DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers

VCIP REPORT | REPORT #21-01804-56 | DECEMBER 20, 2021

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Figure 1. *Pacific district 5 zone 2 vet centers inspected.*
Source: VA OIG inspection team virtual visit photographs.

Abbreviations

OIG	Office of Inspector General
RCS	Readjustment Counseling Service
VCD	vet center director
VCIP	Vet Center Inspection Program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

The VA Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) provides a focused evaluation of aspects 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. This inspection focused on Pacific district 5 zone 2 and four selected vet centers—Fresno, High Desert, and Santa Cruz County in California; and Honolulu, Hawaii.[1]

VCIP inspections are one element of the OIG's oversight to ensure that the nation's veterans receive high-quality and timely Veterans Health Administration (VHA) services. The inspection covers 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. Although it is difficult to quantify the risk of adverse impact to clients served at vet centers, the OIG

[1] VHA, *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 It was rescinded and replaced by VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.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 and interventions for psychological and psychosocial readjustment problems related to specific types of military deployment stressors. Because readjustment counseling services are "designed by law to be provided without a medical diagnosis 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.

recommendations should help vet centers identify areas of vulnerability or conditions that, if addressed, could improve safety and quality of care.

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.

The district 5 zone 2 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]

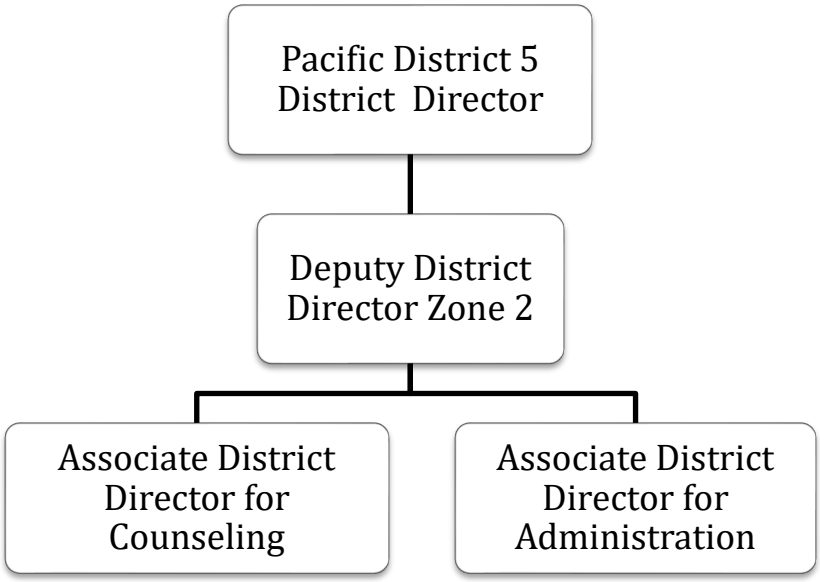

Figure 2. *Pacific district 5 zone 2 leaders.*
Source: VA OIG analysis of district organizational chart.

At the time of the OIG inspection, the district leadership team had worked together for nearly two years. Two of the 24 vet center director (VCD) positions were vacant for at least 12 months; however, both had an acting VCD assigned for ongoing coverage. District leaders were knowledgeable about the basic concepts of healthcare quality and spoke in detail about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and client experiences.[4]

[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, the term *district leaders* refers to the District Director, Deputy District Director, Associate District Director for Counseling, and Associate District Director for Administration.

The VA National Center for Organization Development's VA All Employee Survey is an annual, voluntary survey of VA workforce experiences.[5] District leaders shared in-depth information about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and client experiences. The OIG identified district 5 zone 2's top three fiscal year 2020 All Employee Survey priorities as growth, workload, and innovation.

The OIG reviewed fiscal year 2020 Vet Center Service Feedback survey results and found that district 5 zone 2 results were favorable with four of six questions exceeding national scores.

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 annual clinical and administrative quality reviews completed to ensure compliance with policy and procedures. At the time of the OIG's inspection, Readjustment Counseling Service (RCS) required 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.[6]

The OIG found district 5 zone 2 compliant with completing critical incident quality reviews for active clients with serious suicide or homicide attempts, death by suicide, or homicide when the client was only seen at the vet center.[7] The OIG found noncompliance with requirements for clinical and administrative quality reviews related to remediation plans and deficiency resolution. The OIG issued four recommendations for clinical and administrative quality reviews.

COVID-19 Response

The COVID-19 response review results were gathered through a zone-wide questionnaire to staff and interviews with district leaders and VCDs 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.

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[5] "VA All Employee Survey," VHA National Center for Organization Development, accessed August 10, 2021, https://www.va.gov/ncod/vaworkforcesurveys.asp.

[6] VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010; VHA, *RCS Guidelines and Instructions for Vet Center Administration*, November 23, 2010. Both 2010 policies were rescinded and replaced by VHA Directive 1500(1), *Readjustment Counseling Service,* January 26, 2021, amended May 3, 2021. The 2021 directive uses the term *mortality and morbidity reviews* rather than *critical incident quality reviews*.

[7] 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.

The OIG interviewed district leaders and VCDs of the four selected vet centers and asked about emergency planning; supplies and infrastructure; access and client care—telework and telehealth; and client screening including referral. District leaders were also asked about communication and field guidance. A COVID-19 voluntary questionnaire was sent to 143 employees at the 24 vet centers.

The district leaders and four VCDs indicated supplies were adequate; masks were worn in the vet centers; hand-washing and hand sanitizer stations were available; and safe social distancing was practiced throughout the zone. Overall, employees' responses to the COVID-19 questionnaire showed that communication from district leaders and VCDs was adequate to ensure the safety of clients and staff.

Suicide Prevention

The suicide prevention review included a zone-wide evaluation of electronic client records and a focused review of the four selected vet centers. Results and recommendations related to identified deficiencies were made to the district office.

Vet centers are required to complete a psychosocial assessment including an intake and military history.[8] Overall, the OIG identified deficiencies across the zone with clinician completion of psychosocial assessments and timely completion of lethality risk assessments. The OIG identified deficiencies in electronic client records with clinician coordination and consultation with support VA medical facilities for high-risk clients, adherence to client confidentiality requirements, and clinicians' timely notifications to suicide prevention coordinators of clients with significant safety risks. The OIG found deficiencies with clinical staff consultation following lethality status changes and completion of crisis reports in cases of suicide completions, attempts, gestures, and interventions; as well as homicide attempts, completions, and interventions.

The OIG found the four selected vet centers were compliant with the required availability of nontraditional hours for appointments and a critical event plan.[9] All four VCDs were also compliant with the requirement to review the High Risk Suicide Flag SharePoint site monthly.[10] The OIG found deficiencies with vet center staffs' participation on VA medical facility mental

[8] RCS-CLI-003, *Revised Clinical Site Visit (CSV) Protocol,* January 25, 2019; VHA, *RCS Guidelines and Instructions for Vet Center Client Records,* November 2010; VHA Directive 1500(1), 2021.

[9] *Vet Center Clinical Site Visit (CSV) Report* received from RCS National Service Support (NSS), April 15, 2020.

[10] RCS-CLI-006, *High Risk Suicide Flag Outreach*, April 27, 2020.

health councils.[11] Additionally, three vet centers did not provide evidence of receiving the required Office of Mental Health and Suicide Prevention list of clients with an increased predictive risk for suicide.[12] The four selected vet centers were unable to provide evidence of receiving the high risk for suicide client lists from the support VA medical facility suicide prevention coordinators. The four selected vet centers did not have a standardized communication process of collaboration with the support VA medical facility suicide prevention coordinators.

The OIG issued eight recommendations—seven specific to the suicide prevention zone-wide evaluation of electronic client records and one specific to the four selected vet centers' suicide and intervention processes.[13]

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 OIG determined the four vet centers complied with requirements for having a clinical liaison from the support VA medical facility mental health or social work service.[14] The external clinical consultants were appropriately licensed as were the required mental health professionals on staff at each vet center.[15] The OIG found deficiencies related to the four selected vet centers' external clinical

[11] VHA Handbook 1500.01, September 2010; VHA Directive 1500(1), 2021. "To reinforce the partnership between the Vet Center and the support VA medical facility, to better serve eligible Veterans accessing services at both facilities, and to fully support critical incident response and suicide prevention, a licensed Vet Center staff member will be assigned to participate on all VA Medical Center Mental Health Councils." 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." For the purposes of this report, the OIG uses the term *VA medical facility* instead of *VA medical center*.

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

[13] The Deputy Under Secretary for Health for Operations and Management (10N)'s 2017 "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services," outlined responsibilities shared between RCS and the Office of Mental Health and Suicide Prevention. The OIG does not make recommendations for deficiencies identified in this report related to three suicide prevention-shared responsibilities as recommendations on the deficiencies were directed to the Under Secretary for Health, who has authority over both programs, in an OIG report issued in September 2021—*Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021.

[14] *RCS Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021.

[15] *RCS Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021.

consultant hours and requirements for weekly staff supervision, monthly audit of records, and staff training.[16] 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 to those sites. The four vet centers generally complied with environment of care requirements for the physical environment, general safety, and privacy. However, three of the four vet centers inspected did not have Architectural Barriers Act Accessibility Standards compliant exit signs.[17] The OIG made one recommendation specific to the three selected vet centers.

Conclusion

The OIG conducted a detailed inspection across six review areas and issued 17 recommendations for improvement. 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 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.

Comments

The Readjustment Counseling Service Chief Officer and District Director concurred with recommendations 1–13 and 15–17; they concurred in principle with recommendation 14. An action plan was provided (see responses within the body of the report for the full text of Readjustment Counseling Service comments, and appendixes D and E for the Chief Officer and District Director memorandums). The OIG considers all recommendations open and will follow up on the planned and recently implemented actions to ensure they have been effective and sustained.

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

[16] *RCS Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021; RCS-CLI-003, *Revised Clinical Site Visit Protocol*, January 25, 2019.

[17] Architectural Barriers Act of 1968 (codified as amended at 42 U.S.C. § 4151 et seq.).

Contents

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.[1] 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.[2] Other services include bereavement support for families, referrals to the Veterans Benefits Administration, screening and assessment for employment and education, outreach including Post Deployment Health Reassessment, and help with linkage to Veterans Health Administration (VHA) and community organizations.[3]

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.[4] 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

[1] VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021. Vet centers provide counseling and interventions for psychological and psychosocial readjustment problems related to specific types of military deployment stressors. Because readjustment counseling services are "designed by law to be provided without a medical diagnosis 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. this report.

[2] 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(1) rescinded and replaced multiple VHA guidelines and policies addressing RCS operations that were in effect during the inspection period. Unless otherwise specified, the 2021 directive contains the same or similar language as the September 2010 rescinded handbook. Policy Memorandum RCS-CLI-003, *Revised Clinical Site Visit (CSV) Protocol*, January 25, 2019.

[3] VHA Handbook 1500.01, September 2010; VHA Directive 1500(1), 2021; "Vet Centers (Readjustment Counseling): Vet Center Eligibility," VA, accessed March 24, 2021, https://www.vetcenter.va.gov/Eligibility.asp. Post Deployment Health Reassessments are used to screen and evaluate the health of those returning from combat.

[4] VHA, *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(1), 2021. Unless otherwise specified, requirements in the 2021 directive use the same or similar language as the rescinded November 2010 guidelines. Readjustment counseling is a counseling service provided by readjustment counselors to assist with combat-related psychological and psychosocial readjustment.

American Psychiatric Association recognized posttraumatic stress disorder as an official diagnosis in 1980.[5]

While vet centers initially focused on Vietnam-era veterans, services are now offered to veterans of all combat theaters and active service members as well as their families.[6] From 1979 through 1985, an estimated 305,000 clients received services at vet centers; and by fiscal year 2019, RCS Central Office reported 307,737 clients.[7] 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.[8] Along with the increase in number of clients served, vet centers have undergone expansion to assist veterans and their families through a variety of services. Figure 3 shows a map of vet centers and vet center outstations.[9]

[5] Mayo Clinic, "Post-traumatic Stress Disorder (PTSD)," accessed December 10, 2020, https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967. "Post-traumatic stress disorder (PTSD) is a mental health condition 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, 2010; VHA Directive 1500(1), 2021.

