professional disciplines and specialty VA mental health programs with administrative support from the medical center.”

¹⁴ The Office of Mental Health and Suicide Prevention is the VHA office responsible for sharing a monthly list of veterans who have an increased predictive risk for suicide with Readjustment Counseling Services so vet centers can identify clients who are receiving counseling services and better coordinate care with VA medical facilities.

¹⁵ While the findings apply to the selected four vet centers, the OIG directed recommendations on certain items to the Under Secretary for Health when responsibilities are shared by RCS and the Office of Mental Health and Suicide Prevention.

center. Vet centers were not compliant with the requirement to have an external clinical consultant provide at least four hours of consultation per month.

Vet center directors were not compliant with the requirement to provide one hour a week of supervision to clinical staff and the auditing of records. Overall, the four vet center's staff were noncompliant with completing training requirements.

The OIG identified concerns in external clinical consultation, supervision, and training across the four vet centers. The OIG issued four recommendations specific to the four selected vet centers.

Environment of Care

The environment of care review evaluated the four selected vet centers with results and recommendations specific only to those sites. The four vet centers inspected generally complied with environment of care requirements for the physical environment, general safety, and privacy. However, the four selected vet centers inspected did not have Architectural Barriers Act compliant tactile exit signs.¹⁶ One vet center was noncompliant with having an office manager space that was private, and two vet centers were noncompliant in securing personal information.

The OIG identified issues with one component of general safety and two components of privacy, resulting in two recommendations specific to the four selected vet centers.

Conclusion

The OIG conducted a detailed inspection across six review areas and issued a total of 22 recommendations for improvement, including three to the Under Secretary for Health and 19 to the District Director.¹⁷ The number of recommendations should not be used as a gauge for the overall quality of care provided within the zone. The intent is for the Under Secretary for Health and district leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may interfere with the delivery of quality care.

¹⁶ Architectural Barriers Act of 1968 (codified as amended at 42 U.S.C. § 4151 et seq.); Architectural Barriers Act (ABA) Standards (2015).

¹⁷ Recommendations addressed to the Under Secretary for Health were submitted to the Deputy to the Deputy Under Secretary for Health, performing the delegable duties of the Under Secretary for Health.

Comments

The Acting Under Secretary for Health and District Director concurred with recommendations 1–4, 7–13, 15–17, and 19–22, and concurred in principle with recommendations 5, 6, 14 and 18. An action plan was provided (see responses within the body of the report for full text of the RCS comments, and appendixes D and E for the Under Secretary and District Director memorandums). The OIG considers all recommendations open and will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Contents

Report Overview.....	iii
Background.....	1
Purpose and Scope	7
Methodology.....	7
Results and Recommendations	12
Leadership and Organizational Risks.....	12
Quality Reviews.....	17
COVID-19 Response	27
Suicide Prevention	33
Consultation, Supervision, and Training.....	49
Environment of Care.....	58
Appendix A: Summary of Vet Center Inspection Program Recommendations	64
Appendix B: District 2 Zone 2 Profile.....	68
Appendix C: Vet Center Profiles	69
Appendix D: Under Secretary for Health Memorandum.....	70
Appendix E: RCS Southeast District 2 Director Memorandum	72
OIG Contact and Staff Acknowledgments	73
Report Distribution	74



Background

Vet centers are community-based clinics that provide a wide range of psychosocial services to clients, including eligible veterans, active duty service members, National Guard members, reservists, and their families, to support a successful transition from military to civilian life.¹⁸ Services include individual, group, and family counseling for mental health conditions related to military sexual trauma, posttraumatic stress disorder, and other military-related concerns. Vet center staff assess and manage clients at risk for suicide, substance abuse, and other medical and mental health conditions.¹⁹ Other services include bereavement support for families, referrals to the Veterans Benefits Administration, screening and assessment for employment, outreach including Post Deployment Health Reassessment, and help with linkage to Veterans Health Administration (VHA) and community organizations.²⁰

Vet Center History

The Readjustment Counseling Service (RCS) is an organizational element within VHA with direct-line authority for community-based vet centers and is responsible for the provision of readjustment counseling.²¹ Since opening vet centers in 1979, RCS was one of the first organizations to address the psychological and social effects combat has on veterans before the

¹⁸ VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010, was in effect during the OIG's inspection period. VHA Directive 1500.00(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021, rescinded and replaced multiple VHA guidelines and policies addressing RCS operations that were in effect during the inspection period. Unless otherwise specified, the requirements in the 2021 directive contain the same or similar language as the rescinded November 2010 document. Vet centers provide counseling interventions for psychological and psychosocial readjustment problems related to specific types of military deployment stressor. Readjustment counseling services are "designed by law to be provided without a medical diagnosis." Therefore, those receiving readjustment services are not considered patients. To be consistent with vet center policy and terminology, the OIG refers to veterans receiving such services as clients in this report.

¹⁹ VHA Directive 1500(1), 2021; Policy Memorandum RCS-CLI-003, *Revised Clinical Site Visit (CSV) Protocol*, January 25, 2019.

²⁰ VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), 2021; "Vet Center Eligibility," Vet Centers (Readjustment Counseling), accessed March 24, 2021, <https://www.vetcenter.va.gov/Eligibility.asp>. Post Deployment Health Reassessment's screen and evaluate the health of those returning from combat.

²¹ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), 2021.

American Psychiatric Association recognized posttraumatic stress disorder as an official diagnosis in 1980.²²

While vet centers initially focused on Vietnam-era veterans, services are now offered to veterans and active service members of all combat theaters and their families. From 1979 through 1985, an estimated 305,000 clients received services at vet centers; and by fiscal year 2019, RCS Central Office reported roughly 307,737 clients were seen in one fiscal year alone.²³ In an attempt to serve the growing veteran population, the number of vet centers expanded from 91 in 1979 to 300 as of June 2018.²⁴ Along with the increase in number of clients served, vet centers have undergone expansion to assist clients through a variety of services. Figure 3 shows a map of vet centers and vet center outstations.²⁵

²² Mayo Clinic, “Post-traumatic stress disorder,” accessed December 10, 2020, <https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967>. “Post-traumatic stress disorder (PTSD) is a mental health condition that's triggered by a terrifying event—either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event.” VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), 2021.

²³ VHA Directive 1500 (1), 2021. RCS Central Office is the national office responsible for program policy and supervision of RCS district offices, providing direct line supervision for vet center administrative and clinical functions. Government Accountability Office. *Vietnam Veterans: A Profile of VA's Readjustment Counseling Program*, Report No. GAO/HRD-87-63, August 1987, and *1995 Readjustment Counseling Service: Vet Centers Address Multiple Client Problems, but Improvement Is Needed*, Report No. GAO/HEHS-96-113, July 1996. The OIG defines fiscal year 2019 as October 1, 2018, through September 30, 2019.

²⁴ Blank Jr., Arthur S. “Apocalypse Terminable and Interminable: Operation Outreach for Vietnam Veterans.” *Hospital and Community Psychiatry*. Volume 33, Number 11. November 11, 1982.

²⁵ VHA Directive 1500(1), 2021. RCS outstations promote additional points of access for clients and are aligned under a host vet center. Vet center outstations are distant from established vet centers, and while not having the same staffing requirements, outstations have at least one full-time counselor.

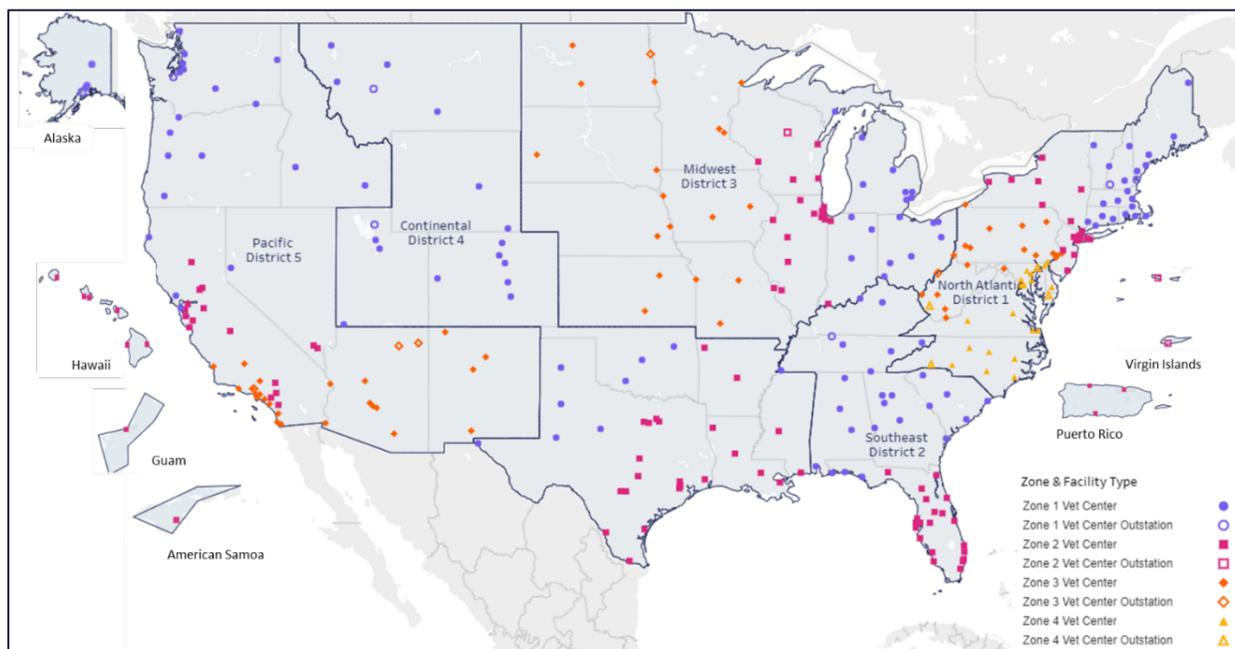


Figure 3. Map of vet centers and vet center outstations. The placement of Alaska, American Samoa, Hawaii, Guam, Puerto Rico, and the Virgin Islands on the map is not representative of their actual geographical location.²⁶

Source: VA OIG developed using VA Site Tracking (January 19, 2021) and RCS data (as of March 8, 2021).

Vet center services and eligibility expanded starting in 1991 with a notable change in 2003 permitting RCS to provide bereavement counseling to surviving parents, spouses, children, and siblings of service members who die of any cause while on active duty.²⁷ Table 1 shows the expansion of vet center eligibility.

²⁶ VA News Release, *VA Deploying 20 New Mobile Vet Centers*, January 4, 2012. Southeast District 2 includes Puerto Rico and the Virgin Islands. Pacific District 5 includes Alaska, Hawaii, Guam, and American Samoa. Not on the map are the locations of mobile vet centers used to provide counseling or outreach services to the community.

²⁷ VA, “Who We Are,” Vet Centers (Readjustment Counseling), accessed June 4, 2019, https://www.vetcenter.va.gov/About_US.asp. This includes activated Reserve and National Guard members as noted in table 1.

Table 1. Vet Center Eligibility Expansion

Year	Vet Center Eligibility Expansion
1991	Veterans who served post-Vietnam
1992	Veterans who experienced military sexual trauma
1996	Veterans who served in World War II and Korean Combat Veterans*
2002	Bereavement counseling to surviving family members of veterans receiving VA services at the time of death and family members of active duty service members killed while on active duty
2003	Veterans of Operation Enduring Freedom (OEF) Veterans of Operation Iraqi Freedom (OIF) Veterans of Global War on Terrorism (GWOT)
2011	Federally activated National Guard and Reserve forces who served in active military in Operation Enduring Freedom and/or Operation Iraqi Freedom
2013	Family members of deployed service members for support Crew members of unmanned aerial vehicles in combat operations or areas of hostility Providers of direct emergent medical care or mortuary services while serving on active military duty
2014	Amended VA’s authority to provide counseling, care and services to active duty service members reporting sexual assault or harassment without a Tricare referral
2020	Forces who served on active service in response to a national emergency or national disaster National Guard in response to a disaster or civil disorder Any individual who participated in a drug-related military action as a member of the Coast Guard

Source: VA OIG analysis of vet center eligibility expansion information. *Vet Center Eligibility*, accessed June 4, 2019, <https://www.vetcenter.va.gov/Eligibility.asp>. National Defense Authorization Act for Fiscal Year 2013, Pub. L. No. 112-239 (2013).

*In 1996, armed hostile periods were expanded to include additional combat eras.

RCS Organizational Structure

RCS is aligned under the VA Under Secretary for Health and has governance of 300 vet centers, 80 mobile vet centers, 18 outstations, and the Vet Center Call Center.²⁸ RCS establishes clinical

²⁸ VA, “Vet Centers (Readjustment Counseling),” accessed July 8, 2019. <https://www.vetcenter.va.gov/>. The Vet Center Call Center, reached at 1-877-WAR-VETS or 1-877-927-8387, is a toll-free, 24-hour per day, 7 days per week, confidential call center for veterans and their families to receive support regarding their military experience or any other readjustment issue. VHA Directive 1500, September 8, 2010; VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*. November 23, 2010; VHA Directive 1500(1), 2021.

and administrative policies for vet center operations.²⁹ The RCS Chief Officer reports directly to the VA Under Secretary for Health and is responsible for formulating program policy for vet centers, providing expertise to the field, and engaging in strategic planning. The RCS Operations Officer reports to the RCS Chief Officer and provides direction and oversight to the district directors who oversee the districts. RCS has five districts, each with two to four zones. Each zone has a range of 18 to 25 vet centers. Figure 4 shows the RCS organizational district and zone structure. Each vet center has a vet center director (VCD) who oversees all vet center operations.³⁰

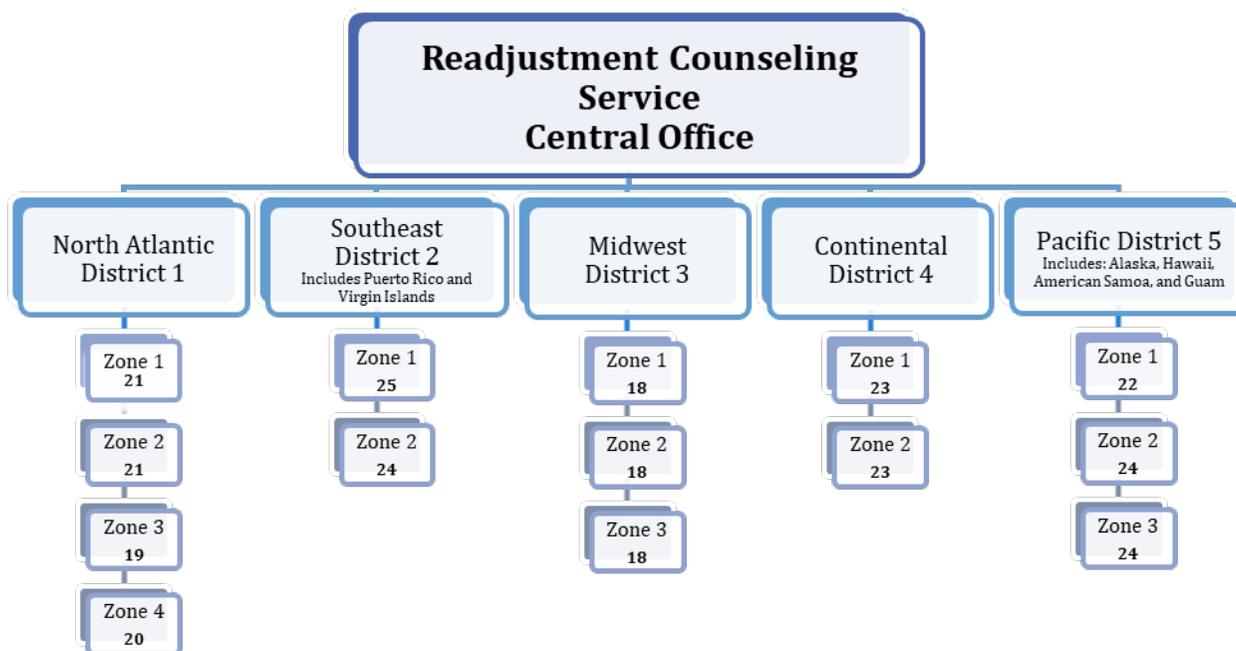


Figure 4. RCS organizational district and zone structure.

Source: VA OIG developed by using analysis of RCS information.

Note: The number of vet centers in each zone is denoted below the respective zone. The OIG did not assess RCS data for accuracy or completeness.