[6] VHA Handbook 1500.01, September 2010; VHA Directive 1500(1), 2021. The 2021 directive clarified that "Family readjustment counseling is contingent upon there being a problem identified that is related to the eligible individuals' readjustment and active involvement in the counseling with family members."

[7] 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 *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 as October 1 of every given year through September 30 of the following year.

[8] Blank Jr., Arthur S. "Apocalypse Terminable and Interminable: Operation Outreach for Vietnam Veterans." *Hospital and Community Psychiatry*. Volume 33, Number 11. November 1982.

[9] 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.

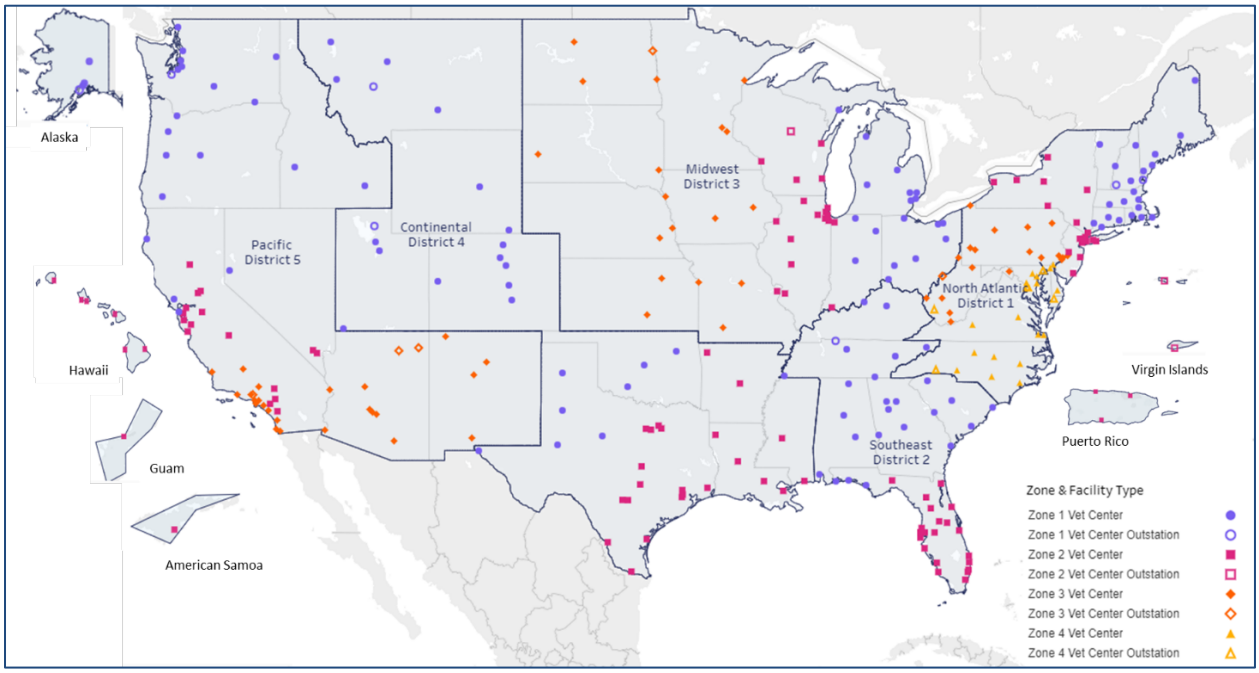

Figure 3. *Map of vet centers and vet center outstations. The placement of Alaska, American Samoa, Hawaii, Guam, Puerto Rico, and the Virgin Islands on the map is not representative of their actual geographical locations.*[10]
Source: Developed by VA OIG using VA Site Tracking (January 19, 2021) and RCS data (received March 2, 2021).

Vet center services and eligibility continue to expand 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."[11] Table 1 shows the expansion of vet center eligibility.

[10] VA News Release, *VA Deploying 20 New Mobile Vet Centers*, January 4, 2012. 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.

[11] "Who We Are," VA 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	Expansion Cohort
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 in the line of duty
2003	Veterans of the Global War on Terrorism (GWOT) Veterans of Operation Enduring Freedom (OEF) Veterans of Operation Iraqi Freedom (OIF)
2011	Federally activated National Guard and Reserve forces who served on active duty in Armed Forces in Operation Enduring Freedom or Operation Iraqi Freedom or both
2013	Family members of deployed service members for counseling Crew members of unmanned aerial vehicles in combat operations or areas of hostility Members of Armed Forces who provided direct emergent medical care or mortuary services while serving on active duty
2014	Amended VA's authority to provide counseling and care and services to active duty service members reporting sexual assault or harassment without a Tricare referral
2020	Forces who served on active duty in response to a national emergency or a major 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.[12] *Vet Center Eligibility, accessed June 4, 2019, https://www.vetcenter.va.gov/Eligibility.asp; Department of Veterans Affairs Health Care Programs Enhancement Act of 2001, Pub. L. No. 107-135 (2002); National Defense Authorization Act for Fiscal Year 2013, Pub. L. No. 112-239 (2013).*
Note: In 1996, armed hostile periods were expanded to include all combat eras. Federal Register, Vol. 77, No. 49, Proposed Rules, March 13, 2012.

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.[13] RCS establishes clinical

[12] Vet Center Eligibility Expansion Act, Pub. L. No. 116-176 (2020).

[13] "Vet Centers (Readjustment Counseling)," VA, 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 2010; VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration,* November 2010; VHA Directive 1500(1), 2021.

and administrative policies for vet center operations.[14] 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 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 clinical and administrative operations.[15]

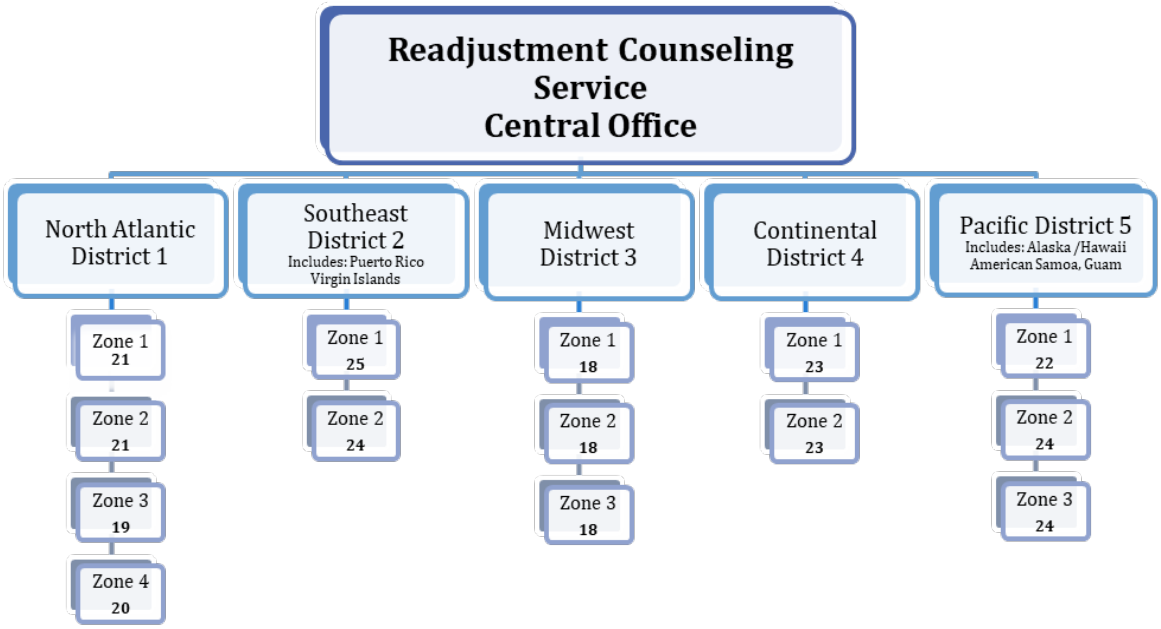

Figure 4. *RCS organizational district and zone structure.*
Source: Developed by the VA OIG after analysis of RCS information.
Note: The number of vet centers in each zone is denoted below the respective zone. The OIG did not assess RCS data for accuracy or completeness.

Electronic Client Record

Vet center services are not required to be documented in the client's VA electronic health record.[16] 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,

[14] VHA Directive 1500, September 2010; VHA Handbook 1500.01, September 2010; VHA Directive 1500(1), 2021.
[15] VHA Handbook 1500.01, September 2010; VHA Directive 1500(1), 2021.
[16] VHA, *RCS Guidelines and Instructions for Vet Center Client Records,* November 2010; VHA Directive 1500(1), 2021.

RCSnet became the sole record keeping system for client services. RCSnet's independence from VA medical facilities 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.[17] The 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.[18]

VA Medical Facilities

Guidelines, as outlined in this paragraph, 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.[19] The support VA medical facility director, in coordination with the VCD, assigns a clinical and administrative liaison.[20] The VA medical facility clinical liaison coordinates services for complex and shared clients.[21] 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.[22] 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.[23]

[17] VHA Handbook 1500.01 September 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.

[18] VHA Directive 1500, September 2010; VHA Directive 1500(1), 2021. Per the Acting RCS National Service Support Director, modernization of the RCSnet electronic client record system for vet centers was being considered but a determination had not been made. RCS Central Office is the national program 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.

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

[20] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021. Support VA medical facilities are facilities that have been identified to assist vet centers with client mental health care.

[21] For the purposes of this report, the OIG uses the term *VA medical facility* instead of *VA medical centers*.

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

[23] VHA Handbook 1500.01, September 2010; VHA Directive 1500(1), 2021.

Purpose and Scope

The purpose of the VA Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) is to provide routine oversight of vet centers providing readjustment services to clients. The OIG inspection examined operations generally from March 1, 2020, through February 28, 2021. This report evaluates aspects of 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 should help vet centers identify areas of vulnerability or conditions that, if addressed, could improve safety and quality of care (see appendix A).[24]

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 response[25]
- Suicide prevention
- Consultation, supervision, and training
- Environment of care

[24] The underlined terms are hyperlinks to other sections of the report. To return from the point of origin, press and hold the "alt" and "left arrow" keys together.

[25] VA, *VHA–Office of Emergency Management, COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan*, Version 1.6, March 23, 2020. "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." "WHO Director-General's opening remarks at the media briefing on COVID-19–11 March 2020," World Health Organization, 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.

Methodology

The OIG announced the inspection to Pacific district 5 zone 2 leaders (district leaders) on May 10, 2021, and conducted virtual site visits from May 10 through May 26, 2021.[26] The OIG interviewed district leaders and four directors at the selected vet centers. Due to travel restrictions during the COVID-19 pandemic, the inspection was conducted virtually.[27]

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 select areas of care within vet centers.

A new VHA directive was issued in January 2021 (amended May 3, 2021) during the OIG's inspection period of VCIP operations discussed in this report.[28] 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—one focused on quality improvement activities and was sent to all VCDs within the zone; the other focused on 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).

[26] For the purposes of this report, the term *district leaders* refers to the District Director, Deputy District Director, Associate District Director for Counseling and Associate District Director for Administration.

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

[28] VHA Directive 1500(1), 2021.