Electronic Client Record

Vet center services are not required to be recorded in a client’s VA electronic health record.³¹ An RCS National Service Support leader noted that prior to fiscal year 2003, RCS used a paper record system to record client visits and data. In fiscal year 2003, a web-based software system called RCSnet was implemented to collect client information. On January 1, 2010, RCSnet

²⁹ VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

³⁰ VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

³¹ VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

became the sole record keeping system for client services. RCSnet's independence from VA's and Department of Defense's electronic health record systems allows vet centers to maintain secure and confidential records that will not be disclosed to VA medical facilities, VA clinics, or the Department of Defense unless there is a signed release of information.³² An RCS National Service Support leader reported working with Cerner Corporation and VA's Office of Electronic Health Record Modernization for the development of an RCS-specific electronic client record system.³³

VA Medical Facilities

Guidelines were established by RCS for vet centers to maintain an active and reciprocal relationship with VA medical facilities to ensure clients receive quality care and needed services. The support VA medical facility director in coordination with the VCD assigns a clinical liaison and an administrative liaison.³⁴ The VA medical facility clinical liaison coordinates services for complex and shared clients.³⁵ The VA medical facility administrative liaison provides support for procurement, engineering functions, commuter benefits, general post funds, and fleet management for U.S. government vehicles.³⁶ As required, vet center staff collaborate with VA medical facilities by participating on mental health councils and coordinating care with VA medical facility suicide prevention coordinators for shared clients.³⁷

³² VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), 2021;38 C.F.R. § 17.2000 – 816 (e). Vet centers will not disclose clients records unless a client authorizes release or there is a specific exemption. For the purposes of this report, the OIG uses the term VA medical facility instead of VA medical center or VHA medical facility.

³³ VHA Directive 1500, September 8, 2010; VHA Directive 1500(1), 2021. Per an RCS National Service Support leader, modernization of the RCSnet as the electronic client record system for vet centers was being considered and a determination had not been made. RCS Central Office is the national office responsible for program policy and supervision of RCS district offices, providing direct line supervision for vet center administrative and clinical functions. Cerner Corporation, Cerner Government Services, "Federal Government," accessed June 29, 2021, <https://www.cerner.com/solutions/federal-government>. Cerner is a corporation that promotes secure modern technology to improve healthcare operations, create solutions, and connect and engage healthcare communities.

³⁴ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. A support VA medical facility is "aligned laterally with every vet center for providing supportive administration and clinical collaboration to better serve eligible individuals."

³⁵ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

³⁶ VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

³⁷ VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. Vet centers provide representation on root cause analysis panels when a client completes suicide and is a shared client with a VA medical facility.

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) is to conduct routine oversight of vet centers providing readjustment services to clients. The OIG inspection examined operations generally from August 1, 2019, through July 31, 2020. This report evaluates the quality of care delivered at vet centers and examines a broad range of key clinical and administrative processes associated with positive client outcomes. The OIG reports its findings to Congress and VHA, so informed decisions can be made on improving care.

The OIG findings are a snapshot of a zone and vet centers' performance within the identified focus areas. Although it is difficult to quantify the risk of adverse impact to clients served at vet centers, the OIG recommendations in this report may help vet centers identify areas of vulnerability or conditions that, if addressed, could improve safety and quality of care ([see appendix A](#)).³⁸

To examine risks or potential risks to clients, the OIG inspection focused on six review areas that influence the quality of client care and service delivery at vet centers:

- Leadership and organizational risks
- Quality reviews
- COVID-19 response³⁹
- Suicide prevention
- Consultation, supervision, and training
- Environment of care

Methodology

The OIG announced the inspection to district 2 zone 2 leaders (district leaders) on September 21, 2020, and conducted virtual site visits from September 21 through October 8, 2020.⁴⁰ The OIG

³⁸ The underlined terms are hyperlinks to another section of the report. To return to the point of origin, press “alt” and “left arrow” keys.

³⁹ “A pneumonia of unknown cause detected in Wuhan, China, was first reported to the World Health Organization (WHO) Country Office in China on 31 December 2019. The virus was later named ‘SARS-CoV-2’ and the disease it causes named ‘coronavirus disease 2019’ (abbreviated ‘COVID-19’).” *VHA – OEM, COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan, Version 1.6*, March 23, 2020. World Health Organization, “WHO Director-General’s opening remarks at the media briefing on COVID-19 – 11 March 2020,” accessed on August 20, 2020, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>.

⁴⁰ For the purposes of this report, district leaders refer to the district director, deputy district director, associate district director for counseling, and associate district director for administration.

interviewed district leaders and four VCDs at the selected vet centers. Due to travel restrictions during the COVID-19 pandemic, the inspection was conducted virtually.⁴¹

The OIG reviewed RCS policies and practices, validated client RCSnet record findings, examined administrative and performance measure data, explored reasons for noncompliance, and virtually inspected selected areas of care within vet centers.

A new VHA directive was issued in January 2021 (amended May 3, 2021), after the OIG's inspection period of VCIP operations discussed in this report.⁴² The new directive rescinded and replaced multiple VHA guidelines and policies addressing RCS operations that were in effect during the inspection period. The OIG compared the rescinded guidelines and policies with the newly issued directive to identify modifications. Unless otherwise specified, requirements in the new directive use the same or similar language as the rescinded RCS-related guidelines and policies under discussion in this report. The OIG findings in this report are based on the RCS-related guidelines and policies that were in effect during the inspection period.

Recommendations are consistent with the 2021 directive addressing RCS operations.

The OIG emailed two questionnaires; the first questionnaire focused on quality improvement activities and was sent to all VCDs within the zone, and the second questionnaire was about the COVID-19 response and was sent to all staff within the zone.

District and Zone Selection

Site selection was completed through randomization, beginning sequentially with the district, zone, and vet centers respectively (see figure 5).

⁴¹ Centers for Disease Control and Prevention, "Travel During COVID-19," accessed March 24, 2021, <https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-during-covid19.html>.

⁴² VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021.

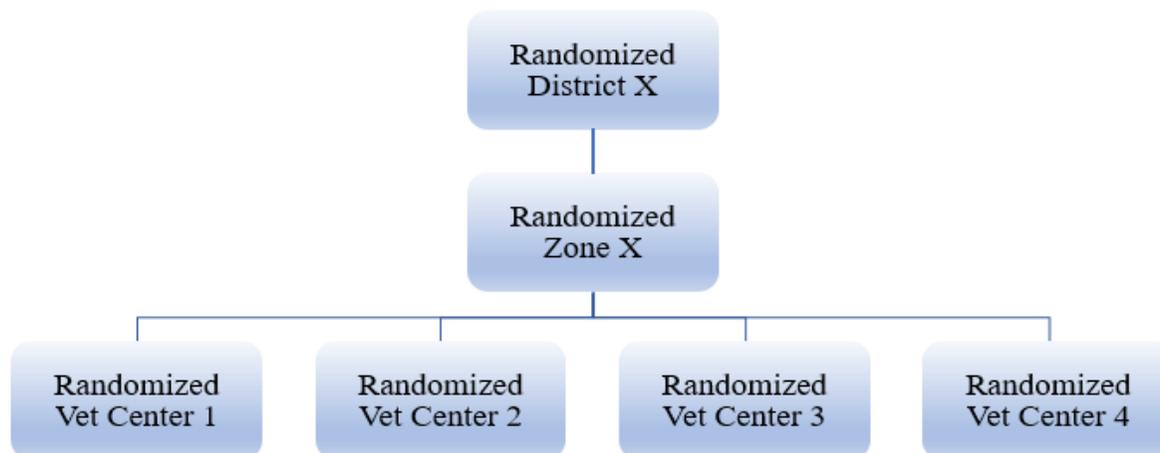


Figure 5. Randomization and selection of inspection sites.
Source: VA OIG.

For this inspection, district 2 zone 2 was randomly selected. Within zone 2, the Clearwater, Ocala, Ponce, and Sarasota Vet Centers were randomly selected. Geographical locations of the district’s zone 2 vet centers are noted in figure 6. For demographic profiles of district 2 zone 2 and the four selected vet centers (see [appendix B](#) and [appendix C](#)). The OIG provided one-day notice to each vet center prior to formal evaluation.⁴³

⁴³ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500 (1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021. Vet centers are comprised of small multidisciplinary teams. The OIG team provided one-day notice for coordination of client care as needed.

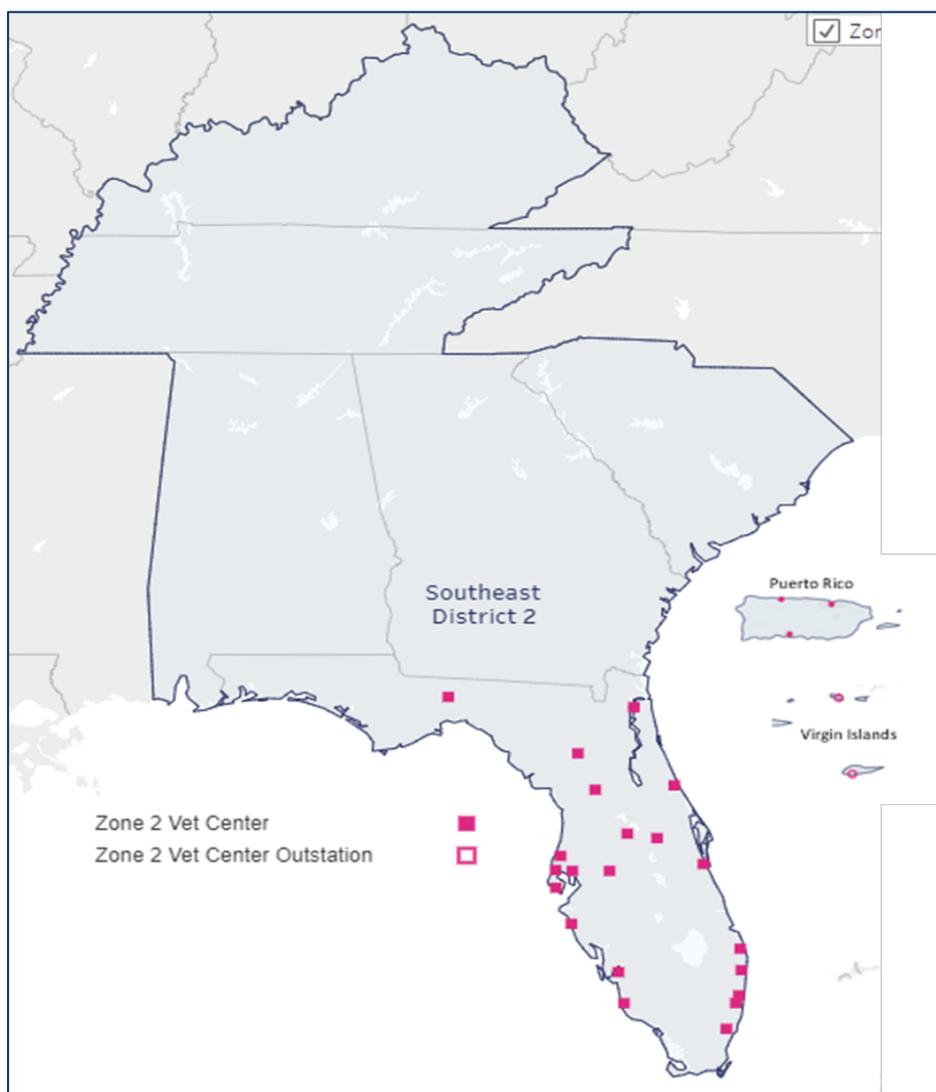


Figure 6. Map of district 2 zone 2 vet centers including outstations.

Source: VA OIG developed using Veteran Affairs Site Tracking (January 19, 2021) and RCS data (as of March 8, 2021).

The leadership and organizational risks review is specific to the district and zone offices and included interviews with district leaders and assessment of

- leadership stability,
- quality improvement activities,
- VA All Employee Survey,
- Vet Center Service Feedback survey results, and
- response results gathered through a zone-wide questionnaire sent to all VCDs.

The assessment of quality reviews included evaluating the vet center clinical and administrative oversight reviews for the zone and evaluating crisis reports and critical incident quality reviews. Results from the leadership and organizational risks review generally do not rise to the level of findings.

The COVID-19 response review results were obtained through a zone-wide questionnaire to staff and interviews with district leaders and VCDs from the four selected vet centers. The COVID-19 review was designed primarily to gather information from leaders and staff within the zone and to draw general conclusions. Results from the COVID-19 response review generally do not rise to the level of findings.

The suicide prevention review included a zone-wide evaluation of RCSnet electronic client records with results and recommendations specific to the district office, and a focused review of the four selected vet centers with results and recommendations to the district office and the four vet center sites.⁴⁴

The consultation, supervision, and training review and environment of care review evaluated the four selected vet centers with results and recommendations specific only to those sites.

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).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, (codified as amended 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leadership if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

⁴⁴ For vet center clients shared with support VA medical facilities, the OIG also reviewed VA electronic health records.

Results and Recommendations

Recommendations target deficiencies that, if improved, would positively influence the quality of client care. District leaders' comments submitted in response to the report recommendations appear under the respective recommendation.

Leadership and Organizational Risks

Leadership and organizational risks can affect a healthcare system's ability to provide safe and sustainable care.⁴⁵ Stable and effective leadership is critical to improving care and sustaining meaningful change within a healthcare system and effective healthcare leadership is essential for achieving quality of care.⁴⁶

The OIG assessed district 2 zone 2's leadership and organizational risks by evaluating the following:

- District leadership position stability
- Quality improvement activities
- VA All Employee satisfaction results
- Vet Center Service Feedback survey
- Leadership and organizational risk questionnaire results⁴⁷

District Leadership Position Stability

The RCS district director oversees the deputy district director who is responsible for an assigned zone (one deputy per zone). The deputy district director supervises the two zone associate district directors. The associate district director for counseling is responsible for providing guidance on all clinical operations, including clinical quality reviews and critical incident reporting. The associate district director for administration is responsible for providing guidance on all administrative operations and administrative quality reviews. VCDs report to the deputy district director and are responsible for overall vet center operations including staff supervision,

⁴⁵ Botwinick L, Bisognano M, Haraden C. *Leadership Guide to Patient Safety*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2006.

⁴⁶ Sfantou, D, Laliotis, A, Patelarou, A, Sifaki-Pistolla, D, Matalliotakis, M, Patelarou, E, *Importance of Leadership Style towards Quality of Care Measures in Healthcare Settings: A Systematic Review*; Healthcare (Basel). 2017 Dec; 5(4): 73. Published online October 14, 2017.

⁴⁷ The leadership and organizational risk questionnaire is a tool the OIG used to ask zone wide VCDs about quality improvement to evaluate knowledge and practices.

administrative and fiscal operations, outreach events, community relations, hiring staff, and clinical programs (see figure 7).⁴⁸

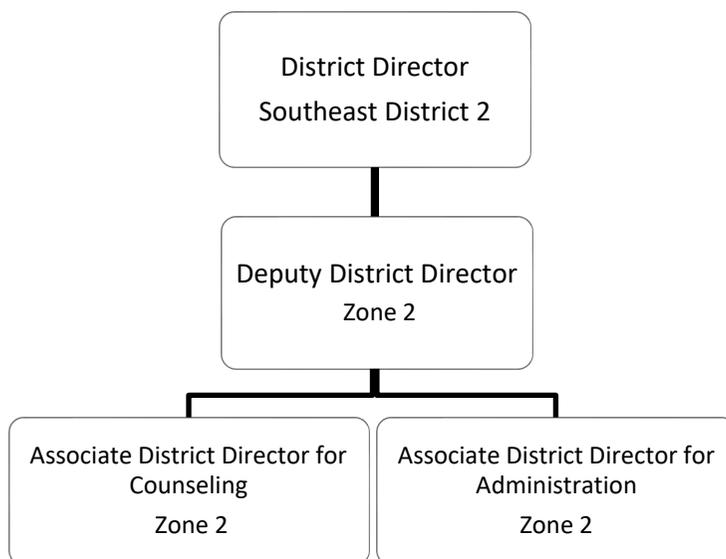


Figure 7. District 2 zone 2 leaders.
Source: VA OIG analysis of district organizational chart.

At the time of the inspection, three of four district leaders had been working together as a group for more than three and a half years. The District Director had served in the position since 2011, the Deputy District Director since 2017, and the Associate District Director for Counseling since 2013. The Deputy District Director reported the Associate District Director for Counseling served as the acting Deputy District Director for more than a year, until March 2020. The Associate District Director for Administration was vacant for 13 days at the time of inspection; however, coverage was provided by the individual holding the same position in zone 1 during the vacancy.

For the 12 months prior to the date of the inspection, seven of 24 VCD positions were vacant in zone 2. Three of these positions, Miami, Ponce, and Jacksonville VCDs, were vacant for greater than six months. However, the District Director confirmed an acting VCD was assigned for the duration of each vacancy. The District Director reported recruitment and retention as barriers for hiring.

⁴⁸ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

Quality Improvement Activities

To assess leaders' knowledge about healthcare quality principles and practices, the OIG interviewed district leaders. Generally, the majority of district leaders reported spending 10 or more hours a week engaged in quality improvement activities across the zone. District leaders stated they did not have a dedicated district quality department and relied on VCDs for quality activities at the vet center level. District leaders were knowledgeable about the basic concepts of healthcare quality and were generally able to speak in detail about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and client experience. The District Director, while having previous knowledge of a just culture, stated the concept was introduced to their leadership team last year.⁴⁹ Overall, district leaders listed general characteristics of a just culture.

Employee Satisfaction

The VA All Employee Survey was originally developed in 2001 to meet VA needs in assessing workforce satisfaction and organizational climate. According to the VHA National Center for Organization Development, the All Employee Survey is an annual, voluntary, census survey of VA workforce experiences.⁵⁰ Responses are confidential and data anonymous. The instrument has been refined several times since 2001 in response to operational inquiries by VA leadership on VA culture and organizational health relationships.⁵¹ Although the OIG recognizes that employee satisfaction survey data are subjective, the information can be a starting point for discussions, be indicative of areas for further inquiry, and be considered along with other information for leaders' evaluation.

District leaders identified the top three fiscal year 2019 VA All Employee Survey priorities as communication, growth, and workload.⁵² The OIG asked district leaders how the VA All

⁴⁹ Health Quality Council of Alberta, accessed March 2, 2021, <https://hqca.ca/healthcare-provider-resources/just-culture/>. "Just culture is an atmosphere of trust in which healthcare workers are supported and treated fairly when something goes wrong with patient care. Just culture is important to patient safety as it creates an environment in which people (healthcare workers and patients) feel safe to report errors and concerns about things that could lead to patient adverse events." The OIG asked leaders to "Describe how you promote a just culture in which staff can experience the psychological safety necessary to bring issues forward."

⁵⁰ "VA All Employee Survey," VA National Center for Organization Development, accessed September 10, 2019, <https://www.va.gov/ncod/vaworkforcesurveys.asp>

⁵¹ "Healthy organizations are places where employees want to work and customers want to receive services." Smith, J. L. and McCarren, H., VHA National Center for Organization Development, *Organizational Health*, "Developing servant leaders contributes to VHA's improved organizational health," Volume 19, Summer 2013. Osatuke, K., Draime, J., Moore, S.C., Ramsel, D., Meyer, A., Barnes, S., Belton, S., Dyrenforth, S.R. (2012). Organization development in the Department of Veterans Affairs. In T. Miller (Ed.), *The Praeger handbook of Veterans Health: History, challenges, issues and developments, Volume IV: Future directions in Veterans healthcare* (pp. 21-76). Santa Barbara, CA: Praeger.

⁵² District leaders identified the top three VA All Employee Survey priorities from survey group responses composed of district 2 zone 2 vet center directors.

Employee Survey results were prioritized and what changes were made within the zone based on the survey findings. District leaders reported implementing actions including but not limited to the following:

- Weekly learning sessions for staff
- Monthly learning meeting for outreach specialists for sharing best practices
- Quarterly town hall meetings
- Additional virtual learning platforms
- Caseload complexity tool
- Weekly VCD meetings

In response to workload improvements, one district leader discussed the potential for counselor occupational burnout that led to the development of a caseload complexity tool. VCDs can use the instrument to evaluate a counselor's caseload for client acuity, lethality risk, complexity, and number of case referrals. The district leader stated the tool results can be used to adjust staff caseloads in order to improve caseload manageability, client care, and reduce occupational burnout. While the district leader reported the caseload complexity tool was used in the zone, the OIG did not review the results of the tool.

Vet Center Service Feedback Survey

RCS requires a Vet Center Service Feedback survey for a client once a case is closed or a client has not been seen in the last one hundred days and other selected criteria are met.⁵³ The Vet Center Service Feedback survey includes feedback from clients. In addition to the requirements described in the report for sending Vet Center Service Feedback, RCS uses the following criteria: clients agree to participate in questionnaire, clients are not receiving services from a VA contracted provider, and there is no indication the client is deceased. Results from the survey provide district leaders and VCDs with feedback to evaluate the effectiveness of readjustment counseling.⁵⁴ The RCS national database system maintains all client survey feedback and compiles district and national data into summary reports.⁵⁵

⁵³ Readjustment Counseling Service, *Response to OIG for RCS Preliminary Research*, April 15, 2020. VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021.

⁵⁴ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021. RCS updated the Vet Center Client Satisfaction survey to the Vet Center Service Feedback survey.

⁵⁵ RCS has a National Service Support section of its program office that maintains its database tracking system.

The OIG found district 2 zone 2 feedback results were favorable.⁵⁶ Overall, fiscal year 2019 Vet Center Service Feedback scores for district 2 zone 2 exceeded national scores. Clients, service members, and family members reported overall average satisfaction with appointment availability, staff courtesy, and vet center services (see table 2).

**Table 2. Vet Center Service Feedback Survey Results
(October 1, 2018 September 30, 2019)**

Questions	District 2 Zone 2 Average Score*	RCS National Average Score*
I was treated in a welcoming and courteous manner by the Vet Center staff.	4.90	4.77
My appointments have been scheduled at a time that was convenient.	4.85	4.72
I would likely recommend the vet center to another Veteran, servicemember, or family member.	4.85	4.77
The Vet Center services were located conveniently in my community.	4.55	4.52
I feel better as a result of the services provided by the Vet Center staff.	4.85	4.66
How satisfied were you with the overall quality of services at the Vet Center?	4.85	4.61

Source: VA OIG developed based on RCS National Service Support data. The OIG did not assess VA’s data for accuracy or completeness.

**Scoring 1=very dissatisfied, 2=dissatisfied, 3=neither satisfied nor dissatisfied, 4=satisfied, 5=very satisfied*

Three district leaders reported the culture of customer service fostered from the top down had a positive impact on Vet Center Service Feedback scores. The Associate District Director for Administration stated the annual budget planning process for vet centers included a checklist for client comfort, functionality of the environment, and transportation access points for the building that contributed to the favorable scores for vet center accessibility. District leaders believed the emphasis they and staff placed on creating a vet center environment that was welcoming and homelike and improved counseling services positively influenced overall quality satisfaction feedback scores.

Leadership and Organizational Risk Questionnaire

To evaluate the perspectives of VCDs about selected quality improvement activities and organizational health, the OIG sent a leadership and organizational risk questionnaire to all zone 2 VCDs consisting of six questions and an optional feedback question. Of the 24

⁵⁶ The OIG considered the Vet Center Service Feedback survey results favorable because scores averaged four or more and exceeded RCS national averages in all categories.

questionnaires distributed, 18 were returned. The questionnaire had open-ended questions (with one exception) with no categories or options provided for selection. The OIG reviewed responses for themes, best practices, and concerns.⁵⁷

Overall, VCDs had a good understanding of quality improvement and perceived their role as important to driving and overseeing quality improvement activities. On average, VCDs reported spending approximately five hours or more per week engaged in quality functions. VCDs stated they promoted a just culture in which staff can experience the psychological safety necessary to bring issues forward. VCDs cited various ways they achieved psychological safety in the work place including individual supervision, weekly team meetings, staff engagement, transparency, and an open-door policy. VCDs reported using the fiscal year 2019 VA All Employee Survey results to develop action plans and set goals with staff. VCDs were asked how leaders supported quality planning. Responses indicated leaders supported quality planning through communications, allotment of administrative time, funding, guidelines, training, and feedback. One respondent described a delay in availability of resources; however, no further details were provided. A review of all the responses showed no safety concerns.

Leadership and Organizational Risks Conclusion

District 2 zone 2's leadership team appeared stable and cohesive, with sufficient coverage in place for position vacancies. Generally, district leaders and VCDs had a good understanding of quality improvement and perceived their role as important to driving and overseeing quality improvement activities. District leaders implemented district-wide quality improvement programs in the past year in response to the 2019 VA All Employee Survey results, and VCDs used the results to establish action plans and goals with staff. District leaders acknowledged they relied on VCDs for quality tasks and stated the need for a dedicated district-level quality department. District leaders reported a fairly recent introduction of the just culture concept and described its key characteristics. District leaders felt the culture of customer service fostered from the top down and the annual budget planning for vet centers had a positive impact on the client and family experience. Questionnaire responses indicated VCDs took actions to create a safe environment for staff to bring issues forward.

Quality Reviews

VHA leaders have articulated the goal to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care.⁵⁸ In its effort to ensure quality of care, client safety, and

⁵⁷ The OIG reviewed and categorized VCD responses for general themes.

⁵⁸ VA, VHA's *Blueprint for Excellence – Fact Sheet*, September 2014.

oversight, RCS policy outlines the use of various tools to monitor its wide range of psychosocial and psychological services to clients.⁵⁹

The OIG evaluated district 2 zone 2's quality oversight in the following areas:

- Clinical and administrative quality reviews
- Critical incident quality reviews

Clinical and Administrative Quality Reviews

RCS requires an annual quality review of all vet centers to ensure compliance with policies and procedures for the administration and provision of readjustment counseling.⁶⁰ Annual quality reviews are composed of separate clinical and administrative reviews.

Clinical quality reviews included multiple areas of evaluation:

- Vet center team composition
- Access to vet center services
- Readjustment counseling
- Active client caseloads
- Clinical productivity
- Customer feedback⁶¹

Administrative quality reviews included multiple areas of evaluation:

- Vet center key staff
- Vet center physical site
- Administrative operations
- Privacy and information security management

⁵⁹ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

⁶⁰ VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. Vet Center Contract for Fee (CFF) Program uses “contract service providers to provide readjustment counseling to eligible individuals and their families in communities distant from established vet centers.” Vet centers managing a CFF program must also have a CFF annual quality review.

⁶¹ RCS-CLI-003, *Revised Clinical Site Visit (CSV) Protocol*, January 25, 2019.

- Quality management
- Fiscal management⁶²

RCS policy requires district directors ensure annual vet center clinical and administrative quality reviews are conducted.⁶³ Deputy district directors are responsible for approving annual clinical and administrative quality reviews and remediation plans.⁶⁴ Associate district directors for counseling and administration conduct the annual quality reviews that result in written reports. Deficiencies identified in the annual quality review are included in the report.⁶⁵

Within 30 days of receiving the annual quality review report, the VCD, with the help of the associate district director for counseling or administration, develops a remediation plan with target dates for deficiencies to be corrected.⁶⁶ Within 60 days from the date the deputy district director approves the remediation plan, the VCD is responsible for resolving all deficiencies.⁶⁷ The associate district director for counseling or administration is required to conduct a follow-up review within 30 days of the target date for completion of the remediation plan to validate the resolution of all deficiencies (see figure 8).⁶⁸

⁶² Readjustment Counseling Service, “District 1 Vet Center Administrative Quality Review Template,” sections I. to VI., revised October 24, 2016.

⁶³ RCS-CLI-001, *Vet Center Clinical and Administrative Site Visits*, November 2, 2018.

⁶⁴ RCS-CLI-001, November 2, 2018; RCS-CLI-003, *Revised Clinical Site Visit (CSV) Protocol*, January 25, 2019.

⁶⁵ RCS-CLI-001, November 2, 2018; RCS-CLI-003, January 25, 2019.

⁶⁶ RCS-CLI-001, November 2, 2018.

⁶⁷ RCS-CLI-001, November 2, 2018; RCS-CLI-003, January 25, 2019.

⁶⁸ RCS-CLI-001, November 2, 2018.

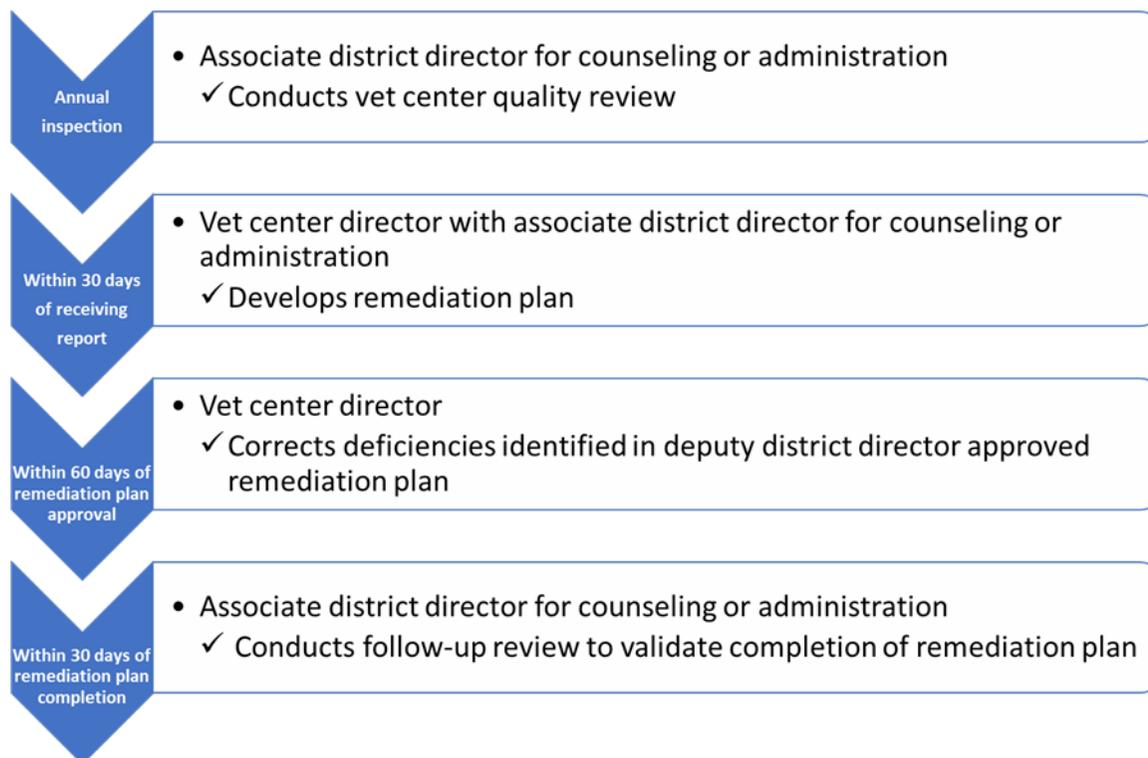


Figure 8. Vet center administrative and clinical quality review process.

Source: VA OIG graphic developed based on RCS guidance, RCS-CLI-001, November 2, 2018. VHA Directive 1500(1), January 26, 2021, amended May 3, 2021, does not include a step for the deputy district director’s approval of the remediation plan; the requirement remains per RCS-CLI-001.

The OIG evaluation for the clinical and administrative review processes for all zone 2 vet centers included interviewing district leaders and review of

- clinical and administrative site visit reports, and
- clinical and administrative remediation plans.⁶⁹

Clinical and Administrative Quality Reviews Findings and Recommendations

Overall, the OIG found district 2 zone 2 noncompliant with requirements for clinical and administrative quality reviews.

District leaders monitored the provision of readjustment counseling and vet center operations through clinical and administrative quality reviews. Quality review responsibilities were managed by the zone Associate District Directors for Counseling and Administration with the

⁶⁹ The OIG interviewed the zone 1 Associate District Director for Counseling who was covering for the zone 2 position at the time of the inspection.

Deputy District Director responsible for final approval of quality review reports and remediation plans. For each vet center, the Associate District Director for Counseling completed an annual clinical quality review and the Associate District Director for Administration completed an administrative quality review. The reviews were separate and each review resulted in a report. Both leaders were knowledgeable about RCS vet center clinical and administrative quality review requirements.

The Deputy District Director told the OIG the Associate District Directors for Counseling and Administration managed the vet center quality reviews. The OIG asked both Associate District Directors how district leaders determined when quality review report deficiencies were resolved. Neither leader reported a standardized process for evaluating corrected deficiencies.

The Associate District Director for Counseling stated clinical quality reviews are templated in RCSnet. To indicate resolution, a radial button is clicked that turns the item gray. When asked for written guidance on this practice, the Associate District Director for Counseling was unable to provide a policy for the practice. Both Associate District Directors reported the template for administrative quality reviews was not yet in RCSnet. The Associate District Director for Administration stated working with VCDs during the remediation process enabled them to ensure deficiencies were corrected.

Since annual quality review reports are required by RCS, a total of 48 (including both clinical and administrative quality reviews) were expected. The OIG found 19 of 48 quality review reports were not completed. On average, it took the deputy district director 43 days to approve quality review reports from the date of the site visit.⁷⁰ The shortest amount of time for a report to be approved was zero days, and the longest 365 days. A delay in the district report approval process might delay the resolution of the vet center deficiency and affect prompt and effective health care quality improvements.

Of the 29 completed quality review reports, 14 had deficiencies.⁷¹ The OIG found that 11 of 14 reports with deficiencies did not complete remediation plans. For the three vet centers with remediation plans, the deputy district director approved the plans. The OIG requested documentation showing resolution for all site visit deficiencies, and identified deficiencies were corrected for one of three remediation plans.⁷²

Table 3 below summarizes results from the OIG's evaluation of zone 2's clinical and administrative quality reviews.

⁷⁰ The OIG concluded the average of 43 days for district leader approval for quality site visit reports was an unreasonable delay.

⁷¹ The 14 reports represent 13 vet centers' quality reviews.

⁷² For the purpose of this report, the OIG team considered action plans as remediation plans.

**Table 3. District 2 Zone 2 Vet Center Quality Reviews
(August 1, 2019 July 31, 2020)**

Requirement	Expected Reports	Completed Reports
Annual Clinical Quality Reviews	24	17
Annual Administrative Quality Reviews	24	12
Total Annual Quality Reviews	48	29

Source: VA OIG analysis based on district 2 zone 2 documents.

The OIG identified the following findings:

- Nineteen of 48 clinical and/or administrative annual quality site reviews were not completed.
- Eleven of 14 quality review reports with deficiencies did not complete remediation plans.

Recommendation 1

The District Director determines reasons clinical and administrative quality reviews were not completed and monitors compliance.

District Director response: Concur

Readjustment Counseling Services (RCS) requires that every Vet Center receive an administrative and clinical oversight visit within a given fiscal year. Since the OIG period of inspection, the clinical quality review has been automated allowing for monitoring compliance. The administrative quality review process remains a manual process and is scheduled monthly for review with trackers in place. The District will monitor compliance.