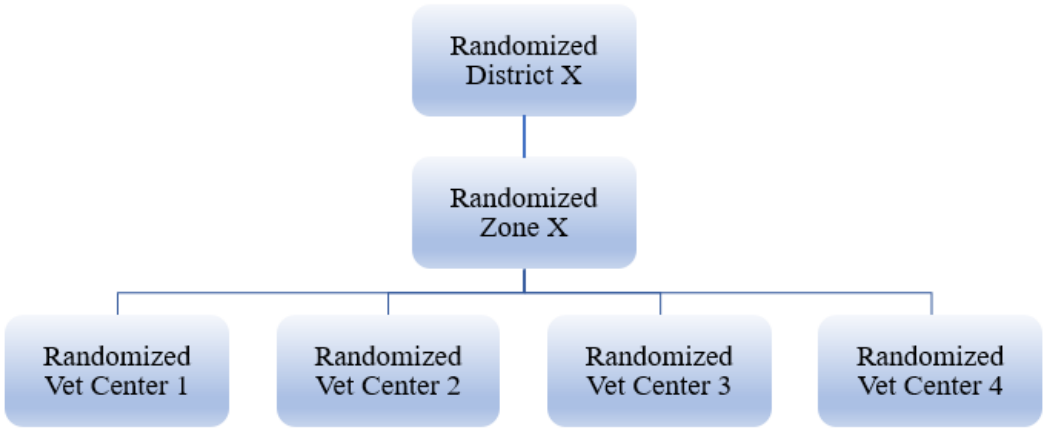

Figure 5. *Randomization and selection of inspection sites.*
Source: VA OIG.

For this inspection, Pacific district 5 zone 2 was randomly selected. Within district 5 zone 2, the Fresno and High Desert Vet Centers in California, the Honolulu Vet Center in Hawaii, and Santa Cruz County Vet Center in California were randomly selected. Geographical locations of the district 5 zone 2 vet centers are noted in figure 6 below. For demographic profiles of district 5 zone 2 and the four selected vet centers see appendixes B and C. The OIG provided one-day notice to each vet center prior to formal evaluation.[29]

[29] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021.Vet centers are composed of small multidisciplinary teams. The OIG team provided one-day notice for coordination of client care as needed.

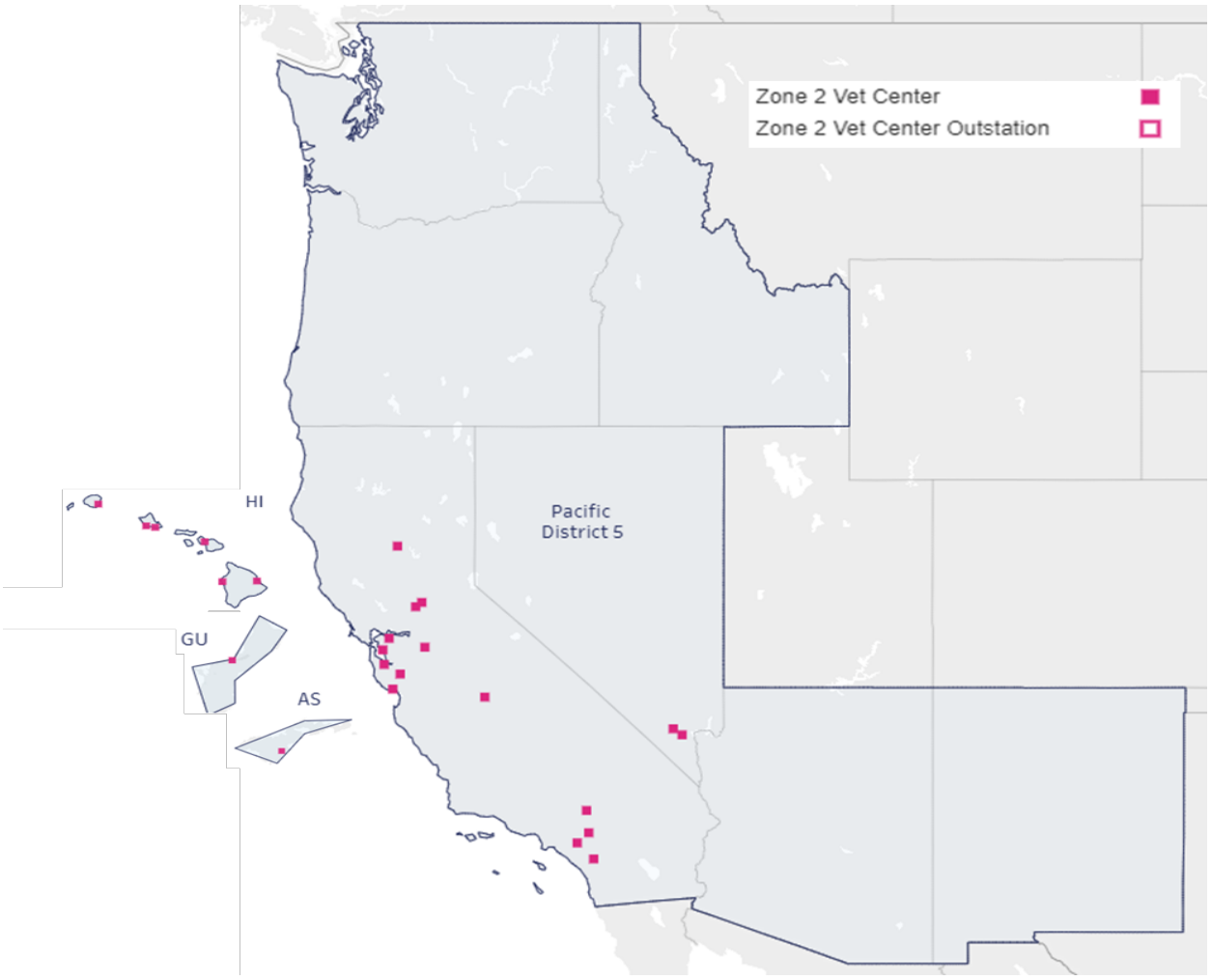

Figure 6. *Map of district 5 zone 2 vet centers including outstations.*
Source: Developed by OIG using VA Site Tracking.

The leadership and organizational risks review is specific to the district and zone office 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 vet center clinical and administrative oversight reviews for the zone and critical incident quality reviews.

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 questionnaire response and interview questions 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.[30]

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.

[30] For vet center clients shared with support VA medical facilities, the OIG also reviewed VHA electronic health records. The Deputy Under Secretary for Health for Operations and Management (10N)'s 2017 "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services," outlined responsibilities shared between RCS and the Office of Mental Health and Suicide Prevention. The OIG does not make recommendations for deficiencies identified in this report related to three suicide prevention-shared responsibilities as recommendations on the deficiencies were directed to the Under Secretary for Health, who has authority over both programs, in an OIG report issued in September 2021—*Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021.

Results and Recommendations

Recommendations target deficiencies that, if improved, would positively influence the quality of client care. The District Director's comments submitted in response to 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.[31] 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.[32]

As noted above, the OIG assessed leadership and organizational risks for district 5 zone 2 by evaluating the following:

- District leadership position stability
- Quality improvement activities
- Employee satisfaction (VA All Employee Survey Results)
- Vet Center Service Feedback survey results
- Leadership and organizational risks questionnaire results[33]

District Leadership Position Stability

RCS district directors oversee deputy district directors who are responsible for an assigned zone (one deputy per zone). Deputy district directors supervise 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 administrative operations and administrative quality reviews. VCDs report to deputy district directors and are responsible for the overall vet center operations including staff supervision, administrative and fiscal

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

[32] 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.

[33] The leadership and organizational risk questionnaire is a tool the OIG developed to ask zone-wide VCDs about quality management to evaluate knowledge and practices.

operations, outreach events, community relations, hiring staff, and clinical programs.[34] Figure 7 shows the leadership organizational structure for district 5 zone 2.

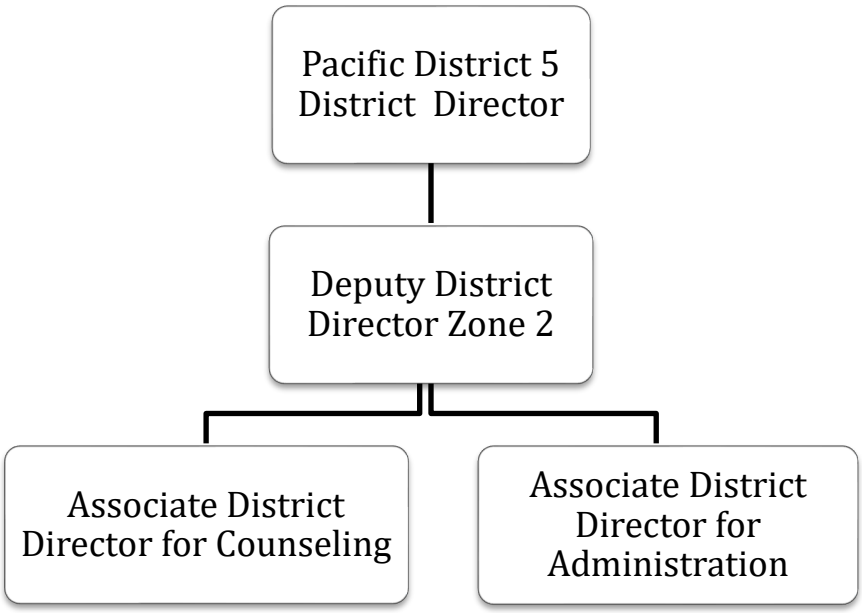

***Figure 7**: District leaders.*
Source: VA OIG analysis of district organizational chart.

At the time of the OIG interviews, the District Director had been in the role since 2016. District leadership was stable and cohesive; leaders had worked together nearly two years. Two of the 24 VCD positions were vacant for at least 12 months; however, acting VCDs were in place for both vet centers. The District Director stated while recruitment incentives were used for one of the vacancies, geographic and cost of living differences were barriers to filling the other vacant position. For the second, the District Director reported the recruiting office had difficulties with the position announcement.

Quality Improvement Activities

To assess leaders' knowledge about healthcare quality improvement concepts, the OIG interviewed district leaders. The information provided in this report section is based on those interviews.

Generally, the majority of district leaders spent greater than 10 hours a week engaged in quality improvement activities for vet centers. District leaders were knowledgeable about the basic concepts of healthcare quality and spoke in detail about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and client experiences. The District Director stated a just culture was promoted through all-hands meetings

[34] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Handbook 1500.01, September 2010; VHA Directive 1500(1), 2021.

to provide staff an open and transparent forum to discuss issues. All district leaders reported having an open door policy for staff. The OIG did not evaluate quality and performance improvement activities.

Employee Satisfaction

In 2001, the VA All Employee Survey was developed to meet VA needs for assessment of workforce satisfaction and organizational climate. According to the VHA National Center for Organization Development, the All Employee Survey is an annual, voluntary survey of VA workforce experiences. Responses are confidential and data anonymous.[35] Since 2001, the instrument has been updated in response to operational inquires by VA leadership on organizational health relationships and VA culture.[36] Although the OIG recognizes that employee satisfaction survey data are subjective, the information can be a starting point for discussions, indicative of areas for further inquiry, and considered along with other information for leaders' evaluation.

The OIG identified the top three fiscal year 2020 VA All Employee Survey priorities for district 5 zone 2 as growth, workload, and innovation. The OIG asked district leaders how the VA All Employee Survey results were prioritized and what changes were made. District leaders implemented actions including, but not limited to, the following:

- Funded professional development trainings selected by staff
- Sent biweekly staff productivity reports to VCDs

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 select criteria is met.[37] The Vet Center Service Feedback survey includes feedback from clients and family members. RCS uses the following criteria for sending a Vet Center Service Feedback survey:

[35] "VA All Employee Survey," VHA National Center for Organization Development, accessed August 10, 2021, https://www.va.gov/ncod/vaworkforcesurveys.asp.

[36] Smith, J. L., McCarren, H., VHA National Center for Organization Development, Organizational Health, "Developing servant leaders contributes to VHA's improved organizational health," Volume 19, Summer 2013. "Healthy organizations are places where employees want to work and customers want to receive services." 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.

[37] VHA Directive 1500(1), 2021; RCS-NSS-001, *Readjustment Counseling Service (RCS) Customer Feedback Procedures,* February 1, 2019.

- The client agreed to participate in questionnaire.
- The client is not receiving services from a VA contracted provider.
- 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.[38] The RCS national database system maintains all client survey feedback and compiles district and national data into summary reports.

The OIG found district 5 zone 2 fiscal year 2020 Vet Center Service Feedback survey results were favorable with scores for four of six questions exceeding national scores. Table 2 details the results of the Vet Center Service Feedback survey.