Status: In progress

Target date for completion: February 2022

Recommendation 2

The District Director evaluates the clinical and administrative quality review report approval process to determine if a timeliness measure is needed and takes action as indicated.

District Director response: Concur

Since the time of review, the clinical site visit has been automated and timelines for the completion of the site visits are included. The District's manual monitoring of the timeline for completing administrative site visits will include the timelines specified in RCS policy.

Status: In progress

Target date for completion: February 2022

Recommendation 3

The District Director determines reasons clinical and administrative quality review remediation plans were not completed, ensures completion, and monitors compliance.

District Director response: Concur

The District Office lacked a standardized process for validating corrected deficiencies after the Vet Center Director's notification of completed reviews. The District will include a review process into the monitoring of site visits as described in the response to the recommendation 2 above.

Status: In progress

Target date for completion: February 2022

Recommendation 4

The District Director evaluates the process for resolution of clinical and administrative quality review deficiencies and takes action as necessary.

District Director response: Concur

The District is evaluating the reconciliation of the remediated items to ensure this step in the process is monitored. Based on the results from the aforementioned evaluation, District leaders will take corrective action and monitor results.

Status: In progress

Target date for completion: February 2022

Critical Incident Quality Reviews

As noted in VHA policy, careful investigation and analysis of client safety events (events not primarily related to the natural course of the patient's illness or underlying condition), as well as evaluation of corrective action, are essential to reduce risk and prevent adverse events.⁷³ RCS

⁷³ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

requires the VCD to complete a crisis report within 24 hours of a serious suicide or homicide attempt or when a client dies by suicide or homicide, with notification to the district and the RCS Central Office within 48 hours.⁷⁴

At the time of the OIG's inspection, RCS also required critical incident quality reviews (also known as mortality and morbidity reviews) for client safety events including serious suicide or homicide attempts, death by suicide, or homicide, when the client is only seen at the vet center.⁷⁵ Vet center clients who are shared with VA medical facilities should have the mortality and morbidity review completed by the VA medical facility.⁷⁶ Critical incident quality reviews follows the psychological autopsy protocol to evaluate actions taken and make recommendations to improve the effectiveness of vet center suicide prevention activities.⁷⁷

To examine the quality oversight process, the OIG requested critical incident quality reviews, reviewed documents, interviewed district leaders, and evaluated crisis reports completed for clinical critical events that occurred during the review period.⁷⁸

Critical Incident Quality Reviews Findings and Recommendations

Overall, the OIG found district 2 zone 2 noncompliant with requirements for critical incident quality reviews. The OIG identified that evaluation of actions taken for clinical critical events and recommendations for improvement of vet center suicide prevention activities did not occur.

A total of eight crisis reports were reviewed, seven for suicide attempts and one for a client death by suicide. A review of documentation showed no crisis reports for homicide-related events.

In response to the request for all critical incident quality reviews, the OIG received one quality review document. The quality review was completed by the support VA medical facility in

⁷⁴ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

⁷⁵ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. The term critical incident quality review is not used in the 2021 directive; the directive refers to all such reviews as mortality and morbidity reviews.

⁷⁶ VHA Handbook 1500.01, September 8, 2010.

⁷⁷ Isometsä, ET, Psychological autopsy studies – a review, *Eur Psychiatry*, November 2001 16(7): 379-85, "Psychological autopsy studies—a review," accessed December 9, 2020, <https://pubmed.ncbi.nlm.nih.gov/11728849/>. "A psychological autopsy synthesizes information from multiple informants and records." VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. A psychological autopsy is completed after a suicide or homicide attempt or completion that documents pertinent information related to the client's case such as family, social and military history, presenting problems, clinical case information, and other factors related to the incident.

⁷⁸ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. Crisis reports are used to document clinical critical events in RCSnet.

response to a death by suicide for a shared client and included participation of the Associate District Director for Counseling. However, the review did not include a vet center course of treatment for the deceased, presenting problems, RCS actions taken, or recommendations to improve the effectiveness of vet center suicide prevention activities as required.⁷⁹ The absence of an RCS review of actions taken for the client death by suicide may have prevented immediate and long-term improvement in suicide prevention activities.

Seven crisis reports for clinical critical events were listed as suicide attempts. Six of the seven reported suicide attempts resulted in the client being transported to a hospital for further evaluation and treatment.⁸⁰ The OIG requested all critical incident quality reviews for the inspection period, one was provided for a death by suicide; however, no reviews were provided for serious suicide attempts, as required.⁸¹

The Associate District Director for Counseling told the OIG it was a judgment call if a critical incident quality review was done for suicide attempts. Based on the Associate District Director's response and absence of documentation, the OIG determined there was no clear process to decide when a critical incident quality review was conducted for a suicide attempt. Crisis reports were completed for suicide attempts; however, the reports did not include any information about critical incident quality reviews.

Recommendation 5

The District Director determines reasons for noncompliance with critical incident quality review (currently known as morbidity and mortality review) of a death by suicide, ensures completion includes an evaluation of vet center services to determine if actions are needed to improve the effectiveness of vet center suicide prevention activities, and monitors compliance.

⁷⁹ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. RCS requires quality review reports to include an evaluation of actions taken and recommendations to improve the effectiveness of vet center suicide prevention activities.

⁸⁰ RCS policy does not define a serious suicide attempt; in the absence of an RCS definition of a serious suicide attempt, the OIG considered the client being transferred to the hospital an indicator of a serious suicide attempt that would have met the criteria for completion of a critical incident quality review.

⁸¹ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. RCS requires quality review reports be completed for serious suicide attempts.

District Director response: Concur in principle

At the time of this review, the District conventionally participated in a root cause analysis conducted by the VA medical center (VAMC) on a shared client (VAMC and Vet Center) who died by suicide. The updated VHA Directive 1500 (January 2021), establishes that when a root cause analysis is conducted by a local VAMC for a shared RCS client, it meets the required standard for a morbidity and mortality review. The purpose of RCS's participation in the VAMC's root cause analysis process is to include any potential implications for RCS's services. It is the decision of the panel to determine actions. VHA considers this recommendation fully implemented and request OIG consider closure.

Status: Request Closure

Target date for completion: Complete

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

Recommendation 6

The District Director determines reasons for noncompliance with critical incident quality reviews (currently known as morbidity and mortality reviews) for serious suicide attempts, ensures completion, and monitors compliance.

District Director response: Concur in principle

The determination of what is a serious suicide attempt is conventionally made by District leaders through consultation with the Vet Center and review of the circumstances of the case and the application of clinical judgement. The District will work to place a non-visit progress note into the record documenting the decision related to whether the event was deemed a serious suicide attempt requiring a morbidity and mortality review.

Status: In progress

Target date for completion: February 2022

COVID-19 Response

On March 11, 2020, because of the spread of COVID-19 globally, the World Health Organization declared a pandemic.⁸² On March 16, 2020, in an effort to ensure continuity of services and to protect uninfected clients and staff from acquiring COVID-19, RCS began to require vet centers to screen all visitors for COVID-19, document screening results, and refer clients with positive screens to the appropriate level of care. RCS issued guidance for telephone and walk-in screening procedures:

- Complete telephone screenings 24 hours prior to all scheduled appointments.
- Refer client calls back to vet centers for screening completion.
- Institute appointment reminder calls to complete screenings.
- Work with local VA medical facility and community health partners to determine appropriate referrals for visitors with positive screens.⁸³

On March 20, 2020, RCS issued a COVID-19 operational assessment guide focused on client needs and local environment for its operational decisions. RCS required (1) districts to report vet center operation levels to its centralized operations office daily, (2) deputy district directors to communicate guidance and operational plans within zones, and (3) VCDs to provide COVID-19 updates to employees during staff meetings.⁸⁴

In response to the pandemic, on March 23, 2020, VHA's Office of Emergency Management issued guidance, the *COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan* (COVID-19 Response Plan), detailing steps for providing access to and delivery of health care while protecting veterans and employees from COVID-19. The COVID-19 Response Plan states that during the pandemic, "RCS will ensure continuity of access to and delivery of readjustment counseling, outreach, and care coordination to veterans, service members and their families, first responders and the public, as appropriate."

⁸² "A pneumonia of unknown cause detected in Wuhan, China, was first reported to the World Health Organization (WHO) Country Office in China on 31 December 2019. The virus was later named 'SARS-CoV-2' and the disease it causes named 'coronavirus disease 2019' (abbreviated 'COVID-19')." *VHA – OEM, COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan, Version 1.6*, March 23, 2020. World Health Organization, "WHO Director-General's opening remarks at the media briefing on COVID-19 – 11 March 2020," accessed on August 20, 2020, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>. Merriam-Webster, *Definition of pandemic*. A pandemic is an outbreak of a disease that occurs over a wide geographic area and affects an exceptionally high proportion of the population, accessed on June 23, 2021, <https://www.merriam-webster.com/dictionary/pandemic>.

⁸³ RCS-OPS-001, Vet Center Novel Coronavirus Screening (COVID-19), March 16, 2020.

⁸⁴ RCS-OPS-004, COVID-19 Readjustment Counseling Service (RCS) Operational Level Assessment, March 20, 2020.

In an effort to keep staff safe and to mitigate against equipment barriers that might interfere with client services, RCS issued telework guidance on March 23, 2020.⁸⁵ The guidance encouraged designating as many telework eligible staff as appropriate but stated decisions must be made in response to local environments. District directors were tasked to ensure that all vet center staff were telework-ready and were given authority to place staff on telework status as appropriate.⁸⁶ An RCS memorandum issued on March 31, 2020, stated “As the population risk of COVID-19 exposure increases, so will our need to leverage telework and telehealth to meet the needs of those we serve.”⁸⁷ In addition to using VA Video Connect (VVC), RCS permitted the use of VA National Telecommunications System (VANTS) teleconferencing for group therapy sessions.⁸⁸

To evaluate district and vet center preparedness for mitigation of and response to potential impacts from the COVID-19 pandemic, the OIG review examined the five following areas:

- Emergency planning
- Communication and field guidance (district leaders only)
- Supplies and infrastructure
- Access and client care—telework and telehealth
- Client screening including referral

District Leaders

The OIG interviewed district leaders to discuss the five topics noted above. The information provided in this section is based on those interviews.

Emergency Planning

Three of four leaders reported feeling initially ill-prepared for the pandemic. District leaders described not having previous experience in managing such an emergency despite their location in a geographic region area subject to hurricanes and earthquakes. One leader described being adequately prepared at the onset of the pandemic and attributed the state of readiness to previous work experience. District leaders reported having an emergency operation plan prior to March 11, 2020, although it had not been evaluated for updates. District 2 deployed mobile vet centers

⁸⁵ RCS-ADM-005, *COVID-19 Readjustment Counseling Service (RCS) Guidance for Telework and Duty Location*, March 23, 2020.

⁸⁶ RCS-ADM-005, March 23, 2020. RCS defines telework-ready as an employee who is eligible to telework, has an approved written telework agreement and has taken required training.

⁸⁷ RCS-OPS-005, *COVID-19 Response: Use of VANTS for Group Counseling*, March 31, 2020.

⁸⁸ VVC is a VHA online platform used for the provision of video telehealth for mental health services. VVC uses computer webcams, smart phones, and tablets to administer telehealth-based therapy to veterans. VANTS was the VA National Telecommunications System used for conference calls (it is no longer operational).

and staff from north to south Florida where they provided support to a VA medical facility. District leaders stated when the pandemic first started, vet centers remained open and staff continued to see clients face-to-face. District leaders reported staff increased use of VANTS line technology and VVC for counseling services although face-to-face services continued to remain available.

Communication and Field Guidance

Three of four leaders reported that initially RCS Central Office communication related to the pandemic was not timely. The District Director and the Associate District Director for Administration reported information was changing so quickly in the beginning that RCS Central Office field guidance was not always timely. Two of the four district leaders felt information was not adequate. In response, the Deputy District Director sought data from websites including the Centers for Disease Control and Prevention (CDC).⁸⁹ The District Director stated when RCS Central Office responded with guidance that supported telehealth services and telework for staff to work remotely, within two weeks of its issuance, the district implemented 300 telework agreements. The Deputy District Director stated the District Director initially led emergency meetings with district leaders twice a day; later the frequency was decreased to twice a week. At the time of the inspection, the leader reported the emergency meetings were still occurring weekly.

Supplies and Infrastructure

One of four district leaders reported an inadequate amount of sanitization supplies when the pandemic started; however, during the OIG interviews, all district leaders reported adequate supplies. One district leader stated the response of RCS to the vet centers' need for personal protective equipment occurred in April 2020. The District Director reported the district received personal protective equipment from the RCS Central Office for the vet centers and that a process was in place to ensure all vet centers had a 90-day supply of masks. The Associate District Director for Counseling confirmed that there was a process in place for vet centers to replenish when mask supplies were low to maintain a 90-day supply. The Associate District Director of Administration stated leases had contract language for cleaning and work was underway to customize the contract language to meet CDC recommended cleaning guidelines. Amenities such as self-serving coffee stations were removed from vet centers secondary to CDC guidelines. Social distancing practices included floor markings for distance, staggering chairs, and outdoor groups for clients when possible.

⁸⁹ The CDC is part of the Department of Health and Human Services. The CDC's mission is to protect America against dangerous health threats.

Access and Client Care—Telework and Telehealth

District leaders reported all staff were authorized to telework and all vet centers started to offer telehealth services. While all staff were authorized to telework, one district leader reported some staff chose not to telework. District leaders created an internal process to track staff telework agreements and telework training requirements. District leaders reported telework agreements were approved for all staff who teleworked.

Client Screening

The District Director stated when clients entered vet centers, screenings were done, temperatures taken, and masks provided. The District Director gave examples of the process if clients chose not to wear masks; they were offered a phone visit and not seen in person by vet center staff.

Vet Center Directors

The OIG interviewed the VCDs of the four selected vet centers about emergency planning, supplies and infrastructure, access and client care, telework and telehealth, and client screening including referral. The information provided in this section is based on those interviews.

Emergency Planning

The four VCDs interviewed were adequately prepared to respond to the pandemic, with Ponce and Sarasota VCDs reporting that district office provided weekly briefings. Each vet center had an emergency plan in place at the onset of the pandemic, but the Clearwater, Ponce, and Sarasota VCDs had not yet evaluated the plans effectiveness since the beginning of the pandemic. The Ponce VCD reported examples of data that were useful throughout the pandemic such as a Department of Health tracker monitoring the infection rate and bed and ventilator availability at local hospitals, while the Clearwater and Ocala VCDs reported that some data such as survival rates, local guidance, or other would have been helpful at the onset. The vet centers reported receiving data from RCS Central Office, community partners, and VA. Each VCD reported having established referral mechanisms with local VA medical facility and community health partners for clients with positive screens for COVID-19, and worked with community stakeholders to assist during the pandemic.

Supplies and Infrastructure

RCS's Moving Forward Plan states that in a culture of safety, all staff should follow cleaning and distancing guidelines established by CDC, VHA, and federal guidance.⁹⁰ The Ponce and Sarasota VCDs reported having adequate cleaning supplies, while the Clearwater and Ocala

⁹⁰ RCS. *RCS Moving Forward Plan, Balancing Readjustment Counseling Services in the COVID-19 Era*. July 11, 2020.

VCDs reported not having an adequate supply of cleaning products and hand sanitizers at the onset of the pandemic. The Clearwater VCD discussed purchasing disinfectant spray with personal funds. The Clearwater, Ponce, and Sarasota VCDs reported implementing a cleaning and disinfecting plan, with the Clearwater and Ponce VCDs reporting cleaning of high touch surfaces and daily cleaning of the office while the Ocala VCD reported being unsure of the disinfecting plan and having a daily cleaning service. The four selected vet centers reported taking steps to encourage social distancing in communal areas and had soap and water stations for hand washing.

Access and Client Care—Telework and Telehealth

RCS's Moving Forward Plan outlines considerations for both virtual and traditional care to safeguard clients and staff. The four VCDs reported that following the onset of the pandemic clinical staff were approved to provide telehealth services. Telehealth services and equipment were available at the four vet centers, and clients who were unable to be seen in person were offered alternative services such as telehealth, teleconferencing, or phone counseling services.

Client Screening Including Referral

Beginning on March 16, 2020, vet centers were required to initiate both telephone and walk-in screenings for all visitors to vet centers, including screenings 24 hours prior to all scheduled appointments. All positive screens were to be referred to local VA medical facilities and community partners and reported to district office for further coordination.⁹¹ The four VCDs reported referring clients with positive COVID-19 screens to the appropriate level of care (client was referred to local VA medical facility or community provider or client was directed to urgent care, an emergency department, or a local health department). The Clearwater and Sarasota VCDs stated efforts were made to place calls 24 hours prior to appointments to screen for COVID-19 symptoms but if unable, clients were screened upon arrival at the vet center. The Ocala and Ponce VCDs reported placing COVID-19 symptom screening calls prior to appointments. The four VCDs stated visitors and walk-in clients were screened at all four vet centers for COVID-19 symptoms.

Zone 2 Staff Questionnaire Responses

The OIG sent a COVID-19 voluntary questionnaire to employees at the 24 zone 2 vet centers.⁹² Of the 141 questionnaires sent, 115 (82 percent) were returned with responses. Employees were asked a series of 14 questions about personal safety, patient safety, communication with district and VCD leaders, COVID-19 mask resources, work assignments, telework, and the availability

⁹¹ RCS-OPS-001, *Vet Center Novel Coronavirus (COVID-19) Screening*, March 16, 2020.

⁹² A questionnaire was sent to 140 employees at the 24 vet centers. One employee received two surveys to provide responses for each of the vet centers the employee represented, creating a total of 141 voluntary questionnaires.

of employee assistance services. The questionnaire contained open-ended questions regarding what staff thought the vet center did well, what needed improvement during the vet centers pandemic response, and lessons learned. The information provided in this section is based on those interviews.

Questionnaire respondents (respondents) indicated that district leaders and VCDs provided communication and thoughtful preparation ensuring employee and client safety. The OIG determined 46 (41 percent) respondents specified they were given new work assignments during the pandemic. Most respondents stated they were offered telework, performed telework, and had telework agreements established. Of the 115 respondents, 98 (85 percent) indicated employee assistance or other types of assistance were available to them since the beginning of the pandemic. Respondents identified best practices since the start of the pandemic such as resource availability for client and staff safety, telehealth, telework, office set-up, and phasing for closing and reopening vet centers. Qualitative responses to “lessons learned” during the pandemic included

- importance of early communication to inform clients of precautionary COVID-19 measures implemented at vet centers,
- critical role of communication to manage the pandemic response,
- need for enhanced safety practices, and
- usefulness of flexibility in treatment delivery so client care can continue.

COVID-19 Response Conclusion

In general, district leaders reported feeling initially ill-prepared for the pandemic despite the issuance of RCS Central Office field guidance within weeks of the pandemic onset. Although initially feeling ill-equipped, district leaders enacted emergency plan procedures and vet centers remained operational. As with many of the nation’s healthcare systems at the onset of the pandemic, sanitation supplies and personal protective equipment were insufficient; however, no shortages existed at the time of the OIG’s inspection. Precautionary measures were implemented with COVID-19 screenings for vet center visitors, and visitors with positive screenings were referred to local care pathways. Since the pandemic, telework rapidly expanded and vet centers increased their reliance on telehealth technology for counseling services. The four VCDs reported following COVID-19 safe practice guidelines and taking appropriate steps to protect the safety of employees and clients. Adequate supplies, hand washing, and hand sanitizer stations were available; masks were worn; and safe social distancing was practiced during the OIG’s virtual inspections of selected vet centers. Overall, employees’ responses to the COVID-19 questionnaire showed that communication, telework, telehealth, and response to the pandemic were managed well by district leaders and VCDs. Employees reported thoughtful preparation was provided by district leaders and VCDs.

Suicide Prevention

The VA *National Suicide Data Report* published in the fall of 2018 found that in 2016, the suicide rate was 1.5 times greater for veterans than for non-veteran adults.⁹³ VA's national strategy for preventing veteran suicide states "Suicide prevention is VA's highest priority, and VA has made great strides in Veteran suicide prevention, especially in crisis intervention."⁹⁴ VHA supports a national goal to reduce suicide within the U.S. by 20 percent by the year 2025 through implementation of a public health model.⁹⁵

RCS was identified as an important part of VA's overall suicide prevention strategy.⁹⁶ On August 28, 2017, a memorandum of understanding between the Office of Mental Health and Suicide Prevention and RCS (Memorandum of Understanding) was signed that required a shared responsibility for suicide prevention between RCS, the Office of Mental Health and Suicide Prevention, and VHA suicide prevention coordinators.⁹⁷ The Memorandum of Understanding defines operations for the identification, notification, and treatment of high risk or suicidal veterans and quality reviews related to veteran suicides for active clients.⁹⁸

VHA has the following requirement for caring for high risk or suicidal veterans:

Each VA medical center must establish a high risk for suicide list and a process for establishing a Category II Patient Record Flag (PRF) to help ensure that patients determined to be at high risk for suicide are provided with follow up for all missed mental health and substance abuse appointments.⁹⁹

The OIG's suicide prevention review evaluated compliance across the zone and at the four selected vet centers for suicide prevention for high risk clients for the following areas:

- Psychosocial and lethality risk assessments (*zone-wide*)
- Access (*four selected vet centers*)

⁹³ VA Office of Mental Health and Suicide Prevention, *VA National Suicide Data Report 2005-2016*, September 2018. The suicide rate included in the report is adjusted for age and gender.

⁹⁴ VA Office of Mental Health and Suicide Prevention, "National Strategy for Preventing Veteran Suicide 2018 2028," accessed December 30, 2019, https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.

⁹⁵ VA Office of Mental Health and Suicide Prevention, "National Strategy for Preventing Veteran Suicide 2018 2028," accessed December 30, 2019, https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.

⁹⁶ Deputy Under Secretary for Health for Operations and Management (10N), "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services." November 13, 2017

⁹⁷ "Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding," August 15, 2017.

⁹⁸ "Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding," August 15, 2017.

⁹⁹ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

- Care coordination and collaboration with VA medical facility (*four selected vet centers*)
- High risk suicide flag client disposition (*four selected vet centers*)
- Crisis plans (*four selected vet centers*)
- Root cause analysis participation and feedback (*four selected vet centers*)

Psychosocial Assessment and Lethality Risk Assessments

RCS states, “the client record is one of the most important components of clinical practice. Properly maintained, the clinical record reflects the quality of treatment.”¹⁰⁰ RCS requires a psychosocial assessment including an intake and military history to be completed by the fifth visit, unless an extension is granted by a supervisor with documentation of a contraindicating clinical circumstance that would prevent completion of these portions in a timely manner.¹⁰¹ Psychosocial assessments are used to gather information about the client “presenting issues and level of functioning” to complete a clinical evaluation.¹⁰²

RCS also requires the completion of a lethality risk assessment, including the clinician’s rationale for the rating, to be “identified by documentation within the first clinical note.”¹⁰³ An RCS Central Office leader reported effective October 2020, RCS replaced the lethality risk assessment within the psychosocial assessment with a “Comprehensive Suicide Risk Assessment and Safety Plan Application.” The new assessment follows the VA/DoD Clinical Practice Guideline by incorporating common terminology used for suicide risk evaluation and consultation practices that are familiar to other clinical providers.¹⁰⁴

¹⁰⁰ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Client Records*, November 23, 2010; VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021.

¹⁰¹ RCS-CLI-003, *Revised Clinical Site Visit (CSV) Protocol*, January 25, 2019; VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Client Records*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. Psychosocial assessments include client intake questions related to the reason for visit, traumatic brain injury screening questions, review of mental status evaluation, evidence of thought disorder and depression, and a health history. Military history includes pre-military developmental history, history of time in service, war zone history, traumatic events, homecoming, impact of military experience, and post military history. Lethality assessment questions cover suicidal thoughts, family history of suicide, feelings related to hopelessness and despair, access to weapons, abuse, alcohol and drug use, homicidal ideations, and serious medical issues.

¹⁰² VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Client Records*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

¹⁰³ RCS-CLI-003, *Revised Clinical Site Visit (CSV) Protocol*, January 25, 2019

¹⁰⁴ *Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services (RCSnet)*, September 19, 2020. *VA/DoD Clinical Practice Guideline For The Assessment And Management Of Patients At Risk For Suicide*, May 2019.

Electronic Client Records

The OIG used zone-wide data extracted from the RCSnet database to evaluate vet center staff compliance with completion of psychosocial and lethality risk assessments.¹⁰⁵ The OIG randomly selected two samples of clients new to vet centers from August 1, 2019, through July 31, 2020:¹⁰⁶

- 60 client records with five or more visits
- 40 clients with four or less visits¹⁰⁷

The OIG reviewed the 60 client records with five or more visits and only retained clients if they had five or more individual counseling visits (excluding veteran outreach specialist visits, group, family, telephone (non-clinical), and bereavement visits). Clients were excluded from the lethality risk assessment sample if the first visit and only encounter was completed by a non-clinician.

For the randomly selected clients, the OIG reviewed electronic client records to determine if intakes and military histories were completed and finalized within the required five visits. If the required intake assessment or military history was not completed, the OIG reviewed records for extenuating circumstances with supervisor approval for delayed documentation. The OIG reviewed electronic client records to determine timely completion of lethality risk assessments by evaluating the first clinical note for inclusion of a clinical rationale for the lethality assessment rating.¹⁰⁸

The OIG was able to determine if intake and military histories were completed through an RCSnet record review. However, the OIG was unable to determine through RCSnet when each section was completed to evaluate timeliness. Despite OIG access to the RCSnet database, dates

¹⁰⁵ The OIG team used a 90 percent benchmark to evaluate electronic client records for compliance with selected RCS requirements for psychosocial assessments (including intake and military histories) and lethality risk assessments.

¹⁰⁶ Sub-population size was randomly selected and weighted for the two samples.

¹⁰⁷ RCS-CLI-003, *Revised Clinical Site Visit (CSV) Protocol*, January 25, 2019. The OIG stratified the population sample given RCS requires completion of the intake and military histories by the fifth visit and lethality by the first visit. The sample of 60 client records (excluding veteran outreach specialist visits, group, family, telephone (non-clinical), and bereavement visits) was reviewed for completion of the intake, military history, and lethality risk assessment. The sample of 40 client records was used to only evaluate completion of the lethality risk assessment since this client group had less than five visits and, therefore, the completion of the psychosocial assessment was not required.

¹⁰⁸ The covering Associate District Director for Counseling told the OIG a first clinical note should document the rationale for a lethality assessment rating. To determine lethality assessment, the OIG team reviewed the first clinical note for a clinical rationale for a lethality rating that included questions from the lethality section of the intake portion of the RCS psychosocial assessment. Lethality section questions included suicidal thoughts, family history of suicide, feelings of hopelessness and despair, access to weapons, physical and sexual abuse history, alcohol and drug use, and serious medical issues.

of completion for intake and military histories were lacking. The OIG discussed with district leaders how staff determines completion dates, and they confirmed they were also unable to determine. District leaders stated RCSnet electronic client records do not have a date visible that would determine when an intake and military history was signed, dated, or completed by clinical staff.¹⁰⁹ The OIG was unable to evaluate if intake and military histories were completed by the fifth visit because of RCSnet limitations.

Psychosocial Assessment and Lethality Risk Assessments Findings and Recommendations

Overall, the OIG found zone 2 vet centers noncompliant with requirements for completion of intake and lethality assessments and military histories summarized in table 4.

**Table 4. Zone 2 Vet Centers Electronic Client Record Reviews
(August 1, 2019–July 31, 2020)**

Psychosocial Section	Number of Client Records Reviewed*	Estimated Percentage Completed Zone-Wide	95% Confidence Interval* (Lower, Upper)
Intake	35	65.7	(50.0, 81.1)
Military History	35	68.6	(52.6, 83.3)
Lethality Risk Assessment	89	30.5	(21.2, 40.5)

Source: VA OIG District 2 Zone 2, RCSnet record reviews.

*The estimate and confidence interval for the lethality risk assessment were calculated using sampling weights based on the proportions of each population sampled. Merriam-Webster. Confidence interval is “a group of continuous or discrete adjacent values that is used to estimate a statistical parameter (such as a mean or variance) and that tends to include the true value of the parameter a predetermined proportion of the time if the process of finding the group of values is repeated a number of times,” accessed on January 21, 2021, <https://www.merriam-webster.com/dictionary/confidence%20interval>.

The OIG identified the following findings:

- Vet centers did not consistently complete the intake portion of the psychosocial assessment.
- Vet centers did not consistently complete the military history portion of the psychosocial assessment.

¹⁰⁹ RCS Acting Director for the National Service Support (NSS) informed the OIG that RCS Central Office is working with Cerner Corporation and VA’s Office of Electronic Health Record Modernization for the development of an RCS-specific electronic client record system. Per district leader interviews, the OIG was unclear of RCSnet’s role in the new electronic client record system.

- Vet centers did not consistently complete lethality risk assessments with the first individual clinical note.

Recommendation 7

The District Director ensures intake assessments are completed and monitors compliance across all zone vet centers.

District Director response: Concur

The District provided training to the field on electronic monitoring of intake assessment completion during FY 2021. The Vet Center Director and District leadership will monitor compliance.

Status: In progress

Target date for completion: February 2022

Recommendation 8

The District Director ensures military histories are completed and monitors compliance across all zone vet centers.

District Director response: Concur

The District provided training to the field on electronic monitoring of military history completions during FY 2021. The Vet Center Director and District leadership will monitor compliance.

Status: In progress

Target date for completion: February 2022

Recommendation 9

The District Director ensures lethality risk assessments are completed and monitors compliance across all zone vet centers.

District Director response: Concur

The District provided training to the field on electronic monitoring of lethality risk assessment completed during FY 2021. The Vet Center Director and District leadership will monitor compliance.

Status: In progress

Target date for completion: February 2022

Recommendation 10

The District Director, in collaboration with Readjustment Counseling Service Central Office, evaluates the limitations of current tools and tracking methods including reasons completion dates are unavailable in RCSnet and ensures compliance with standards for timely completion of intake assessments and military histories.

District Director response: Concur

The District has provided training in FY 2021 to the field regarding completion of intake assessments and military histories by the 5th visit. The Vet Center Director and District leadership will monitor compliance.

Status: In progress

Target date for completion: February 2022

Vet Center Suicide Prevention

The remainder of the report provides inspection findings at the following randomly selected vet centers located in district 2 zone 2:

- Clearwater Vet Center, Florida
- Ocala Vet Center, Florida
- Ponce Vet Center, Puerto Rico
- Sarasota Vet Center, Florida

Access

According to the Memorandum of Understanding, RCS core values includes providing veterans with appointments outside of regular business hours and consists of appointment availability in the mornings, evenings, and weekends at all of its vet centers.¹¹⁰ To assess for compliance, the

¹¹⁰ “Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding,” November 13, 2017.

OIG interviewed the four VCDs and reviewed documents provided of available nontraditional hours at each vet center.

Care Coordination and Collaboration with VA Medical Facilities

To help with care coordination for clients, a vet center designee is required to attend all support VA medical facility mental health council meetings.¹¹¹ The Office of Mental Health and Suicide Prevention and RCS memorandum issued on November 13, 2017, by the Deputy Under Secretary for Health for Operations and Management outlines the following responsibilities:

- Standardizing a communication process between RCS and suicide prevention coordinators
- Sharing lists of flagged veterans at high risk for suicide between support VA medical facilities and RCS
- Timely notification of clients with significant safety risks to suicide prevention coordinators¹¹²
- Training for RCS staff
- Dissemination of a list from the Office of Mental Health and Suicide Prevention to RCS identifying veteran at increased predictive risk of suicide¹¹³
- Identifying those who were receiving RCS counseling services¹¹⁴

The OIG interviewed the four VCDs and requested the following:

- Evidence of the VCD's or designee's participation on VA medical facility mental health council meetings
- VA medical facility high risk for suicide flag lists received
- Office of Mental Health and Suicide Prevention lists received

¹¹¹ VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. Mental health councils at "Each VA medical center must establish and maintain a Mental Health Executive Council that includes representation from core mental health professional disciplines and specialty VA mental health programs with administrative support from the medical center."

¹¹² Timely was defined by the OIG as notification that occurs as soon as pertinent information that would promote safety is available.

¹¹³ Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH-VET) identifies veterans who have a higher risk for suicide through predictive analytics.

¹¹⁴ "Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding," November 13, 2017.

- Documents supporting a standardized communication process with the support VA medical facility suicide prevention coordinator

High Risk Suicide Flag Client Disposition

Isolation and social disconnectedness may leave some clients more vulnerable to self-harm, particularly those who are identified as being high risk for suicide.¹¹⁵ To help monitor these clients, RCS staff created a SharePoint site for VA medical facility identified high risk suicide flag clients who currently receive or have received vet center services within the past 12 months.¹¹⁶ As of May 11, 2020, VCDs were required to review the site monthly for clients seen at their vet center, determine if outreach was needed, and document a disposition.

To assess for compliance, the OIG requested documentation of clients from each vet center identified on the high risk suicide flag SharePoint and any documented disposition from May 2020, through July 31, 2020.

Crisis Plans

RCS serves clients who can be at a higher risk for violence and suicide based on certain factors. According to RCS guidelines,

Characteristics which may render clients at risk include: gender (the majority of completed suicides are males); age (risk increases with age); familiarity with weapons (guns are often used in suicides); and disproportionate percentage of psychological problems (PTSD [posttraumatic stress disorder], substance abuse), risk increases with the number and severity of psychiatric diagnoses.¹¹⁷

RCS has several preparatory steps required to reduce the occurrence of a crisis event and minimize the severity should one occur. One requirement is for vet centers to have a written plan addressing how staff responds to crisis situations.¹¹⁸ The OIG requested and reviewed crisis plans to assess for compliance.

¹¹⁵ RCS-CLI-006, *High Risk Flag Suicide Outreach*, April 27, 2019.

¹¹⁶ Microsoft, *Definition of SharePoint*. A website to securely store, organize, share, and access information, accessed July 15, 2021. <https://support.microsoft.com/en-us/office/what-is-sharepoint-97b915e6-651b-43b2-827d-fb25777f446f>.

¹¹⁷ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021.