Table 2. District 5 Zone 2 Vet Center Service Feedback Survey Results October 1, 2019–September 30, 2020

Feedback Survey Item	District 5 Zone 2 Average Score*	RCS National Average Score*
I was treated in a welcoming and courteous manner by the Vet Center staff.	4.54	4.67
My appointments have been scheduled at a time that was convenient.	4.19	4.59
I would likely recommend the vet center to another Veteran, service member, or family member.	4.88	4.55
The Vet Center services were located conveniently in my community.	4.80	4.39
I feel better as a result of the services provided by the Vet Center staff.	4.82	4.39
How satisfied were you with the overall quality of services at the Vet Center?	4.85	4.48

Source: Developed by VA OIG based on RCS National Service Support data provided by the District 5 Director. The OIG did not assess VA data for accuracy or completeness.

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

District leaders reported high scores were attributable to vet center staff who ensured client care was prioritized and created a welcoming home-like vet center environment.

[38] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021. The Vet Center Service Feedback survey was formerly known as the Vet Center Client Satisfaction survey. The 2021 directive did not update the survey title and the requirements for administration remained the same.

Leadership and Organizational Risks Questionnaire

The OIG sent a leadership and organizational risk questionnaire to all district 5 zone 2 VCDs consisting of six questions and an optional feedback question to evaluate the perspectives of VCDs about select quality improvement activities and organizational health. Of the 24 questionnaires distributed, 23 were returned.[39] The questionnaire had open-ended questions (with one exception) with no categories or options provided for selection. Responses were aggregated and open-ended question responses reviewed for themes.[40] The information provided in this section is based on the questionnaire responses. The OIG did not validate respondent answers for accuracy.

Overall, VCDs identified district leaders as supportive of vet center quality improvement efforts. District office communication, engagement, and training were examples of district support for quality improvement activities. VCDs had a good understanding of quality management principles and perceived their role as important to quality oversight. Fourteen of 23 (61 percent) VCDs indicated they spent less than five hours per week engaged in quality related functions. VCDs used a variety of methods to promote psychological safety in the work place including staff engagement, transparency, weekly team meetings, and treating all staff fairly. Stability of vet center operations was ensured through vet center staff and the support of other VCDs and zone leaders.

Leadership and Organizational Risks Conclusion

The district 5 zone 2 leadership team was stable and cohesive with coverage in place for two VCD vacancies. District leaders and VCDs had a general understanding of quality management principles and perceived their role as important to driving and overseeing quality improvement activities. District leaders discussed actions implemented from the 2020 VA All Employee Survey results to improve organizational performance. They noted that client and family feedback survey scores showed above average satisfaction. Questionnaire responses indicated VCDs identified district leaders as supportive for quality improvement activities, and a variety of strategies were used to promote psychological safety in vet centers.

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.[41] In its effort to ensure quality of care, client safety, and

[39] The OIG sent several electronic messages to the Guam VCD as reminders to complete the questionnaire but did not receive a response.

[40] The OIG reviewed and categorized VCD responses for general themes using a manual counting method for frequency of responses. Some responses were analyzed but not included in this review due to infrequency, lack of clarity, or redundancy.

[41] VA, *Veterans Health Administration'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.[42]

The OIG evaluated quality oversight in district 5 zone 2 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 services.[43] Annual quality reviews are composed of separate clinical and administrative reviews. Clinical and administrative quality reviews are similar processes that follow the same time frames and policy, but are completed independently, produce separate reports, and are documented differently.[44]

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 feedback[45]

Administrative quality reviews included multiple areas of evaluation:

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

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

[43] VHA Handbook 1500.01, September 2010. VHA Directive 1500(1), 2021.

[44] RCS-CLI-004, *Implementation of Automated Vet Center Clinical Site Visit (CSV) Operations*, November 4, 2019; VHA Directive 1500(1), 2021.

[45] RCS-CLI-003, January 25, 2019.

- Quality management
- Fiscal management[46]

RCS policy requires district directors ensure annual vet center clinical and administrative quality reviews are conducted.[47] Deputy district directors are responsible for approving annual clinical and administrative quality reviews and remediation plans.[48] Associate district directors for counseling and administration conduct the annual quality reviews that result in written reports. Deficiencies identified in the annual quality reviews are also included in the report.[49]

Within 30 days of receiving the clinical or administrative 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.[50] Within 60 days from the date the deputy district director approves the remediation plan, the VCD is responsible for resolving all deficiencies.[51] 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.[52] Figure 8 depicts the annual vet center quality review process.

46 Readjustment Counseling Service, *District 1 Vet Center Administrative Quality Review Template*, sections I–VI, revised October 24, 2016. The template was provided by RCS Central Office on July 7, 2020.

47 RCS-CLI-001, *Vet Center Clinical and Administrative Site Visits*, November 2, 2018; VHA Directive 1500(1), 2021.

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

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

50 RCS-CLI-001, November 2, 2018.

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

52 RCS-CLI-001, November 2, 2018.

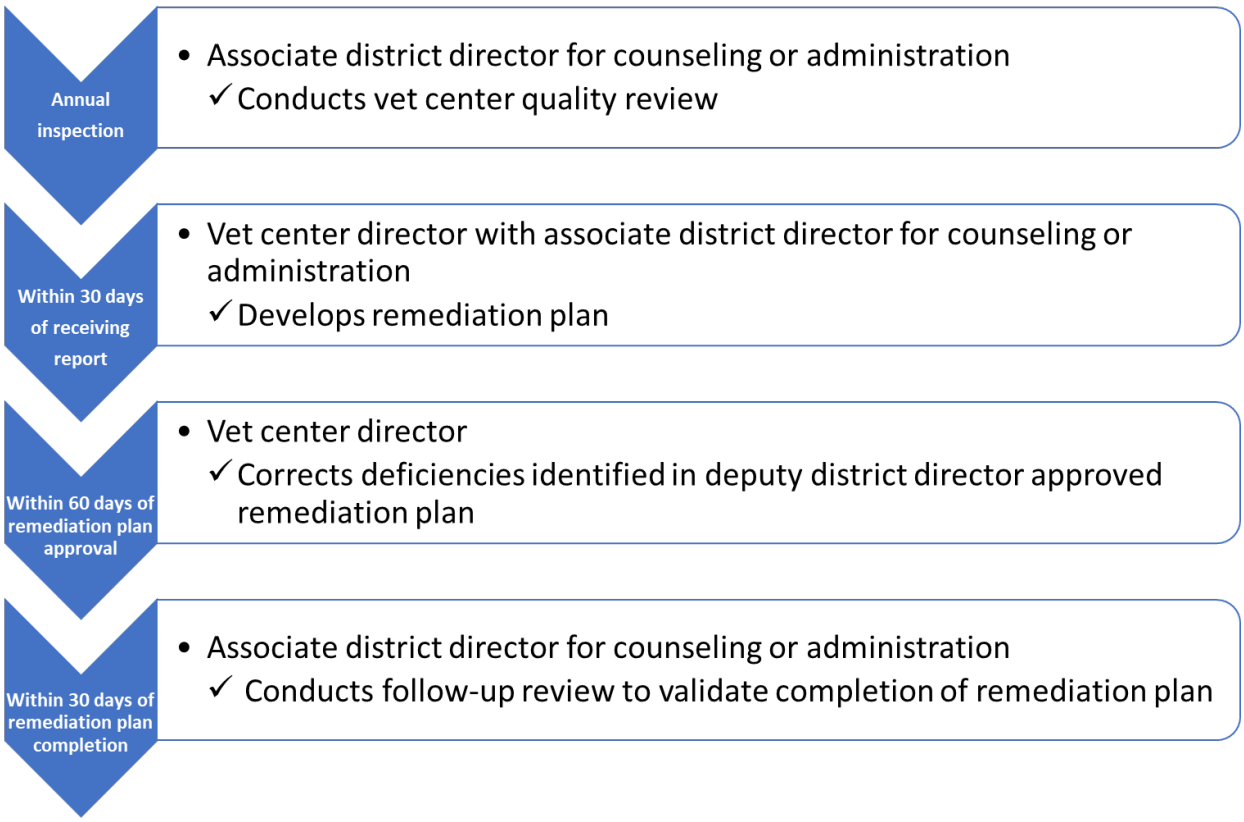

Figure 8. *Vet Center administrative and clinical quality review process.*
Source: Developed by VA OIG using, RCS-CLI-001, November 2, 2018, and VHA Directive 1500(1), 2021. RCS-CLI-001 was not rescinded by the 2021 directive; while the 2021 directive does not include a step for the deputy district director's approval of the remediation plan, the requirement remains per RCS-CLI-001.

The OIG evaluation for the clinical and administrative quality review processes for all district 5 zone 2 vet centers included interviewing district leaders as well as a review of

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

Clinical Quality Reviews Findings

Overall, the OIG found district 5 zone 2 noncompliant with RCS requirements for annual clinical quality reviews. Clinical quality review responsibilities were primarily managed by the Associate District Director for Counseling with the Deputy District Director responsible for final approval of the quality review report.[53]

[53] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration,* November 2010; VHA Directive 1500(1), 2021; RCS-CLI-003, January 25, 2019.

Clinical quality reviews were completed for 23 of the 24 vet centers. One site visit report had a site visit date but visit information was not populated and it was unsigned. On average, clinical site visit reports were approved within 19 days of the site visit; three of the 23 reports exceeded the 30 day approval time frame. Of the 23 completed clinical quality site visit reports, 22 vet centers had clinical deficiencies identified; all had remediation plans (see table 3).

Across the 22 vet centers with completed remediation plans, clinical deficiencies were identified and most were addressed with documentation of resolution. The Associate District Director for Counseling was knowledgeable of the clinical oversight process and discussed RCSnet report limitations for clinical chart audits and workarounds developed to monitor staff caseloads and documentation.

Table 3. District 5 Zone 2 Vet Center Clinical Quality Reviews

Requirement	Expected Reports	Completed Reports
Annual Clinical Quality Reviews	24	23
Clinical Quality Remediation Plans	22	22

Source: VA OIG analysis based on district 5 zone 2 documents.
Note: The OIG requested the most recent quality reviews completed on or prior to February 28, 2021.

The OIG identified the following findings:

- The Deputy District Director's approval date for clinical site visit remediation plans could not be determined resulting in no clear time frame for deficiency resolution.
- Date of clinical deficiency resolution could not be identified.[54]

RCS guidance states clinical quality reviews and remediation plans are documented in RCSnet to improve monitoring of site visits and to allow for trending of deficiencies for quality improvement activities.[55] RCS requires deputy district director approval of remediation plans to establish the 60-day time frame for deficiency resolution. The OIG found that the RCSnet remediation plan did not have a location or process to record the deputy district director approval signature or date.

The OIG was able to determine documentation of deficiency resolution; however, the RCSnet remediation plan did not indicate the date of resolution when items were completed. Due to these limitations, the OIG was not able to determine if the clinical deficiencies were resolved within the required time frame of 60 days from deputy district director's approval of the remediation plan.

[54] Although there was a finding for the time period of this review, the OIG determined that VHA Directive 1500(1) issued in 2021 removed the requirement for deputy district director approval of the remediation plan. The current policy guidelines are congruent with the process steps in RCSnet for clinical remediation plans.

[55] RCS-CLI-004, November 4, 2019.

Administrative Quality Reviews Findings

Overall, the OIG found the zone to be noncompliant with administrative quality oversight reviews.

The Associate District Director for Administration completed an administrative quality site review for 23 of the 24 vet centers. On average, the administrative site visit reports were approved within 71 days of the site visit; 11 out of 23 reports were approved within 30 days of the administrative site visit. Of the 23 completed administrative quality site visit reports, 20 vet centers had administrative deficiencies identified; 12 of the 20 vet centers had remediation plans (see table 4). Across the 23 vet centers with quality site visit reports, deficiencies were identified in the 12 remediation plans. Of the 12 remediation plans, one was not approved by the Deputy District Director. The OIG was unable to determine if remediation plan deficiencies were resolved because of lack of documentation. The Associate District Director for Administration told the OIG that once remediation plans were approved, verification of actions taken to resolve the deficiencies did not occur until the following year at the time of the next site visit.