¹¹⁸ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

Root Cause Analysis Participation and Feedback

Root cause analysis (RCA) is a review of systems and processes that surround an adverse event or a close call.¹¹⁹ The review consists of an interdisciplinary team of individuals familiar with the event and staff with varying educational backgrounds and experience. The team works together to understand the “what” and “why” of the events and identify changes that could be made to reduce the likelihood of reoccurrence.¹²⁰ If an adverse event or close call occurs, such as a death by suicide or suicide attempt of a client receiving care at a vet center, a vet center clinician is required to be on and receive feedback from the VA medical facility RCA team when clinically shared cases are reviewed.¹²¹

The OIG requested a list of all clients from the VISN 8 office who died by suicide with a completed RCA.¹²² This list was cross referenced with RCSnet clients to determine if there were shared clients between support VA medical facilities and the four vet centers inspected. The OIG also requested RCA feedback and participation documentation from the vet centers reviewed and interviewed VCDs as needed.

Vet Center Suicide Prevention Findings and Recommendations

While the findings apply to the selected four vet centers, the OIG directed recommendations on certain items to the Under Secretary for Health when responsibilities are shared by RCS and the Office of Mental Health and Suicide Prevention.

The OIG found the four selected vet centers had crisis plans. The four vet centers did not have shared clients with support VA medical facilities who died by suicide during the OIG review period, and therefore vet center staff did not participate on RCA panels.

The OIG found issues related to the following:

- Nontraditional hours
- Vet center participation in VA medical facility mental health council meetings

¹¹⁹ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. Adverse events are defined 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.” 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. Such events have also been referred to as “near miss” incidents.”

¹²⁰ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

¹²¹ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010. VHA 1500(1), January 26, 2021, amended May 3, 2021.

¹²² VISN 8 is comprised of all the support VA medical facilities that collaborate with and support vet centers in district 2 zone 2 per Veteran Affairs Site Tracking (as of January 19, 2021). This methodology may have limitations as it may not have captured all deaths by suicide, only those with a completed root cause analysis.

- Receipt of the Office of Mental Health and Suicide Prevention list identifying veterans at increased predictive risk for suicide¹²³
- Receipt of the VA medical facility high risk suicide flag list
- Standardized communication process between vet centers and suicide prevention coordinators at support VA medical facilities
- RCS High Risk Suicide Flag SharePoint site monthly review and disposition documentation

Nontraditional Hours

The OIG found that three of the four vet centers complied with providing nontraditional hours. The Clearwater Vet Center temporarily suspended nontraditional hours beginning November 2019 due to staff shortages and had not resumed at the time of the inspection.

Recommendation 11

The District Director determines reasons the Clearwater Vet Center did not have nontraditional hours as required and ensures compliance.

¹²³ As noted above, the Office of Mental Health and Suicide Prevention list refers to REACH-VET.

District Director response: Concur

Due to unexpected staffing shortages, extended hours were temporarily suspended. The staffing shortage has been remedied. Extended hours are available and are often adjusted based on demand for services. Clearwater Vet Center Hours of Operation (Including Non-Traditional Hours) are as follows:

Monday:	8:00AM	4:30PM
Tuesday:	8:00AM	7:30PM
Wednesday:	8:00AM	7:30PM
Thursday:	8:00AM	4:30PM
Friday:	8:00AM	4:30PM
Saturday:	By Request	
Sunday:	Closed	Closed

VHA considers this recommendation fully implemented and request OIG consider closure.

Status: Request Closure

Target date for completion: Complete

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

Mental Health Council

VA medical facility mental health council meetings are comprised of essential mental health disciplines and specialty programs, and medical facilities “are encouraged to include representation from Readjustment Counseling Centers (Vet Centers) in this Council.”¹²⁴ VA medical facility mental health councils are responsible for the following:

- “Proposing strategies to improve care and consulting with management on methods for improvement and innovation in treatment programs”
- Coordinating communication
- Evaluating mental health policy impact¹²⁵

RCS recognizes the importance of mental health councils with coordinating care for clients between vet centers and VA medical facilities and states “Vet Center staff need to participate on

¹²⁴ VHA Handbook 1160.01, *Uniform Mental Health Services in VHA Facilities and Clinics*, September 11, 2008, amended November 16, 2015.

¹²⁵ VHA Handbook 1160.01, September 11, 2008, amended November 16, 2015.

all VA Medical Center Mental Health Councils.”¹²⁶ Although RCS requires participation, the OIG did not find any policy or guidance specifying how attendance is tracked and requested evidence of attendance.

The Ocala VCD reported that many of the Mental Health Council meetings were canceled due to COVID-19. For meetings prior to the pandemic, the VCD did not have evidence supporting attendance. The OIG found that the Ponce Vet Center also did not have evidence to demonstrate participation on the Mental Health Council although the VCD reported staff attendance. Both Sarasota and Clearwater VCDs stated all Mental Health Council meetings in the review period were canceled.

Overall, the four vet centers did not provide the OIG any policy or guidance to ensure participation despite the RCS requirement of participation on mental health councils.

Recommendation 12

The District Director, in collaboration with the support VA medical facility clinical or administrative liaisons, determines the reasons for noncompliance with the Clearwater, Ocala, Ponce, and Sarasota Vet Centers staff participation on mental health councils, and takes action as indicated to ensure compliance with Readjustment Counseling Service requirements.

District Director response: Concur

The District will work with the VAMC to determine the status of their meetings, RCS attendance at those meetings and develop a plan for corrective action. The Vet Center Director and District leadership will monitor compliance.

Status: In progress

Target date for completion: February 2022

Office of Mental Health and Suicide Prevention List

The Office of Mental Health and Suicide Prevention is responsible for sharing with RCS a monthly list of veterans who have an increased predictive risk for suicide, so vet centers can identify clients on the list who are receiving counseling services and better coordinate care with VA medical facilities.¹²⁷ The OIG found that the four VCDs reported not receiving the list from

¹²⁶ VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010; VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021.

¹²⁷ “Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding,” November 13, 2017; “VA Suicide Prevention Efforts,” factsheet, January 3, 2019, accessed April 1, 2020, https://www.mentalhealth.va.gov/suicide_prevention/docs/VA_Suicide_Prevention_Program_Fact_Sheet_508.pdf. Increased predictive risk for suicide was developed by VA’s REACH VET program to determine veterans who have a higher risk for suicide through predictive analytics.

Office of Mental Health and Suicide Prevention. The Ocala VCD told the OIG they did not know that receiving the list was a requirement. The Clearwater VCD thought they received the list once. The VCD provided the OIG with a copy of a list; however, upon review, it was a client list from the RCS's high risk suicide flag SharePoint site.

Recommendation 13

The Under Secretary for Health ensures that the Chief Officer collaborates with the Office of Mental Health and Suicide Prevention to determine reasons for noncompliance with vet centers' receipt of the monthly Office of Mental Health and Suicide Prevention list of clients with an increased predictive risk for suicide, ensures coordination of care with VA medical facilities for vet center clients on the list, and monitors compliance.¹²⁸

Under Secretary for Health response: Concur

Readjustment Counseling Service (RCS) does not believe there are implications for the Office of Mental Health and Suicide Prevention for this finding. During the period of this review, the Recovery Engagement and Coordination for Health Veterans Enhanced Treatment (REACH VET) initiative had not been implemented in RCS. Since then, RCS, in collaboration with the Office of Mental Health and Suicide Prevention, developed and implemented a plan that transfers data to RCS that includes VA medical center (VAMC) patients with a High Risk Suicide Flag and those identified through the REACH VET initiative. Vet Centers are not required to coordinate with the VAMC on this list of names, as the VAMC has additional outreach practices to those identified. Vet Centers review matched cases and determine an appropriate disposition for follow-up. It is important to note that unless there is a psychiatric emergency or imminent concern for safety, RCS privacies require authorization by the client for coordination. RCS, after piloting and training, implemented the REACH Vet initiative in June 2021 and will work with the District Director to monitor compliance.

Status: In progress

Target date for completion: February 2022

OIG response: The OIG anticipates that vet center staff will follow RCS's VHA 1500(1), *Readjustment Counseling Service*, released January 2021 (amended May 2021), that includes the requirement that "Vet Center providers will collaborate with external providers, VA and non-VA, to ensure coordination of care for all individuals considered to have any level of risk" for suicide (assuming a release of information has been obtained).

The OIG considers this recommendation open.

¹²⁸ Recommendations addressed to the Under Secretary for Health were submitted to the Deputy to the Deputy Under Secretary for Health, performing the delegable duties of the Under Secretary for Health.

High Risk Suicide Flag List

The Memorandum of Understanding states that Office of Mental Health and Suicide Prevention will share an updated list of clients who have been designated as high risk for suicide by the VA medical facility. This list is shared to improve clinical care and management of these clients, this may include initiating services at vet centers, but also encourages vet center referrals to VA medical facilities when appropriate.¹²⁹

The OIG found Clearwater, Ponce, and Sarasota Vet Centers received high risk for suicide client lists from the support VA medical facility suicide prevention coordinators, not from the Office of Mental Health and Suicide Prevention. These three vet centers were unable to provide high risk for suicide client lists for certain months during the OIG review period. One of the three who did receive lists was unsure why some months were missing, while another VCD reported receiving monthly lists but discarding them if active clients were not identified on it. The Ocala VCD was not aware of the requirement until two weeks before the inspection.

Recommendation 14

The Under Secretary for Health ensures that the Chief Officer collaborates with the Office of Mental Health and Suicide Prevention to determine the reasons updated lists of clients designated as high risk for suicide were not consistently received by vet centers, and ensures a process for vet centers' receipt of the list in accordance with the Office of Mental Health and Suicide Prevention and Readjustment Counseling Service Memorandum of Understanding.

Under Secretary for Health response: Concur in principle

RCS does not believe there are implications for the Office of Mental Health and Suicide Prevention for this finding. RCS, in collaboration with the Office of Mental Health and Suicide Prevention, developed and implemented a plan to transfer data to RCS that includes VAMC patients with a high-risk suicide flag and those identified through the REACH VET initiative. Since the development of the Memorandum of Understanding (MOU), RCS has centralized the process as described above and is currently revising the Office of Mental Health and Suicide Prevention MOU to correctly reflect this change and will monitor compliance. RCS required Vet Centers to implement the reconciliation of the high-risk data in late April 2020. RCS will hold additional national training and work with district leaders to monitor compliance.

Status: In progress

Target date for completion: February 2022

¹²⁹ "Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding," November 13, 2017.

Standardized Communication Process

In the 2017 Memorandum of Understanding, RCS was identified as a crucial entity in the VA's suicide prevention strategy. Standardizing communication between suicide prevention coordinators and vet center staff was a component of the memorandum that sought to formalize the relationship between the Office of Mental Health and Suicide Prevention and suicide prevention coordinators, and RCS.¹³⁰

The OIG found while each of the vet centers inspected did have informal contact with the suicide prevention coordinators at the support VA medical facility, the four vet centers did not have a standardized communication process with the support VA medical facility suicide prevention coordinator; for example, a local memorandum of understanding or standard operating procedure outlining the process. The Ponce VCD verbalized a process whereby the vet center would contact the local VA medical facility in cases of lethality changes or when clients required further evaluation or intervention; however, the local memorandum of understanding that the VCD provided did not outline the process involved nor did it specify how the vet center and VA medical facility suicide prevention coordinator would standardize communication and collaboration. The OIG concluded that the absence of a written policy or protocol raises concerns about the sustainability of the communication and collaboration process.

Recommendation 15

The Under Secretary for Health ensures that the Chief Officer collaborates with the Office of Mental Health and Suicide Prevention to determine reasons for noncompliance with a standardized communication and collaboration process between suicide prevention coordinators and vet centers in accordance with the Office of Mental Health and Suicide Prevention and Readjustment Counseling Service Memorandum of Understanding, and initiates action as necessary.

¹³⁰ "Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding," November 13, 2017.

Under Secretary for Health response: Concur

The referenced MOU with the Office of Mental Health and Suicide Prevention (see attachment A) includes language that was intended to improve coordination with Suicide Prevention Coordination; however, it is outdated language and is currently under revision. Since the signing of the referenced MOU, RCS has published VHA Directive 1500(1) dated January 26, 2021. The Directive sets in policy Vet Center coordination for suicide prevention to include the VAMC clinical liaison to coordinate suicide prevention activities. The Directive also requires the Vet Center to coordinate with the Suicide Prevention Coordinator when referring clients that are at high-risk and referred to the VAMC to support the referral and coordinate services. VHA considers this recommendation fully implemented and request OIG consider closure.

Status: Request Closure

Target date for completion: Complete

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

RCS High Risk Suicide Flag SharePoint

On May 11, 2020, RCS required VCDs to review a national SharePoint site that lists clients designated as high risk for suicide by VA medical facilities who were active at vet centers within the past 12 months. Once reviewed, if clients were identified from the vet center, VCDs were responsible for determining a plan of action with staff, if needed, and documenting a disposition on the SharePoint site. The OIG found VCDs for Clearwater, Ponce, and Ocala Vet Centers reported reviewing the RCS SharePoint site, but Clearwater and Ocala VCDs were unable to provide documentation to support the monthly reviews. The Clearwater VCD reported once a disposition was entered on the site, the client was no longer visible to the VCD. The Sarasota VCD did not review the site, nor document a disposition, reporting that it was not necessary as they had a collaborative relationship with and received this information from the suicide prevention coordinator.

Recommendation 16

The District Director determines reasons for noncompliance with high risk for suicide flag SharePoint site requirements and the tracking of continuity of care for clients with a high risk suicide flag at the Sarasota Vet Center, takes action to ensure requirement is met, and monitors compliance.

District Director response: Concur

Corrective actions have been implemented, including staff re-training, guidelines, and tracking. The District will monitor compliance.

Status: In progress

Target date for completion: February 2022

Consultation, Supervision, and Training

Each vet center is assigned a clinical liaison and an external clinical consultant from the support VA medical facility.¹³¹ Clinical liaisons help coordinate care for shared clients with the support VA medical facility, whereas external clinical consultants provide guidance on complex or emergent cases.¹³²

Vet centers are comprised of small multidisciplinary teams, are community-based, and traditionally located outside of VA medical facilities. Vet center teams are at least four staff consisting minimally of a VCD, an office manager, and two or more counselors.¹³³ Vet centers are required to have at least one VA-qualified licensed mental health professional on staff.¹³⁴

VCDs are accountable for the clinical and administrative oversight of readjustment counseling that include the following therapies: individual and group counseling; family counseling for military-related issues; bereavement counseling for family members; and counseling for conditions related to military sexual trauma.¹³⁵ VCDs provide staff supervision, participate or designate staff to attend VA medical facility mental health councils, maintain VA and community partnerships, and supervise counselors.

In 2014, VA released a report suggesting an average of 20 veterans died by suicide daily. Of those 20 veterans, six had used VA care in the year of, or the year prior to their death. In

¹³¹ VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010; VHA 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021.

¹³² VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

¹³³ Some vet centers depending on demographic needs may be assigned a Global War on Terrorism outreach technician or a veteran outreach specialist. For vet centers assigned a mobile vet center, staffing includes a driver and counselor.

¹³⁴ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

¹³⁵ RCS policy states the team leader is responsible for vet center operations including staff supervision, and administration and clinical programs. The OIG learned in December 2019 during communications with vet center and district office leaders that the team leader position was referred to as a vet center director. VHA Handbook 1500.01.

February 2016, the VA Under Secretary for Health stated the need for continued review and certification of suicide prevention training annually for all VA medical facility employees.¹³⁶

Following the initial mandated training, staff were required to complete the corresponding refresher courses for their positions.¹³⁷ Military sexual trauma is reported to VA medical facility providers at a rate of one in four for women and one in 100 for men. RCS clinical staff are required to complete military sexual trauma training.¹³⁸

RCS requires vet center staff to have a basic level of cross training to promote its mission of assisting veterans' post-war social and psychological readjustment, and to enhance small team functionality. Vet center staff are required to complete annual in-service training that includes cross training in 16 core curriculum topics.¹³⁹ Additional training may be required based on position assignment. The annual in-service training curriculum includes all major vet center service components and administrative functions.¹⁴⁰

The OIG's consultation, supervision, and training review evaluated compliance at the four selected vet centers. The OIG evaluated the following areas:

- Clinical liaison consultation
- External clinical consultation
- VHA-qualified mental health professional on staff
- Supervision
- Staff training

¹³⁶ VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017.

¹³⁷ VHA Directive 1071, December 22, 2017.

¹³⁸ VHA Directive 1115.01, *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017.

¹³⁹ The 16 topics include veterans' postwar social and psychological readjustment problems, assessment and counseling for war-related posttraumatic stress disorder, assessment and counseling for military-related sexual trauma, vet center administrative and fiscal functions, VA medical facility administrative support services, vet center clinical assessment and record keeping, diverse service needs of special veteran populations, vet center community outreach practices, crisis response and suicide prevention, individual, group and family readjustment counseling, building relationships in the community to promote veterans access to care, working with the media to promote the vet center program, and veterans' contribution to country and community, military history, culture and experience specific to the vet center eligible combat theaters, staff training and experience profile (STEP), working knowledge of VHA health care services and VBA benefits, and vet center bereavement services. VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010.

¹⁴⁰ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

Consultation

Clinical Liaison Consultation

The clinical liaison is either from VA medical facilities mental health or social work service.

External Clinical Consultation

External clinical consultants are appointed from either the support VA medical facility or, if unavailable, the private sector, to provide a minimum of four hours per month of consultation. They are required to be licensed and VHA-qualified mental health professionals credentialed through the support VA medical facility. External clinical consultants provide consultation when a client presents as suicidal or homicidal to assess the probability of suicide or homicide and develop an intervention. External clinical consultants also complete peer case reviews and assist vet center clinicians in the treatment of complex and emergent veteran cases.¹⁴¹

To evaluate compliance, the OIG interviewed VCDs and reviewed the following documentation:

- Vet center staffing spreadsheet
- Vet center oversight trackers
- Documentation demonstrating external clinical consultation four hours a month¹⁴²

VHA-Qualified Mental Health Professional on Staff

Each vet center is required to maintain one licensed and credentialed VA-qualified mental health provider. To assess for compliance, the OIG completed the following steps:

1. A staffing summary was requested from each vet center listing all VA-qualified staff employed from August 1, 2019, through July 31, 2020.
2. If the vet center had more than one VA-qualified mental health provider on staff,
 - a. The OIG randomly selected one individual, and
 - b. Requested credentialing documentation of that individual from RCS's Centralized Human Resource Management Organization.

¹⁴¹ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021.

¹⁴² A staffing spreadsheet was requested from each vet center requesting information on appointed liaisons and consultants and what service line they were appointed from. The OIG also retrieved the oversight tracker from RCSnet populated by each vet center documenting current VA medical facility support staff.

Supervision

RCS requires VCDs use supervision and staff meetings to accomplish objectives including staff cohesion, problem solving, case coordination, and collaboration with VA medical facilities. The VCD schedules weekly one hour supervision with clinical staff and conducts weekly staff meetings composed of vet center staff to accomplish the objectives. If the VCD is not a VA-qualified mental health professional, a clinical designee who is licensed will provide individual supervision to clinical staff.¹⁴³ VCDs must also complete a monthly chart audit of 10 percent of every counselor's active client records.

To assess for compliance, the OIG conducted interviews virtually with the four VCDs and requested the following documentation:

- Weekly supervision for all counselors on staff from May 1, 2020, through July 31, 2020 (13 weeks per counselor)
- Monthly chart audits of 10 percent of each counselor's caseload from August 1, 2019, through July 31, 2020 (12 months per counselor)

Training

In December 2017, VHA clinical staff, including RCS staff, were mandated to annually complete Suicide Risk Management Training for Clinicians and non-clinical staff were required to complete the S.A.V.E. training through the VHA Employee Education System.¹⁴⁴ Clinical staff are required to complete Suicide Prevention for Clinicians training within 90 days of entering their position and annually thereafter and non-clinical staff must complete S.A.V.E. or S.A.V.E. refresher training.¹⁴⁵

All VA medical facilities and vet centers provide military sexual trauma services. Clinical staff are also required to complete VHA military sexual trauma training within 90 days of entering their position.¹⁴⁶ All vet center staff, regardless of position, are required to complete in-service training annually.¹⁴⁷

¹⁴³ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. The 2021 directive requires the VCD provide "individual supervision to all Vet Center staff, counselors, outreach workers, and office managers on an ongoing basis."

¹⁴⁴ S.A.V.E. is an acronym that stands for Signs, Ask, Validate, Encourage, and Expedite and is a training video collaboration with VA and PsychArmor Institute.

¹⁴⁵ VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017.

¹⁴⁶ VHA Directive 1115.01, *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017.

¹⁴⁷ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

To determine compliance, the OIG requested VA Talent Management System training records and proof of attendance for required training completed for all staff employed from August 1, 2019, through July 31, 2020.¹⁴⁸

Consultation, Supervision, and Training Findings and Recommendations

The four vet centers showed overall compliance with clinical liaison and external clinical consultant appointments from mental health or social work services and licensing of external clinical consultants. VCDs could identify who the external clinical consultant was and utilized them for consultation. The four vet centers had at least one licensed and credentialed VHA-qualified mental health professional on staff. Table 5 summarizes the findings of the consultation, supervision, and training review.

¹⁴⁸ Talent Management System is a computer system used by VA staff for education and other services.

**Table 5. Consultation, Supervision, and Training
(August 1, 2019, through July 31, 2020)**

Elements Reviewed	Findings			
	Clearwater Vet Center	Ocala Vet Center	Ponce Vet Center	Sarasota Vet Center
VHA Clinical Liaison				
Assigned	Compliant	Compliant	Compliant	Compliant
Social Work or Mental Health Service Department	Compliant	Compliant	Compliant	Compliant
External Clinical Consultant				
Assigned	Compliant	Compliant	Compliant	Compliant
Licensed	Compliant	Compliant	Compliant	Compliant
Four Hours a Month of External Clinical Consultation	Noncompliant	Noncompliant	Noncompliant	Noncompliant
VHA- Qualified Mental Health Provider				
On staff	Compliant	Compliant	Compliant	Compliant
Licensed	Compliant	Compliant	Compliant	Compliant
Credentialed	Compliant	Compliant	Compliant	Compliant
Supervision				
Monthly Audit (10%) of each Counselor's Caseload August 1, 2019–July 31, 2020	Noncompliant	Noncompliant	Noncompliant	Noncompliant
Clinical Supervision (one hour a week) May 1–July 31, 2020	Noncompliant	Noncompliant	Noncompliant	Noncompliant
Staff Training				
Annual Suicide Prevention for Clinical Staff	Noncompliant	Noncompliant	Noncompliant	Noncompliant
Annual Suicide Prevention for Non-Clinical Staff	Compliant	Compliant	Compliant	Noncompliant
Military Sexual Trauma Training	Noncompliant	Noncompliant	Noncompliant	Noncompliant
Annual In-service Training	Compliant	Noncompliant	Noncompliant	Noncompliant

Source: VA OIG analysis of District 2 Zone 2 documents and interview results.

Note: The OIG did not assess RCS data for accuracy or completeness.

The OIG found deficiencies in the following:

- External clinical consultation hours
- Clinical Supervision requirements
- Required monthly auditing of counselor caseload
- Staff training completion

External Clinical Consultation

RCS requires four hours of external clinical consultation monthly.¹⁴⁹ The OIG found the four VCDs did not have a tracking mechanism (for example, meeting minutes or sign in sheets) to ensure four hours of consultation were completed each month. Additionally, vet centers did not have a process for coverage when the external clinical consultant was absent, or in the event of canceled meetings. VCDs reported that when the clinical consultant was on leave, absent, or the meeting was canceled, rescheduling was attempted, but not consistently rescheduled in all instances.

Recommendation 17

The District Director determines reasons for noncompliance with processes for completing and tracking four hours of external clinical consultation per month at the Clearwater, Ocala, Ponce, and Sarasota Vet Centers, ensures that vet center directors implement processes, and monitors compliance.

District Director response: Concur

A new process is being finalized to document the date that external consultant meetings occur. The District will receive training on the use of this new process and the District will monitor compliance.

Status: In progress

Target date for completion: February 2022

Supervision

As noted in RCS policy, regularly scheduled weekly supervision helps with staff cohesion, problem solving, and client case coordination, and assists with the coordination of care with VA partners. RCS requires one hour a week of scheduled supervision with each clinical staff member; however, RCS does not specify how weekly supervision is tracked to ensure completion.

¹⁴⁹ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), 2021.

The OIG found the four vet centers were noncompliant with the provision of weekly staff supervision. The Clearwater and Sarasota VCDs believed supervision was completed weekly with some missed weeks but were unable to provide evidence of supervision for the entire review period. The Ocala VCD was unaware that there were missing weeks of supervision. The Ocala VCD had 27 of 39 (69 percent) weeks, the Clearwater VCD had 12 of 32 (38 percent) weeks, the Ponce VCD had 22 of 39 (56 percent) weeks, and the Sarasota VCD had 15 of 52 (29 percent) weeks of documented weekly supervision.¹⁵⁰ VCDs cited reasons for noncompliance included not documenting all sessions, not being aware of missing supervision or having a supervision style that was informal without documentation. The OIG found the four vet centers did not have a process for coverage in the VCD's or designee's absence. The Ponce VCD was in the position since March 2020 and did not have access to prior supervision records. The VCD was also on leave during the review period resulting in weeks without arranged staff supervision.

Recommendation 18

The District Director determines reasons for noncompliance with staff supervision provided by vet center directors at the Clearwater, Ocala, Ponce, and Sarasota Vet Centers, ensures staff supervision occurs as required, and monitors compliance.

District Director response: Concur in principle.

With the publication of the new VA Directive 1500 in January 2021, the requirement for 1 hour of clinical supervision weekly has been removed. VHA considers this recommendation fully implemented and requests OIG consider closure.

Status: Request Closure

Target date for completion: Complete

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

Monthly Audit

Oversight is one of the main responsibilities of a VCD to ensure quality clinical services. District leaders use chart audits as a way to provide oversight. RCS policy requires VCDs to complete a 10 percent audit of each counselor's active client caseload. The OIG found all four VCDs were noncompliant.¹⁵¹ The Ocala and Sarasota VCDs provided RCSnet audit reports to demonstrate

¹⁵⁰ There were 13 full weeks during the review period. The total number of weeks was calculated using 13 weeks multiplied by the number of counselors on staff during the review period. Calculations were adjusted based on staff who were not employed for the entire review period.

¹⁵¹ There were 12 months in the review period. The total number of audits required was calculated using 12 months multiplied by the number of counselors on staff during the review. Calculations were adjusted based on staff who were not employed for the entire review period.

compliance. However, after the OIG reviewed the audit reports with each VCD, the Ocala and Sarasota directors reported errors, and that the documents were not an accurate reflection of completed audits.

The Sarasota VCD used a tracking tool to complete chart audits but the tracking tool did not have caseload numbers and the OIG was unable to determine if 10 percent of each counselor's caseload was reviewed. The Clearwater VCD reported not completing the monthly audits because of competing priorities and the need to prioritize client care. The Ponce VCD stated that monthly audits were not completed because of natural disasters, administrative challenges, and time management concerns.

Recommendation 19

The District Director verifies and determines reasons for noncompliance with monthly RCSnet chart audits at the Clearwater, Ocala, Ponce, and Sarasota Vet Centers, ensures chart audits are completed as required, and monitors compliance.

District Director response: Concur

Chart audits are now more easily tracking RCS's electronic record. The District will monitor compliance.

Status: In progress

Target date for completion: February 2022

Staff Training

RCS requires completion of mandatory trainings for both clinical and non-clinical staff. The OIG found the four vet centers were noncompliant with completion of annual suicide prevention training and military sexual trauma training for clinical staff. Three of the four vet centers were compliant with non-clinical staff completion of S.A.V.E. or S.A.V.E. refresher training. Three of four vet centers were noncompliant with vet center staff completing annual in-service training in fiscal year 2019.¹⁵² The Sarasota VCD did not review assignments for accuracy but did monitor completion of assigned trainings. The Clearwater and Sarasota VCDs reported required training may have been completed, but they may not appear in the Talent Management System records.

The OIG interviewed the Associate District Director for Administration who reported that Talent Management System training can be assigned by

¹⁵² All face-to-face training conference were canceled in fiscal year 2020 due to COVID-19. Alternate trainings were made available but were not required.

- staff members supervisor,
- Talent Management System administrator, or
- automatic assignment by RCS or VHA.

The VCD provides a copy of all completed trainings to the associate district director for administration during the administrative quality review site visit to review compliance. The associate district director for administration stated that the district office list of mandatory trainings is outdated and needs to be updated to include current required trainings.

Recommendation 20

The District Director determines reasons for errors in training assignments and why completed trainings are not being recorded for employees at the Clearwater, Ocala, Ponce, and Sarasota Vet Centers, ensures all staff complete mandatory trainings as required, and monitors compliance.

District Director response: Concur

A new process is in development to establish guidelines for the assignment, tracking and follow-up of mandatory trainings. The District will work with the RCS national training manager to identify the required trainings and ensure electronic assignments are established and monitored for compliance.

Status: In progress

Target date for completion: March 2022

Environment of Care

VHA defines environment of care as “the building or space, including how it is arranged and the special features that protect patients, visitors, and staff; equipment used to support patient [client] care or to safely operate the building or space; and people, including those who work within the hospital, clients, and anyone else who enters the environment, all of whom have a role in minimizing risks.”¹⁵³ RCS requires that the interior layout and design of a vet center is welcoming and promotes access to readjustment counseling services and support in a non-institutional setting.¹⁵⁴

¹⁵³ VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.

¹⁵⁴ VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

The environment of care review evaluated compliance with RCS guidance at the four selected vet centers. The OIG completed virtual inspections with FaceTime video, conducted virtual interviews, and reviewed relevant documents. The OIG evaluated three areas:

- Physical environment
- General safety
- Privacy

Physical Environment

To assess compliance with physical environmental cleanliness, the OIG virtually inspected the exterior to assess if it appeared clean, neat, and presentable and reviewed interior furnishings for cleanliness, and determine whether they were in good repair, serviceable, and welcoming or non-institutional. The OIG also assessed if the waiting area was large and comfortable, able to accommodate clients and their families, and that the interior was decorated with items that depicted military appreciation.¹⁵⁵

General Safety

The Architectural Barriers Act of 1968 applies to buildings or facility spaces leased in whole or in part by the United States after August 12, 1968.¹⁵⁶ Facilities subject to the Architectural Barriers Act must comply with the Architectural Barriers Act Accessibility Standard.¹⁵⁷ The OIG assessed whether vet centers complied with the Architectural Barriers Act Accessibility Standard for compliant accessible entrances, designated parking spaces, and exit signs for persons with disabilities.¹⁵⁸

Vet centers are also required to have a current emergency and crisis plan that addresses “contingencies for phone and computer disruptions, weather/national disaster emergency plan, site/facility emergency plan, site/facility temporary relocation plan, management of disruptive behavior, violence in the workplace, and handling of suspicious mail and bomb threats.”¹⁵⁹ Vet center staff are also required to identify and minimize objects that could be potentially used as

¹⁵⁵ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

¹⁵⁶ Architectural Barriers Act of 1968 (codified as amended at 42 U.S.C. §§ 4151- 4156).

¹⁵⁷ 41 C.F.R. § 102–76.65(a).

¹⁵⁸ Architectural Barriers Act Accessibility Standards (codified at Appendices C and D to 36 C.F.R. part 1191).

¹⁵⁹ Readjustment Counseling Service, *District 1 Vet Center Administrative Quality Review Template*, revised October 24, 2016; VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

weapons within their environment.¹⁶⁰ The OIG assessed if crisis and emergency management plans were comprehensive and current, and virtually inspected the vet centers to determine if any objects could be used as weapons in the environment.

Privacy

“Vet centers provide a safe and confidential place for veterans to talk that helps mitigate the effects of stigma on combat and sexually traumatized veterans.”¹⁶¹ Vet centers are required to have an office space for the VCD and each counselor, as well as a group counseling room, that is soundproof and appropriate for confidential counseling. The office manager is required to have a separate space that affords privacy for sensitive duties, while being able to access the waiting area to receive clients.¹⁶² Any documents or items displaying protected health information must be secured. Confidential records must be stored in a room that is double-locked and complies with VHA security requirements.¹⁶³ The OIG virtually assessed each vet center’s offices, group counseling rooms, and storage rooms to determine compliance with privacy requirements. Table 6 details the findings of the environment of care review.

¹⁶⁰ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

¹⁶¹ VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

¹⁶² VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

¹⁶³ VHA Handbook 0730/4, *Security and Law Enforcement*, March 29, 2013, requires floor to ceiling security, per VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010.

Table 6. Environment of Care

Review Elements	Findings			
	Clearwater Vet Center	Ocala Vet Center	Ponce Vet Center	Sarasota Vet Center
Physical Environment				
Clean Exterior	Compliant	Compliant	Compliant	Compliant
Neat Exterior	Compliant	Compliant	Compliant	Compliant
Presentable Exterior	Compliant	Compliant	Compliant	Compliant
Interior Design and Furnishings Clean	Compliant	Compliant	Compliant	Compliant
Interior Design and Furnishings in Good Repair	Compliant	Compliant	Compliant	Compliant
Interior Design and Furnishings Serviceable	Compliant	Compliant	Compliant	Compliant
Interior Design and Furnishings Appropriate, Welcoming, and Non-Institutional	Compliant	Compliant	Compliant	Compliant
Large Waiting Area	Compliant	Compliant	Compliant	Compliant
Comfortable Waiting Area	Compliant	Compliant	Compliant	Compliant
General Safety				
Accessible Entrance	Compliant	Compliant	Compliant	Compliant
Designated Accessible Parking	Compliant	Compliant	Compliant	Compliant
Exit Signs Architectural Barriers Act Compliant	Noncompliant	Noncompliant	Noncompliant	Noncompliant
Crisis Management Plan	Compliant	Compliant	Compliant	Compliant
Objects Potentially used as Weapons Minimal	Compliant	Compliant	Compliant	Compliant
Privacy				
Private, Soundproof Office Space for Confidential Counseling (Counselors and Director)	Compliant	Compliant	Compliant	Compliant
Group Counseling Room	Compliant	Compliant	Compliant	Compliant
Office Manager Space Private and Accessible to Clients	Compliant	Compliant	Noncompliant	Compliant
Personal Information Secured	Noncompliant	Compliant	Compliant	Noncompliant
Secure Double-Locked Room for Client Records	Compliant	Compliant	Compliant	Compliant

Source: VA OIG analysis of environment of care inspections conducted from September 21, 2020, to October 8, 2021.