Table 4. District 5 Zone 2 Vet Center Administrative Quality Reviews

Requirement	Expected Reports	Completed Reports
Annual Administrative Quality Reviews	24	23
Administrative Quality Remediation Plans	20	12

Source: VA OIG analysis based on district 5 zone 2 documents.
Note: The OIG request was for the most recent vet center quality reviews completed on or prior to February 28, 2021.

The OIG identified the following findings:

- A remediation plan was not approved by the Deputy District Director.
- District leaders did not provide documentation to demonstrate all deficiencies were corrected.
- The time frame of deficiency resolution could not be determined for all identified administrative deficiencies.

Clinical and Administrative Quality Review Recommendations

Recommendation 1

The District Director determines reasons for missing and incomplete clinical quality reviews, remediation plans, and resolution of deficiencies; ensures completion; and monitors compliance.

District Director response: Concur

RCS requires that every Vet Center receive a clinical quality review each Fiscal Year (FY). The clinical quality review process is entered and monitored through a web-based portal; the District has implemented a monthly review process to ensure compliance with all aspects of the process. It is important to note that since the date of this review, quality review time has been clarified to reflect RCS' intention that quality reviews be conducted within a FY. The District will monitor compliance.

Status: Ongoing

Target date for completion: July 2022

Recommendation 2

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

District Director response: Concur

The District's monitoring of the clinical site visits will include a monthly manual review process to ensure all deficiencies are tracked and resolved as specified in RCS policy.

Status: Ongoing

Target date for completion: July 2022

Recommendation 3

The District Director determines reasons for missing and incomplete administrative quality reviews, remediation plans, and resolution of deficiencies; ensures completion; and monitors compliance.

District Director response: Concur

The administrative site visits remain a manual process. Electronic signature validation will be required and monitored/tracked by the District as part of the validation process.

Status: Ongoing

Target date for completion: July 2022

Recommendation 4

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

District Director response: Concur

The District's manual monitoring of the administrative site visits will include a monthly District review process to ensure all deficiencies are tracked and resolved as specified in RCS policy.

Status: Ongoing

Target date for completion: July 2022

Critical Incident Quality Reviews

VHA's National Patient Safety Improvement Handbook states that careful investigation and analysis of client safety events (events not primarily related to the natural course of the client's illness or underlying condition) as well as evaluation of corrective action are essential to reduce risk and prevent adverse events.[56] RCS 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.[57]

At the time of the OIG inspection, RCS 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.[58] For vet center clients who are also seen at a VA medical facility, the mortality and morbidity review should be completed by the VA medical facility.[59] Critical incident quality reviews follow RCS psychological autopsy protocol to evaluate actions taken and make recommendations to improve the effectiveness of vet center suicide prevention activities.[60]

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[56] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

[57] VHA Handbook 1500.01, September 2010; VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration;* November 2010; VHA Directive 1500(1), 2021.

[58] VHA Handbook 1500.01, September 2010; VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration;* November 2010; VHA Directive 1500(1), 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.

[59] VHA Handbook 1500.01, September 2010.

[60] Isometsä, ET, "Psychological autopsy studies – a review," Eur Psychiatry, November 2001 16(7): 379-85, 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), 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.

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

Critical Incident Quality Reviews Findings and Recommendations

The OIG found district 5 zone 2 compliant with requirements for critical incident quality reviews.[61] Of 32 crisis reports reviewed, the OIG identified three clients who died by suicide. The district completed two critical incident quality reviews and the Associate District Director for Counseling reported a third review was underway at the time of the OIG inspection.[62] A review of the documentation showed no crisis reports entries for homicide-related events. District leaders completed critical incident quality reviews for three clients with serious suicide attempts.

The Associate District Director for Counseling reported performance improvement activities were conducted through sharing critical incident quality review outcomes during counselor conference calls and emails to field staff. The Deputy District Director stated a debriefing with vet center teams was conducted after critical quality incident reviews for quality purposes and to provide staff support.[63]

COVID-19 Response

On March 11, 2020, because of the spread of COVID-19 globally, the World Health Organization declared a pandemic.[64] On March 16, 2020, 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 also issued guidance for telephone and walk-in screening procedures:

[61] 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.

[62] According to the district leader, the ongoing critical incident quality review that was originally thought to be a suicide was a homicide.

[63] VHA Handbook 1050.01, March 4, 2011.

[64] VHA–OEM, *COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan*, *Version 1.6*, March 23, 2020. "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." World Health Organization, "WHO Director-General's opening remarks at the media briefing on COVID-19 – 11 March 2020," accessed 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. *Merriaum-Webster.com Dictionary*, "pandemic," accessed June 23, 2021, https://www.merriam-webster.com/dictionary/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

- 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[65]
- Work with local VA medical facility and community health partners to determine appropriate referrals for visitors with positive screens[66]

On March 20, 2020, RCS issued a COVID-19 operational assessment guide focused on client needs and local environment for its operational decisions.[67] RCS required districts to report vet center operation levels to its centralized operations office daily, deputy district directors to communicate guidance and operational plans within zones, and VCDs to provide COVID-19 updates to employees during staff meetings.[68]

In response to the pandemic, VHA's Office of Emergency Management issued the *COVID-19 Response Plan*, *Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan* (COVID-19 Response Plan) on March 23, 2020, that detailed 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, to the COVID-19 outbreak."[69]

With a stated goal of keeping staff safe and to mitigate against equipment barriers that might interfere with client services, RCS issued telework guidance on March 23, 2020.[70] 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.[71] 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

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

[66] RCS has five geographic regions known as districts that are subdivided into distinct zones. Vet centers are located within respective district zones. RCS-OPS-001.

[67] RCS-OPS-004, *COVID-19, Readjustment Counseling Service (RCS) Operational Level Assessment*, March 20, 2020.

[68] *VHA Office of Emergency Management, COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan*, Version 1.6, March 23, 2020; RCS-OPS-004, March 20, 2020.

[69] *COVID-19 Response Plan*, March 23, 2020.

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

[71] RCS defines telework-ready as an employee who is eligible to telework, has an approved written telework agreement, and has taken required training.

needs of those we serve." In addition to using VA Video Connect, RCS permitted the use of a VANTS teleconferencing for group therapy sessions.[72]

To evaluate district and vet center preparedness for mitigation and response of potential impacts from the COVID-19 pandemic. The OIG review examined the 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 the four district leaders to discuss the five topics noted above. The information provided in this report section is based on those interviews.

Emergency Planning

A majority of the district leaders initially did not feel adequately prepared for the COVID-19 pandemic; however, they quickly adjusted, figured out what needed to be done, and changed the care delivery model from face-to-face encounters to virtual visits. Two district leaders said there was not an emergency operation plan in place prior to the pandemic on March 11, 2020.

Communication and Field Guidance

Two district leaders indicated RCS Central Office field guidance related to COVID-19 was timely and adequate; the other two did not feel it was adequate. District leaders communicated RCS Central Office field guidance across the district and zone. There were daily conference calls initially but as the pandemic response stabilized, calls decreased to twice a week.

Supplies and Infrastructure

Vet centers had adequate sanitation supplies and face masks for staff. Distancing guidelines were maintained. Leaders reported vet centers had plans in place to determine what needed to be cleaned and disinfected.

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

Access and Client Care—Telework and Telehealth

All staff were authorized to telework, with approved telework agreements in place for individuals who utilize telework, and all vet centers offered telehealth services.

Client Screening Including Referral

Clients were called by vet centers 24 hours prior to scheduled appointments for screening of COVID-19 symptoms. Screening was conducted when clients entered vet centers, temperatures taken, and masks provided. If clients chose not to wear masks, telehealth was offered, and clients were not seen in person. When clients screened positive for COVID-19 symptoms, referral pathways were followed.[73]

Vet Center Directors

The OIG interviewed 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 report section is based on those interviews.

Emergency Planning

The four VCDs felt adequately prepared to respond to the pandemic and each vet center had an emergency plan in place at the onset of the pandemic. Since the beginning of the pandemic, two VCDs evaluated the emergency plan's effectiveness and two did not. All VCDs received useful pandemic-related information. One VCD stated it would have been helpful to have received information specific about the impact of the pandemic on their local communities. The four VCDs had established referral mechanisms with local VA medical facilities and community health partners for clients with positive screens for COVID-19. All VCDs worked with community partners and stakeholders 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.[74] Cleaning supplies at three of four vet centers were adequate at the onset of the pandemic and a plan was in place at all four vet centers to determine what needed to be cleaned and disinfected. All four vet centers inspected took steps to encourage social distancing and had soap and water stations for hand washing.

[73] The referral pathway for a client who screened positive for COVID-19 was an additional evaluation at an appropriate community referral source, such as a VA medical facility or community provider.

[74] RCS, *RCS Moving Forward Plan, Balancing Readjustment Counseling Services in the COVID-19 Era*, July 11, 2020; COVID-19 Response Plan, March 23, 2020.

Access and Client Care—Telework and Telehealth

The RCS Moving Forward Plan outlines considerations for both virtual and traditional care to safeguard clients and staff.[75] All four vet centers were able to provide telehealth services following the onset of the pandemic. Necessary equipment and training were available at each vet center. Clients who were unable to be seen in person were offered alternative services at all four inspected vet centers, such as telehealth, teleconferencing, or counseling by phone.[76] Telework was available to all staff.

Client Screening Including Referral

At all four vet centers, clients were called and screened for COVID-19 symptoms prior to scheduled and walk-in appointments. Per RCS policy, clients with positive screens were to be referred to local VA medical facility and community partners and reported to the district office for further coordination.[77]

Zone-Wide Staff Questionnaire Responses

The OIG sent a COVID-19 voluntary questionnaire to zone 2 vet center staff. Of the 143 questionnaires sent, 124 (87 percent) were returned with responses. Staff were asked 14 questions about personal and patient safety, leadership communication, personal protective equipment, work assignments, telework, and employee assistance. The questionnaire included open-ended questions that asked what the vet center did well, what needed improvement, and lessons learned during the pandemic. The information provided in this section is based on those questionnaire responses.

Respondents indicated that district leaders and VCDs provided routine communication and guidance that helped with employee and client safety. Sixty-seven percent of respondents stated teleworking was occurring; most respondents reported being offered telework (95 percent) and completing telework agreements (94 percent) during the pandemic. Of 121 employees, 87 (72 percent) indicated employee assistance or other types of assistance were available. Qualitative responses to "what went well" included

- enactment of COVID-19 safety procedures,
- implementation of telehealth mechanisms to continue to provide care to clients, and
- good communication amongst their individual vet center teams and receipt of timely information from vet center leadership.

[75] RCS, *RCS Moving Forward Plan, Balancing Readjustment Counseling Services in the COVID-19 Era*; *COVID-19 Response Plan*, March 23, 2020.

[76] *COVID-19 Response Plan*, March 23, 2020.

[77] RCS-OPS-001, March 16, 2020. Vet Center Novel Corona Virus screening requires referral to VA and community health partners and immediate reporting to RCS Central Office for positive screening.

Employees indicated that "lessons learned" included the adaptability and flexibility of vet centers to safely serve clients through telehealth.

COVID-19 Responses Conclusion

At the onset of the pandemic, district leaders reported quickly adjusting and offering alternative care modalities such as telehealth, teleconferencing and phone counseling. District leaders held daily conference calls with staff to communicate RCS Central Office field guidance. VCDs reported having emergency plans in place with adequate cleaning supplies. Precautionary measures were implemented with COVID-19 screenings for vet center visitors and those with positive screenings were referred to local health care pathways. Since the pandemic, telework expanded and vet centers increased their reliance on telehealth technology for counseling services. The four VCDs reported following COVID-19 safe practice guidelines and took appropriate steps to protect the safety of employees and clients. Overall, responses to the COVID-19 questionnaire showed employees felt the communication and guidance from district leaders and VCDs was adequate to ensure the safety of clients and staff. The majority of employees indicated the implementation of telehealth and telework was a positive action that worked well for vet centers.