Environment of Care Findings and Recommendations

The OIG virtually inspected areas within the designated vet centers and found general compliance with the exterior and interior being clean and presentable, and the interior design being welcoming and non-institutional. There were large and comfortable waiting areas, with furnishings that were clean, in good repair, and serviceable. Objects that could potentially be used as weapons were minimized. The four vet centers complied with the Architectural Barriers Act standards for accessible entrance and designated parking spaces for persons with disabilities. Each vet center had a current emergency and crisis plan with required components. The OIG found compliance at the four vet centers with private office spaces for the director and counselors, at least one group counseling room, and double-locked rooms for storage of confidential client records.

The OIG found that one vet center did not meet the RCS requirement for “A separate office which affords privacy for sensitive duties for the office manager with open access to the waiting area to accommodate the reception of veterans.”¹⁶⁴ The Ponce Vet Center location at the time of inspection did not have a separate office space for the office manager. The VCD’s office could only be accessed by walking through the office managers office raising privacy concerns as clients were assigned to the VCD clients. The OIG discussed the privacy concerns with VCD who informed the OIG that this would be addressed at a new vet center location, which opened on October 16, 2020. The OIG conducted a virtual inspection of the new location that included separate offices for the office manager and VCD and therefore, did not make a recommendation on this element.

The OIG found deficiencies in the following:

- General Safety
- Privacy

Architectural Barriers Act

The OIG found all four vet centers noncompliant in one element of general safety. Specifically, RCS requires that each vet center follow Architectural Barriers Act Accessibility Standard and each egress have signage and “doors at exit passageways, exit discharge, and exit stairways shall be identified by *tactile* signs complying with 703.1, 703.2, and 703.5.”¹⁶⁵ The OIG found the four vet centers did not have a tactile sign posted near any of their doors at exit discharge.

¹⁶⁴ VHA, *RCS Guidelines and Instructions for Vet Center Administration*, November 23, 2010.

¹⁶⁵ 36 C.F.R. § Pt. 1191, App. D.; Architectural Barriers Act (ABA) Standards (2015).

Recommendation 21

The District Director evaluates and determines reasons for noncompliance with tactile (braille) signage at the Clearwater, Ocala, Ponce, and Sarasota Vet Centers and ensures all exit doors are compliant with the Architectural Barriers Act.

District Director response: Concur

The District will ensure that braille signage is added to all Vet Centers within the District.

Status: In progress

Target date for completion: November 2021

Privacy

RCS requires that “Confidential/sensitive information is secured.”¹⁶⁶ Clearwater and Sarasota Vet Centers did not have personal information securely stored. During the virtual inspection, one vet center had protected health information viewable on the office manager’s desk. The office manager was escorting the VCD during the virtual inspection and was not at the desk. At another vet center, a telephone message book was left open and visible to the OIG in the office manager’s room and was used to record messages from clients.

Recommendation 22

The District Director reviews reasons for noncompliance with securing confidential and sensitive information at the Clearwater and Sarasota Vet Centers and ensures all vet center employees safely and securely store protected health information.

District Director response: Concur

These two instances were isolated situations involving misplaced documents, which occurred during the Environment of Care virtual review. The involved staff have been retrained on information security and privacy. VHA considers this recommendation fully implemented and requests OIG consider closure.

Status: Request Closure

Target date for completion: Complete

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

¹⁶⁶ Readjustment Counseling Service, “District 1 Vet Center Administrative Quality Review Template,” section IV.b., revised October 24, 2016.

Appendix A: Summary of Vet Center Inspection Program Recommendations

The intent of the OIG recommendations is for VCDs to use them as a road map to help improve operations and clinical care. The 22 recommendations, including three for the Under Secretary for Health and 19 for the District Director, address system issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. OIG Recommendations According to Associated Requirements

Quality	Requirement	Recommendation
Clinical and Administrative Quality Reviews	Annual vet center quality review site visit	<ol style="list-style-type: none"> 1. The District Director determines reasons clinical and administrative quality reviews were not completed and monitors compliance. 2. The District Director evaluates the clinical and administrative quality review report approval process to determine if a timeliness measure is needed and takes action as indicated.
	VCD and Associate District Director develop remediation plan	<ol style="list-style-type: none"> 3. The District Director determines reasons clinical and administrative quality review remediation plans were not completed, ensures completion, and monitors compliance.
	Associate District Directors validate resolution of deficiencies	<ol style="list-style-type: none"> 4. The District Director evaluates the process for resolution of clinical and administrative quality review deficiencies and takes action as necessary.
Critical Incident Quality Reviews	Completion of critical incident quality reviews for all serious suicide attempts of active clients	<ol style="list-style-type: none"> 5. The District Director determines reasons for noncompliance with critical incident quality review (currently known as morbidity and mortality review) of a death by suicide, ensures completion includes an evaluation of vet center services to determine if actions are needed to improve the effectiveness of vet center suicide prevention activities, and monitors compliance.

Critical Incident Quality Reviews	Completion of critical incident quality reviews for all completed suicides of active clients	6. The District Director determines reasons for noncompliance with critical incident quality reviews (currently known as morbidity and mortality reviews) for serious suicide attempts, ensures completion, and monitors compliance.
Suicide Prevention	Requirement	Recommendation
Intake Assessment	Completion of psychosocial assessments within five visits	7. The District Director ensures intake assessments are completed and monitors compliance across all zone vet centers.
Military History	Completion of military histories within five visits	8. The District Director ensures military histories are completed and monitors compliance across all zone vet centers.
Lethality Risk Assessment	Completion of lethality risk assessments during the first clinical encounter	9. The District Director ensures lethality risk assessments are completed and monitors compliance across all zone vet centers.
Intake Assessment and Military History	Completion of psychosocial assessments within five visits	10. The District Director, in collaboration with Readjustment Counseling Service Central Office, evaluates the limitations of current tools and tracking methods including reasons completion dates are unavailable in RCSnet and ensures compliance with standards for timely completion of intake assessments and military histories.
Access	Nontraditional Hours	11. The District Director determines reasons the Clearwater Vet Center did not have nontraditional hours as required and ensures compliance.
Care Coordination and Collaboration with VA medical facility	Participation on VA medical facility mental health council	12. The District Director, in collaboration with the support VA medical facility clinical or administrative liaisons, determines the reasons for noncompliance with the Clearwater, Ocala, Ponce, and Sarasota Vet Centers staff participation on mental health councils, and takes action as indicated to ensure compliance with Readjustment Counseling Service requirements.
	Monthly receipt of the Office of Mental Health and Suicide Prevention list and subsequent processes	13. The Under Secretary for Health ensures that the Chief Officer collaborates with the Office of Mental Health and Suicide Prevention to determine reasons for noncompliance with vet centers' receipt of the monthly Office of Mental Health and Suicide Prevention list of clients with an increased predictive risk for suicide, ensures coordination of care with VA medical facilities for vet center clients on the list, and monitors compliance.

Care Coordination and Collaboration with VA medical facility	Receipt of updated VA medical facility high risk suicide flag list	14. The Under Secretary for Health ensures that the Chief Officer collaborates with the Office of Mental Health and Suicide Prevention to determine the reasons updated lists of clients designated as high risk for suicide were not consistently received vet centers, and ensures a process for vet centers' receipt of the list in accordance with the Office of Mental Health and Suicide Prevention and Readjustment Counseling Service Memorandum of Understanding.
	Standardization of communication and collaboration process with VA medical facility Suicide Prevention Coordinator	15. The Under Secretary for Health ensures that the Chief Officer collaborates with the Office of Mental Health and Suicide Prevention to determine reasons for noncompliance with a standardized communication and collaboration process between suicide prevention coordinators and vet centers in accordance with the Office of Mental Health and Suicide Prevention and Readjustment Counseling Service Memorandum of Understanding, and initiates action as necessary.
High Risk Suicide Flag SharePoint Review	Monthly review and documentation in RCS's high risk suicide flag SharePoint site	16. The District Director determines reasons for noncompliance with high risk for suicide flag SharePoint site requirements and the tracking of continuity of care for clients with a high risk suicide flag at the Sarasota Vet Center, takes action to ensure requirement is met, and monitors compliance.
Consultation, Supervision, and Training	Requirement	Recommendation
External Clinical Consultation	Documentation of four hours of external clinical consultation per month	17. The District Director determines reasons for noncompliance with processes for completing and tracking four hours of external clinical consultation per month at the Clearwater, Ocala, Ponce, and Sarasota Vet Centers, ensures that vet center directors implement processes, and monitors compliance.
Supervision	One hour weekly supervision with clinical staff members	18. The District Director determines reasons for noncompliance with staff supervision provided by vet center directors at the Clearwater, Ocala, Ponce, and Sarasota Vet Centers, ensures staff supervision occurs as required, and monitors compliance.
	Monthly 10 percent client record audit for each counselor	19. The District Director verifies and determines reasons for noncompliance with monthly RCSnet chart audits at the Clearwater, Ocala, Ponce, and Sarasota Vet Centers, ensures chart audits are completed as required, and monitors compliance.

Training	Completion of all mandatory trainings	20. The District Director determines reasons for errors in training assignments and why completed trainings are not being recorded for employees at the Clearwater, Ocala, Ponce, and Sarasota Vet Centers, ensures all staff complete mandatory trainings as required, and monitors compliance.
Environment of Care	Requirement	Recommendation
General Safety	All exit signage Architectural Barriers Act compliant	21. The District Director evaluates and determines reasons for noncompliance with tactile (braille) signage at the Clearwater, Ocala, Ponce, and Sarasota Vet Centers and ensures all exit doors are compliant with the Architectural Barriers Act.
Privacy	Confidential/sensitive information secured	22. The District Director reviews reasons for noncompliance with securing confidential and sensitive information at the Clearwater and Sarasota Vet Centers and ensures all vet center employees safely and securely store protected health information.

Source: VA OIG recommendations.

Appendix B: District 2 Zone 2 Profile

**Table B.1. Zone 2 Profile
(October 1, 2018–September 30, 2019)**

Profile Element	Zone 2	
Total budget dollars	\$ 14,127,245.53	
Unique clients	10,930	
New clients	3,955	
Active duty clients	376	
Spouse/family clients	2,022	
Bereavement clients	64	
Position	Authorized	Filled
Total full-time	160	150
Zone staff*	4	4
Vet center director	25	24
Clinical staff	84	78
Veterans Outreach Program Specialist †	23	21
Office staff	24	23

Source: VA OIG analysis of information from district 2 zone 2 leaders.

Note: At the time of inspection, district 2 zone 2 reported 24 vet centers. Zone profile reports on the fiscal year, not the review period for inspection.

**Zone staff includes District Director, Deputy District Director, and the Associate District Directors for Administration and Counseling.*

† Veteran outreach program specialists are responsible for vet center outreach services. Veteran outreach program specialists conduct face-to-face outreach to contact, inform, engage, and bring local eligible individuals into the vet center for needed services.

Profile Summary: From October 1, 2018, through September 30, 2019, district 2 zone 2 operated on a total budget of \$14,127,245.53 and served 10,930 unique clients; 3,955 new clients, 376 active duty, 2,022 spouses and family members, and 64 bereavement clients. There were a total of 160 positions, with 10 total vacancies throughout the zone as of September 22, 2020.

Appendix C: Vet Center Profiles

The table below provides general background information for the four selected zone 2 vet centers.

Table C.1. FY19 Vet Center Profiles

Profile Element	Clearwater Vet Center	Ocala Vet Center	Ponce Vet Center	Sarasota Vet Center
Total budget dollars (excluding salaries, leases and mobile vet centers)	\$11,800	\$9,000	\$7,155	\$14,000
Number of:				
• Unique clients	434	464	585	578
• Bereavement clients	2	5	0	6
• Active duty clients	8	9	15	6
• Spouse/family clients	72	138	115	153
• New clients	184	239	144	261
Total Number of Positions (as of 9/22/20)				
• Total full-time positions	6	6	6	7
• Total part-time positions	N/A	N/A	N/A	N/A
• Vet center director	1	1	1	1
• Clinical staff	3	3	3	4
• Veterans outreach specialist	1	1	1	1
• Office staff	1	1	1	1
• Other	N/A	N/A	N/A	N/A

Source: VA OIG analysis of information provided by District 2¹⁶⁷.

Note: The OIG did not assess VA's data for accuracy or completeness.

¹⁶⁷ The total budget dollars for selected vet centers is for fund control point 0160 (expenses, medical services) as defined by VA financial policy, it excludes salaries, leases, and mobile vet centers. VA Financial Policy, *Volume II, Appropriations, Funds, and Related Information, Chapter 2, Budget Cycle and Fund Symbols*, September 2012 (latest version approved April 16, 2018).

Appendix D: Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: September 1, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers (2020-02014-HI-1030)(VIEWS 5763085)

To: Program Director, Office of Healthcare Inspections (54MH00)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report on the Vet Center in District 2 Zone 2. The Veterans Health Administration (VHA) concurs with recommendations 13 and 15 and concurs in principle with recommendation 14. Attached is the action plan addressing recommendations 13, 14 and 15 found in the report.
2. Readjustment Counseling Services (RCS) Vet centers are an essential component of VHA's efforts to deliver quality services to Veterans, Service members and their families. Over the past several years, RCS has worked to modernize the organization and workforce, improve staff training, automate functions and oversight, and update policies and procedures. This OIG review is an important and valued feedback loop for the implementation of policies and procedures.
3. RCS appreciates the OIG review and looks forward to continuing to deliver quality services to Veterans, Service members and their family.
4. I concur with the OIG's recommendations to the Office of the Under Secretary for Health and provide the attached action plan. The Veterans Health Administration has fully implemented the action plan for recommendation 15 and continues its work on recommendations 13 and 14.
5. Comments and action plans for recommendations 1 - 12 and 16 - 22 are provided by the Vet Center District Director.
6. VHA has some technical comments to improve accuracy and completeness of the report.
7. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Steven L. Lieberman, M.D.

OIG Response to the Acting Under Secretary for Health Memo

During VHA's review of an OIG draft report, it is usual practice for VHA to submit comments that may disclose information that could change OIG findings in the final report.¹⁶⁸ For this report, VHA provided the OIG comments referenced in the Acting Under Secretary for Health's memo during the draft review phase. The OIG considered the comments and determined they did not change any findings in the report. However, based on information received from VHA and verified by the OIG, table 1 was modified to include additional eligibility criteria and the RCS Chief Officer's organizational reporting structure was revised.

¹⁶⁸ VA OIG GM Directive 306, *Comments to Draft Reports*, April 10, 2014, amended April 24, 2019.

Appendix E: RCS Southeast District 2 Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 1, 2021

From: District Director, Southeast District 2 (RCS2)

Subj: OIG Draft Report, Vet Centers Inspection Program-District 2 Zone 2 (2020-02014-HI-1030)
(VIEWS 5763085)

To: Program Director, Office of Healthcare Inspections (54MH00)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, *Vet Centers Inspection Program-District 2 Zone 2*. The Veterans Health Administration (VHA) District Director for Southeast District 2 concurs with recommendations 1 through 12 as well as recommendations 16 through 22 and provides an action plan in the attachment.
2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Sarita Figueroa, MBA

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Jill Murray, LCSW, Director Ryan Mairs, MSW, LICSW Lauren Olstad, LCSW Bina R. Patel, PhD, LCSW Laura Savatgy, MPA
Other Contributors	Josephine Andrion, MHA, RN Felicia Burke, MS Shirley Carlisle Dustin Campbell Alicia Castillo-Flores, MBA, MPH Limin Clegg, PhD Dawn Dudek, LCSW Vivian Hicks Roy Fredrikson, JD Kathy Gudgell, JD, RN Adam Hummel, MPPA Misti Kincaid William Eli Lawson Mahshid Lee, LCSW Sarah Levis, LCSW Christine Micek, MSN, RN, CPPS Natalie Sadow, MBA Yinghua Shi Laura Snow, LCSW, MHCL Robyn Stober, JD, MBA Laura Tovar, LSCSW Tammra Wood, LCSW

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
RCS Chief Officer
Director, Southeast District 2

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate
Florida: Marco Rubio, Rick Scott
Georgia: Jon Ossoff, Raphael Warnock
U.S. House of Representatives
Florida: Gus M. Bilirakis, Vern Buchanan, Kat Cammack, Kathy Castor, Charlie Crist, Mario Diaz-Balart, Byron Donalds, Val Demings, Ted Deutch, Neal Dunn, Carlos A. Gimenez, Lois Frankel, Scott Franklin, Matt Gaetz, Al Lawson, Brian Mast, Stephanie Murphy, Bill Posey, John Rutherford, Maria Elvira Salazar, Darren Soto, Greg Steube, Michael Waltz, Debbie Wasserman Schultz, Daniel Webster, Frederica S. Wilson
Georgia: Sanford Bishop, Earl "Buddy" Carter, Austin Scott
Resident Commissioner for the Commonwealth of Puerto Rico: Jenniffer González-Colón
Delegate to Congress from the U.S. Virgin Islands: Stacey E. Plaskett

OIG reports are available at www.va.gov/oig.