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.[78] 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."[79] 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.[80]

RCS was identified as an important part of VA's overall suicide prevention strategy.[81] 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. The Memorandum of Understanding

[78] 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.

[79] VA Office of Mental Health and Suicide Prevention, "National Strategy for Preventing Veteran Suicide 2018 2028," accessed November 1, 2018, https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.

[80] VA Office of Mental Health and Suicide Prevention, "National Strategy for Preventing Veteran Suicide 2018 2028," accessed November 1, 2018, https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.

[81] Deputy Under Secretary for Health for Operations and Management (10N), *Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service,* November 13, 2017.

defines operations for the identification, notification, and treatment of high risk or suicidal veterans and quality reviews related to veteran suicides for active clients.[82]

Staff at VA medical facilities are responsible for identifying high risk individuals and activating a patient record flag in the client's VHA electronic health record, visible to RCS counselors. 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.[83]

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 in the following areas:

- Psychosocial and lethality risk assessments *(zone-wide)*
- Care coordination and collaboration with VHA—RCS and VA medical facility shared high risk for suicide clients *(zone-wide)*
- Access *(four selected vet centers)*
- Care coordination and collaboration with VA medical facilities *(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 (Zone-Wide)

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." 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 the required time frame.[84] Psychosocial assessments are used to gather information about the client "presenting issues and level of functioning" to complete a clinical evaluation.

[82] Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding, 2017.

[83] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, amended November 16, 2015.

[84] RCS-CLI-003, January 25, 2019; VHA, *Readjustment Counseling Service Guidelines and Instruction for Client Records*, November 2010; VHA Directive 1500(1), 2021.

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."[85] An RCS Central Office leader reported that effective October 2020, RCS replaced the lethality risk assessment within the psychosocial assessment with a "Comprehensive Suicide Risk Assessment and Safety Plan."[86] The new assessment follows the 2019 VA/DoD Clinical Practice Guideline by incorporating common terminology used for suicide risk evaluation and consultation practices that are familiar to other clinical providers.[87]

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. The OIG randomly selected two samples of clients new to vet centers from March 1, 2020, through February 28, 2021.[88] The samples included

- 60 electronic client records with five or more visits, and
- 40 clients with four or less visits.[89]

The OIG reviewed electronic client records to determine if intake 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 electronic client records for extenuating circumstances. The OIG reviewed electronic client records to determine timely completion of lethality risk assessments by evaluating the first clinical note for either a rationale for a lethality rating or reference to and completion of a lethality or risk assessment.[90] The OIG team used a 90 percent benchmark to evaluate electronic client records for compliance with selected RCS

[85] RCS-CLI-003, January 25, 2019.

[86] "Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services (RCSnet)", September 19, 2020.

[87] *VA/DoD Clinical Practice Guideline For The Assessment And Management Of Patients At Risk For Suicide*, May 2019.

[88] The sub-population size was randomly selected and weighted for the two samples.

[89] RCS-CLI-003, 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 was reviewed for completion of the intake, military history, and lethality risk assessment. The sample of 40 client records was used to evaluate completion of the lethality risk assessment as this client group had less than five visits; therefore, completion of the psychosocial assessment was not required.

[90] For clients seen before October 12, 2020, the OIG reviewed electronic client records for clinical rationales for the inclusion of lethality section questions from the RCS intake assessment that assessed for 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. For clients seen on or after October 12, 2020, the OIG reviewed clinical rationales for inclusion of narrative sections from the new RCS risk assessment that assessed for suicidal ideation, suicidal history, risk and protective factors, and warning signs. Timely completion refers to completion of the note or assessment within two business days of client contact.

requirements for psychosocial assessments (including intake and military histories) and lethality risk assessments.

The OIG was able to determine intake and military history completion through a RCSnet record review. However, the OIG was unable to determine the date of completion for each section through RCSnet. Therefore, the OIG was unable to evaluate if intake and military histories were completed by the fifth visit as required.

The OIG was able to determine timely completion of lethality assessments through the electronic client record review if the assessment was documented in its entirety in the first clinical note. However, the OIG was unable to determine when the lethality portion of the intake assessment and the new risk assessment was completed.

Despite the OIG having access to the RCSnet database, dates of completion for the lethality portion in the intake assessment and the new risk assessment were unidentifiable. Due to RCSnet limitations, the OIG reviewed the first clinical note and visit in the electronic client record for documentation that the clinician completed one of the following:

- A full lethality assessment
- The lethality portion of the intake assessment
- The new risk assessment[91]

Psychosocial Assessment and Lethality Risk Assessments Findings and Recommendations (Zone-Wide)

Overall, the OIG found district 5 zone 2 vet centers noncompliant with requirements for completion of intake and lethality assessments, summarized in table 5 below.[92]

[91] The lethality portion of the intake assessment and the new risk assessment had creation dates but did not have completion dates in RCSnet or the database.

[92] Based on the statistical analysis, the OIG concluded there was not a finding for military history.

Table 5. District 5 Zone 2 Vet Centers RCSnet Electronic Client Record Review March 1, 2020–February 28, 2021

Electronic Client Record Section	Number of Electronic Client Records Reviewed	Estimated Percentage (%) Completed Zone-Wide	95% Confidence Interval*
Intake	60	41.7	(30.0, 55.0)
Military History	60	86.7	(76.7, 95.0)
Lethality Risk Assessment	100	21.8	(13.9, 30.2)

Source: VA OIG district 5 zone 2 RCSnet electronic client 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 January 21, 2021, https://www.merriam-webster.com/dictionary/confidence%20interval.*

The OIG identified the following findings:

- Vet center counselors did not consistently complete the intake portion of the psychosocial assessment.
- Vet center counselors did not consistently complete lethality risk assessments with the first individual clinical visit.

Recommendation 5

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 the steps necessary to ensure the proper completion and electronic monitoring of intake assessments within RCSNet in FY 2021. The Vet Center Director and District leadership will monitor compliance.

Status: Ongoing

Target date for completion: July 2022

Recommendation 6

The District Director ensures lethality risk assessments are completed on the first clinical visit and monitors compliance across all zone vet centers.

District Director response: Concur

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

Status: Ongoing

Target date for completion: July 2022

Recommendation 7

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 not visible in RCSnet and ensures compliance with standards for timely completion of intake assessments and lethality risk assessments.

District Director response: Concur

The District has provided training in FY 2021 to the field regarding the requirements for, and completion of, intake assessments, military histories, and risk assessments. The Vet Center Director and District leadership will monitor compliance and work with RCS record system administrators to improve electronic monitoring.

Status: Ongoing

Target date for completion: July 2022

Suicide Prevention and Intervention (Zone-Wide)

Care Coordination and Collaboration with VA Medical Facilities—RCS and VA Medical Facility Shared High Risk Clients

As outlined in the 2017 Memorandum of Understanding, there is a "shared responsibility for suicide prevention among the Office of Mental Health and Suicide Prevention (OMHSP), Suicide Prevention Coordinators (SPCs), and Readjustment Counseling Service (RCS)."[93] Further, RCS clinical staff are required to consult and coordinate care with the support VA medical facility for all clients who are high risk for suicide, and to provide timely notification to suicide prevention coordinators when clients pose a significant safety risk.[94] Vet center staff are required to follow confidentiality requirements when coordinating care with the VA medical

[93] Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding, 2017.

[94] Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding, 2017.

facility.[95] Effective June 1, 2019, RCS required vet center counselors to seek consultation from the VCD, external clinical consultant, or the support VA medical facility suicide prevention coordinator for all clients with lethality changes.[96] Prior to October 12, 2020, RCSnet lethality designations included non-lethal, mild, moderate, and severe. According to the RCS Deputy Chief Officer, effective October 12, 2020, lethality designations changed to low, intermediate, and high.

Electronic Client Records

The OIG evaluated suicide prevention and intervention by reviewing 45 randomly selected high-risk clients seen at vet centers throughout the zone between March 1, 2020, through December 31, 2020.[97] The OIG extracted each client's lethality history from the RCSnet database as RCS confirmed information was not available in the section of RCSnet used by vet center staff and for OIG electronic client record review.

The OIG evaluated each electronic client record for the following:

- Consultation and coordination of services with support VA medical facility for shared clients within 60 days after high risk for suicide flag placement
    - Adherence to confidentiality requirements if consultation and coordination occurred
- Timely notification to VA medical facility suicide prevention coordinator if the client posed a significant safety risk[98]
    - Adherence to confidentiality requirements if notification occurred

[95] 38CFR§17.2000-*Vet Center Services,* September 17, 2013.

[96] RCS-CLI-003, January 25, 2019. "Vet Center counselors seek consultation from the Vet Center Director, the External Clinical Consultant (assigned by the nearest VAMC), the VHA Suicide Prevention Coordinator, or any combination thereof, for all clients who are assessed as at mild-risk or greater, consistent with the most recent publication of VHA Directive 1500." Effective October 12, 2020, RCS issued new requirements for completion of the risk assessment in accordance with VHA Directive 1500(1) that states "For individuals assessed to be at Intermediate to High-Risk either acute, chronic, or both: (a) The Vet Center counselor will seek consultation on the case through the Vet Center Director, ADD/C, VA assigned External Clinical Consultant, and/or other VHA mental health professionals to include the Suicide Prevention Coordinator at the support VA medical facility." The OIG evaluated both.

[97] There were 45 clients at high risk for suicide during this time period in district 5 zone 2; therefore, no sampling was needed. The whole population was used for the review. The OIG extracted all high risk for suicide (newly activated and reactivated) clients from all district 5 zone 2 vet centers support VA medical facilities and cross referenced the clients with RCSnet database to identify shared clients. The data extraction period was adjusted (shortened by two months from review period) to allow time for RCS clinical staff to complete required care coordination following high risk flag placement, lethality status changes, and crisis events.

[98] In the absence of a RCS definition, the OIG considered significant safety risk as suicide or homicide attempts and imminent risk of suicide or homicide.

- Consultation with the VCD, external clinical consultant, or suicide prevention coordinator within 30 days of a client lethality status change
- Progress notes within the review period in the electronic client record documenting suicide or homicide completions, attempts, gestures, or interventions exist, and whether each progress note has a corresponding crisis report[99]

Suicide Prevention and Intervention Findings and Recommendations (Zone-Wide)

The OIG found vet centers in district 5 zone 2 were generally not compliant with requirements of coordination and confidentiality of shared clients for suicide prevention and intervention.[100] The OIG was unable to determine if district 5 zone 2 was compliant with timely notification when the client posed a significant safety risk due to the small client sample size.[101]

The OIG excluded two of 45 electronic client records whose cases were closed. Overall, the OIG found the 43 records reviewed in zone 2 noncompliant with RCS requirements for consultation, communication, and confidentiality for shared clients with VA medical facilities as noted in table 6 below.

Table 6. Vet Centers' Suicide Prevention and Intervention Client Record Review March 1, 2020–December 31, 2020

Review Area	Number of Records Reviewed	Percent Compliant (%)
Vet Center staff consulted with and coordinated services with the shared VA medical facility for care of clients with high risk for suicide flag placement.	43	30
Vet Center staff followed confidentiality requirements when consulting with and coordinating services with the shared VA medical facility.	43	2
A vet center counselor assigned or documented a lethality change of mild (low) or greater, and the counselor consulted with the VCD, external clinical consultant, or VHA suicide prevention coordinator at the support VA medical facility.	31	42
Progress notes documenting suicide or homicide completions, attempts, gestures, or interventions exist, and each progress note has a corresponding crisis report.	15	47

Source: VA OIG district 5 zone 2, RCSnet record reviews.

The OIG identified the following findings for district 5 zone 2:

[99] RCS-CLI-003, January 25, 2019.

[100] 38 CFR 17.2000 (e), Vet Center Confidentiality Requirements.

[101] Due to a small sample size (zone 2 had seven client records), a percentage could not be calculated for the timeliness requirement.

- Vet centers did not consistently consult or coordinate with VA medical facilities on shared clients with high risk for suicide flag placement.
- For clients where coordination occurred with VA medical facilities, vet centers did not consistently follow confidentiality requirements.
- Vet centers that had clients with a documented lethality change of mild (low) or greater (high) did not consistently consult with a VCD, external clinical consultant, or VA medical facility suicide prevention coordinator.
- Vet centers did not consistently complete a crisis report when progress notes indicated a death by suicide or homicide, attempt, gesture, or intervention existed.

Recommendation 8

The District Director ensures clinical staff consult and coordinate care with the shared support VA medical facility for clients with high risk for suicide flag placement and monitors compliance across all zone vet centers.

District Director response: Concur

The District Director ensures clinical staff follow confidentiality requirements when consulting and coordinating care with the support VA medical facility for shared clients flagged as high risk for suicide and monitors compliance across all zone vet centers. 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. The reconciliation of these lists will be monitored by the District to ensure compliance.

Status: Ongoing

Target date for completion: July 2022

Recommendation 9

The District Director ensures clinical staff follow confidentiality requirements when consulting and coordinating care with the support VA medical facility for shared clients at high risk for suicide and monitors compliance across all zone vet centers.

District Director response: Concur

The District provided training to the clinical staff on the importance of communicating the benefits of consultation and coordination of care with VAMC [VA Medical Center] providers to the client at the beginning of Vet Center services and to obtain permission for this collaboration through a Release of Information form as appropriate. Compliance is monitored through the VCD's monthly RCSNet report provided to the ADD/C for oversight.

Status: Ongoing

Target date for completion: July 2022

Recommendation 10

The District Director ensures clinical staff consult with the vet center director, external clinical consultant, or suicide prevention coordinator following a lethality status change as required and monitors compliance across all zone vet centers.

District Director response: Concur

The District Office established a Post-Crisis Working Group to establish appropriate steps vet center staff should take following a crisis or lethality change. The Group developed a 'Quick Reference Guide' which spells out the expectations for consultation. This new Guide, along with other new expectations have been presented to clinical staff in the District. As a follow-on to the Group's work, clinical staff are assigned on a rotating basis, to review charts to ensure compliance with these expectations.

Status: Ongoing

Target date for completion: July 2022

Recommendation 11

The District Director ensures clinical staff complete crisis reports as required and monitors compliance across all zone vet centers.

District Director response: Concur

The District has provided training to clinical staff regarding the completion of a log a crisis report in RCSNet. Crisis reports are logged for suicide attempts or completions in the District. Coordination with District ADD/C's occur shortly after the log a crisis is completed and the District monitors compliance through the completion of a case review, or a determination is made and documented in RCSNet. The District will continue to monitor compliance.

Status: Ongoing

Target date for completion: July 2022

Vet Center-Specific Suicide Prevention

The remainder of the report provides inspection findings at the following four randomly selected vet centers in district 5 zone 2:

- Fresno Vet Center, California
- High Desert Vet Center, California
- Honolulu Vet Center, Hawaii
- Santa Cruz County, California

Access

According to the 2017 Memorandum of Understanding, RCS core values include providing veterans with appointments outside of regular business hours with appointment availability in the mornings, evenings, and weekends at all vet centers.[102] To assess for compliance, the OIG interviewed 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 councils.[103] The 2017 Memorandum of Understanding outlines additional responsibilities:

[102] Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding, 2017.

[103] VHA Directive 1500(1), 2021; VHA Handbook 1160.01, 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."

- Standardizing a communication process between RCS and support VA medical facility suicide prevention coordinators
- Sharing lists of veterans at high risk for suicide between VA medical facilities and RCS
- Notifying suicide prevention coordinators of clients with significant safety risks in a timely manner
- Training for RCS staff
- Disseminating a list from the Office of Mental Health and Suicide Prevention to RCS identifying veterans at increased predictive risk of suicide[104]
- Identifying veterans who were receiving RCS counseling services[105]

The OIG interviewed VCDs and requested the following:

- Evidence of the VCD or designee participation in VA medical facility mental health council meetings
- Office of Mental Health and Suicide Prevention lists received
- VA medical facility high risk for suicide flag lists received
- 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 at high risk for suicide.[106] 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.[107] As of May11, 2020, VCDs were required to review the site monthly for clients seen at their vet center, determine if outreach is needed, and document a disposition.[108]

[104] The Office of Mental Health and Suicide Prevention list refers to Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH-VET). REACH-VET identifies veterans who have a higher risk for suicide through predictive analytics.

[105] Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding, 2017.

[106] RCS-CLI-006, *High Risk Flag Suicide Outreach*, April 27, 2020.

[107] 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; RCS-CLI-006, April 27, 2020.

[108] RCS-CLI-006, April 27, 2020.

To assess for compliance, the OIG requested documentation of clients from each vet center identified on the High Risk Suicide Flag SharePoint site and documented dispositions from March 1, 2020, through February 28, 2021.

Crisis Plans

RCS serves clients who may 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.[109]

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 respond to crisis situations.[110] The OIG requested and reviewed crisis plans from the four selected vet centers to assess compliance with RCS preparatory steps for crisis events.

Root Cause Analysis Participation and Feedback

Root cause analysis is a review of systems and processes that surround an adverse event or a close call such as a death by suicide or suicide attempt of a client.[111] 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.[112] The vet center staff should be included in the root cause analysis investigation and receive feedback from the support VA medical facility root cause analysis team when shared cases are reviewed.[113]

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

[110] Vet Center Clinical Site Visit (CSV) Report received from RCS National Service Support (NSS), April 15, 2020.

[111] 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."

[112] VHA Handbook 1050.01, 2011.

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

Vet Center-Specific Suicide Prevention Findings and Recommendations

The OIG found the four selected vet centers complied with nontraditional hours allowing clients easier access to services and had updated crisis plans. The High Desert VCD reported that the posted vet center hours did not reflect nontraditional hours but two counselors were available to provide services outside of the posted hours. The OIG found the four VCDs compliant with the requirement to review the RCS High Risk Suicide Flag SharePoint site monthly and document dispositions for vet center clients. None of the four vet centers had shared clients with support VA medical facilities who died by suicide during the OIG inspection period; therefore, vet center staff did not participate on root cause analysis panels.

The OIG found issues related to

- vet center participation in mental health council meetings,
- receipt of the Office of Mental Health and Suicide Prevention list identifying veterans at increased predictive risk for suicide,[114]
- receipt of the VA medical facility list of veterans flagged at high risk for suicide, and
- standardized communication process between vet centers and suicide prevention coordinators at support VA medical facilities.

Mental Health Council

VA medical facility mental health council meetings are composed of essential mental health disciplines and specialty programs, and medical centers "are encouraged to include representation from Readjustment Counseling Centers (Vet Centers) in this Council."[115] VA medical facility mental health councils are responsible for

- "[p]roposing strategies to improve care and consulting with management on methods for improvement and innovation in treatment programs,"
- coordinating communication, and
- evaluating mental health policy impact.[116]

RCS recognizes the importance of mental health councils with coordinating care for clients between vet centers and VA medical facilities. According to RCS policy, "Vet Center staff need to participate on all VA Medical Center Mental Health Councils."[117] Although RCS requires

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

[115] VHA Handbook 1160.01, amended November 16, 2015.

[116] VHA Handbook 1160.01, amended November 16, 2015.

[117] VHA Directive 1500.01, September 2010.

participation, the OIG reviewed submitted documentation and did not find a policy or guidance specifying how attendance is tracked.

The OIG found all four vet centers were noncompliant with attendance at VA medical facility mental health council meetings. The Fresno VCD reported meetings had been canceled due to the COVID-19 pandemic and provided documentation of attendance for one month of the inspection period. The High Desert VCD reported attending the meetings as the representative for multiple vet centers and indicated meetings were recorded, but transcripts of the meetings were not available. The VCD provided a spreadsheet of documented meeting attendance; the OIG accepted this documentation of evidence of attendance for two meetings. The Honolulu VCD reported meetings were held quarterly and if the VCD was unavailable, a counselor would attend. The VCD provided evidence of attendance for one meeting. The Santa Cruz County VCD provided documentation of participation in three of four quarterly meetings. The VCD stated a designee attended the August meeting, however there was no supporting documentation of attendance.

Recommendation 12

The District Director, in collaboration with the support VA medical facility clinical or administrative liaison, determines the reasons for noncompliance with staff participation on mental health councils at the Fresno, High Desert, Honolulu and Santa Cruz County Vet Centers, and takes action as required.

District Director response: Concur

The Deputy District Director is working with VISN 21 and VISN 22 leadership to ensure all VHA support facilities understand the requirement to have Vet Center representation on the mental health council as members. The District will continue to monitor this situation to ensure compliance.

Status: Ongoing

Target date for completion: July 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 with 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.[118] Three of four VCDs interviewed indicated they did not receive the list in the

[118] Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding, 2017. 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.

review period. The Fresno VCD was familiar with the list methodology and purpose but did not receive the list. The Honolulu VCD reported receiving the list from the suicide prevention team lead monthly. The VCD emailed the list to clinical staff and the veteran outreach program specialist and reviewed the list during clinical staff meetings. The VCD provided evidence for one month but stated the lists were not retained. The High Desert VCD reported not receiving a list since February 2020. The Santa Cruz County CD reported the list was not received.

In its inaugural Vet Center Inspection Program report published September 30, 2021, the OIG made a recommendation on this matter to the Under Secretary for Health:

> 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.

Therefore, the OIG does not make a recommendation on the matter in this report.[119]

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.[120]

The OIG found no evidence the vet centers received the high risk for suicide client lists from the support VA medical facility suicide prevention coordinators. The Fresno VCD reported the list was not received at the onset of the COVID-19 pandemic and throughout the duration of the inspection period, but reported recent communication with the suicide prevention coordinator to begin receiving the list.[121] The High Desert VCD reported the list was not shared due to privacy concerns. The Honolulu VCD reported the vet center did not receive a list, was not aware of the requirement, and did not know why the list was not received. The Santa Cruz County VCD reported the list was received from the suicide prevention coordinator every one to two months. If no vet center clients were identified on the list, it was not retained.

In its inaugural Vet Center Inspection Program report, published September 23, 2021, the OIG made a recommendation on this matter to the Under Secretary for Health:

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[119] VA OIG, *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021.

[120] Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding, 2017.

[121] The time frame of the inspection review period is from March 1, 2020, through February 28, 2021.

> 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 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 RCS Memorandum of Understanding.

Therefore, the OIG does not make a recommendation related to updated lists of clients designated as high risk for suicide in this report.[122]

Standardized Communication Process

In the 2017 Memorandum of Understanding, RCS was identified as a crucial entity in VA's suicide prevention strategy. Standardizing communication between suicide prevention coordinators and vet center staff was a component of the Memorandum of Understanding that sought to formalize the relationship with the Office of Mental Health and Suicide Prevention, suicide prevention coordinators, and RCS.[123]

The OIG found the four selected vet centers did not have a standardized communication process with the support VA medical facility suicide prevention coordinator. However, each vet center did have informal contact with the suicide prevention coordinator at the support VA medical facility. None of the four VCDs were able to provide documentation of a local memorandum of understanding or standard operating procedure outlining a standardized communication process.

The Fresno VCD reported formalizing a process for communication and collaboration with the VA medical facility suicide prevention coordinator after the time period of the inspection.[124] During the OIG inspection, the Fresno VCD contacted the VA medical facility suicide prevention coordinator and scheduled reoccurring meetings to discuss clinical cases. The High Desert VCD stated if a client required consultation there was communication with the suicide prevention coordinator to consult about the case, but there was not a standardized communication process in place. The Honolulu VCD reported an ad hoc relationship with the suicide prevention coordinator with no standardized communication and collaboration between vet center clinical staff and the suicide prevention coordinator. The Honolulu VCD stated a standardized process was never implemented because of staff turnover and staff shortages at the VA medical facility. The Santa Cruz VCD identified a point of contact from the support VA medical facility however there was no formal process for communication to discuss clinical cases.

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[122] VA OIG, *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021.

[123] Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding, 2017.

[124] The time frame of the inspection review period is March 1, 2020, through February 28, 2021.

In its inaugural Vet Center Inspection Program report, the OIG made a recommendation on this matter to the Under Secretary for Health:

> 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 RCS Memorandum of Understanding, and initiates action as necessary.

Therefore, the OIG does not make a recommendation related to standardized communication in this report.[125]

Consultation, Supervision, and Training

Each vet center is assigned a clinical liaison and an external clinical consultant from the support VA medical facility.[126] Clinical liaisons help coordinate care for shared clients with the support VA medical facility, whereas external clinical consultants provide guidance on complex or shared cases.[127]

Vet centers are composed 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.[128] Vet centers are required to have at least one VHA-qualified licensed mental health professional on staff (see table 7).[129]

VCDs are accountable for the clinical and administrative oversight of readjustment counseling services 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.[130] VCDs provide staff supervision, participate in

[125] VA OIG, *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021.

[126] VHA Directive 1500(1), 2021.

[127] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021; RCS-CLI-003, January 25, 2019.

[128] Depending on demographic needs, some vet centers 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.

[129] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500.01, September 2010; VHA Directive 1500(1), 2021

[130] RCS policy states the team leader is responsible for vet center operations including staff supervision, administrative duties, 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, September 2010.

VA medical facility mental health councils, maintain VA and community partnerships, and supervise staff.

In 2014, VHA released a report suggesting an average of 20 veterans died by suicide daily. Of those 20 veterans, six had used VHA care in the year of, or the year prior to their death. In February 2016, the VHA Under Secretary for Health stated the need for continued review and certification of suicide prevention training annually for all VHA employees. Following the initial mandated training, staff were required to complete the corresponding refresher courses for their positions.[131] On October 15, 2020, VHA updated the suicide prevention training course and refresher requirements for clinicians.[132]

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.[133]

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. Additional training may be required based on position assignment.[134] The annual in-service training curriculum includes all major vet center service components and administrative functions.[135]

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

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

[131] VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017. This includes information retrieved from the Office of Mental Health and Suicide Prevention, *Suicide Among Veterans and Other Americans VHA 2001-2014*. In 2020, VHA released a report that found in 2018 an average of 18 veterans died by suicide daily. Of those 18 veterans, seven had recently used a VA medical facility in the year of, or the year prior to, their death. US Department of Veterans Affairs, *2020 National Veteran Suicide Prevention Annual Report*. Office of Mental Health and Suicide Prevention.

[132] VHA Memorandum, *Agency-Wide Required Suicide Prevention Training* (VIEWS 3346983), October 15, 2020.

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

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

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

Consultation

Clinical Liaison

RCS policy states that the clinical liaison is assigned by the support VA medical facility for care collaboration.[136]

External Clinical Consultant

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.[137] External clinical consultants are required to be licensed and a VHA-qualified mental health professional 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. They also complete peer case reviews and assist vet center counselors in the treatment of complex and emergent veteran cases.[138]

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

- Vet center staffing spreadsheet
- Documentation demonstrating external clinical consultation four hours a month[139]

VHA-Qualified Mental Health Professional

Each vet center is required to maintain one licensed and credentialed VHA-qualified mental health provider.[140] To assess for compliance, the OIG completed the following steps:

1. A staffing summary was requested from each vet center listing all VHA-qualified staff employed from March 1, 2020, through February 28, 2021.
2. If the vet center had more than one VHA-qualified mental health provider on staff

[136] VHA Directive 1500(1), 2021.

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

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

[139] A staffing spreadsheet was requested from each vet center requesting information on appointed liaisons and consultants and service lines.

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

a. the OIG randomly selected one individual, and

b. requested credentialing documentation for the employee from RCS's Centralized Human Resource Management Organization.

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.[141] If the VCD is not a VHA-qualified mental health professional, a clinical designee who is licensed will provide individual supervision to clinical staff.[142] VCDs must also complete a monthly chart audit of 10 percent of every counselor's active electronic client records.[143]

To assess for compliance, the OIG evaluated supervision through interviews with the four VCDs and reviewed documentation of

- weekly supervision for all counselors on staff from November 30, 2020, through February 28, 2021 (13 weeks per counselor), and
- monthly chart audits of 10 percent of each counselor's caseload from March 1, 2020, through February 28, 2021 (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 Risk Management Training for Clinicians within 90 days of entering their positions and annually thereafter.[145] In October 2020, VHA updated course requirements for all clinicians and implemented a new Skills Training for Evaluation and Management of Suicide course to be completed within 90 days of hire or as annual refresher training.[146]

[141] RCS-CLI-003, January 25, 2019.

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

[143] RCS-CLI-003. January 25, 2019.

[144] S.A.V.E. refers to "Signs," Ask,", "Validate," and "Encourage" and "Expedite" and is a training video collaboration with VA and PyschArmor Institute. The VHA Employee Education System is responsible developing and maintaining web-based training through the Talent Management System.

[145] VHA Directive 1071, 2017.

[146] VHA Memorandum, *Agency-Wide Required Suicide Prevention Training* (VIEWS 3346983), October 15, 2020.

All VA medical facilities and vet centers provide military sexual trauma services. RCS clinical staff are required to complete VHA military sexual trauma training within 90 days of entering their position.[147] All vet center staff, regardless of position, are required to complete in-service training annually.[148]

To determine compliance, the OIG requested VA Talent Management System training records and evidence of attendance for required training completed for all staff employed from March 1, 2020, through February 28, 2021.[149]

Consultation, Supervision and Training Findings and Recommendations

As displayed in table 7, the four selected vet centers showed overall compliance with clinical liaison appointments from support VA medical facilities. All vet centers were compliant with having licensed external clinical consultants. Three of four vet centers had external clinical consultants assigned from the support VA medical facilities. One of four vet centers did not have an external clinical consultant from the support VA medical facility, but did have contracts in place for an external clinical consultation with licensed community mental health providers. The OIG found all four vet centers had at least one licensed and credentialed VHA-qualified mental health professional on staff.

The OIG identified deficiencies in the following areas (see table 7):

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

[147] VHA Directive 1115.01, 2017.

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

[149] The Talent Management System is a web-based program used by VA staff for education and other services.

Table 7. District 5 Zone 2 Consultation, Supervision, and Training
March 1, 2020–February 28, 2021

Review Elements	Findings			
	Fresno Vet Center	High Desert Vet Center	Honolulu Vet Center	Santa Cruz County 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* March 1, 2020 through February 28, 2021	**Noncompliant**	**Noncompliant**	**Noncompliant**	**Noncompliant**
Clinical Supervision (one hour a week) November 30, 2020 through February 28, 2021	**Noncompliant**	**Noncompliant**	**Noncompliant**	**Noncompliant**
Staff Training				
VHA Annual Suicide Prevention for Clinical Staff	Compliant	**Noncompliant**	Compliant	**Noncompliant**
VHA Annual Suicide Prevention for Non-Clinical Staff	Compliant	**Noncompliant**	Compliant	Compliant
VHA Military Sexual Trauma Training	**Noncompliant**	Compliant	**Noncompliant**	**Noncompliant**
RCS Annual In-service Training	**Noncompliant**	**Noncompliant**	**Noncompliant**	**Noncompliant**

Source: VA OIG analysis of district 5 zone 2 documents (received March 1, 2020 through February 28, 2021) and interview results. The OIG did not assess RCS's data for accuracy or completeness.
**10 percent of each counselor's caseload.*

External Clinical Consultation

RCS requires four hours of external clinical consultation monthly.[150] The OIG found that none of the four selected vet centers met the required four hours of external clinical consultation per month.

The Fresno VCD provided documentation of the external clinical consultant schedule but stated some of the meetings might have been canceled. The Fresno and High Desert VCDs stated external clinical consultation was scheduled on a reoccurring basis but neither had a process in place to reschedule meetings when canceled. Both VCDs stated the external clinical consultants were available when needed in addition to scheduled consultation.

The Honolulu VCD provided the OIG a direct support services report, meeting minutes, and emails regarding external clinical consultation. The OIG was unable to verify all entries in the direct support services report as many entries lacked specific information such as external clinical consultant name. The Honolulu VCD reported meeting the four-hour requirement when both a suicide prevention case manager and a psychiatrist were available. However, the VCD reported due to hiring and staffing issues at the VA medical facility, the suicide prevention case manager was no longer attending the meeting. As a result, the vet center was receiving two instead of four hours of external clinical consultation per month.

The Santa Cruz County VCD provided the OIG two documents as evidence of external clinical consultation. The first was an Outlook calendar showing ongoing appointment dates and times, some on federal holidays, that did not include the external consultant name or duration of consultation.[151] The OIG did not accept the Outlook calendar as evidence of external clinical consultation. The second document was a consultation and audit tracker for January and February 2021. The January document had two documented consultations; however, duration was not recorded. The February document had one entry with the external clinical consultant name, cases presented, and meeting duration. The OIG accepted the February consultation and audit tracker as evidence of external clinical consultation.

Recommendation 13

The District Director determines reasons for noncompliance with completing and tracking the required four hours of external clinical consultation per month, ensures that Vet Center Directors have processes to track consultation hours, and monitors compliance at the Fresno, High Desert, Honolulu, and Santa Cruz County Vet Centers.

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

[151] Microsoft Outlook allows users to manage and share their calendar to schedule meetings.

District Director response: Concur

The District provided training to the VCD's on the importance of external consultation and the use of a document to track the frequency and length of time of all external consultation meetings. Compliance is monitored monthly by the VCD's and the ADD/C.

Status: Ongoing

Target date for completion: July 2022

Supervision

RCS requires VCDs use supervision to help accomplish objectives including staff cohesion, problem solving, case coordination, and collaboration with VA medical facilities. At the time of the OIG inspection, one hour a week of scheduled supervision was required with each clinical staff member. If the VCD was not a VHA-qualified mental health professional, a licensed clinical designee was to provide individual supervision to clinical staff.[152] RCS policy does not specify how weekly supervision is tracked to ensure completion.[153]

The OIG found the four vet centers were noncompliant with the provision of weekly staff supervision. The Fresno VCD had 11 of 65 weeks of documented weekly supervision and believed the requirement for individual supervision was one hour per month for licensed clinical staff and two hours per month for unlicensed clinical staff. The Fresno VCD stated weekly staffing and consultation was completed with clinical staff to review cases, but this was conducted as a group, not individually. The High Desert VCD had 28 of 44 weeks of documented weekly supervision and provided supervision documents that addressed caseload, high-risk cases, audit information, and counselor specific needs. The documents indicated the date and time of supervision but did not indicate meeting length. The OIG accepted the documentation provided as evidence of compliance when a corresponding Outlook calendar invitation was also provided as documentation for duration of the meeting. The Honolulu VCD stated supervision was occurring, but the documentation was not always retained. The VCD provided documentation supporting weekly supervision for 17 of 26 weeks. The Santa Cruz County VCD submitted an Outlook calendar printout of scheduled supervisions and a form to record counselor supervision and individual consultation. The VCD documented 5 of 38 weeks of supervision and stated individual supervision was not always documented due to time constraints; a process with documentation was recently implemented.

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

[153] 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.

Recommendation 14

The District Director determines reasons for noncompliance with staff supervision provided by the Vet Center Directors at the Fresno, High Desert, Honolulu, and Santa Cruz County 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(1) in January 2021 the requirement for one hour of supervision weekly has been removed. As stated in Directive 1500, the Vet Center Director functions as the readjustment counseling supervisor for all Vet Center counseling staff on a regular and recurring basis. Section 3.3.a. of the RCS Clinical Site Visit Protocol is being revised accordingly. Vet Center Director supervision of counseling staff is monitored annually by the ADD/Cs during their annual oversight.

Status: Complete

Target date for completion: N/A

OIG comment: 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. A methodology to complete oversight is accomplished through chart audits. RCS policy requires VCDs to complete a 10 percent audit of each counselor's active client caseload.

To assess for compliance, the OIG requested and reviewed the monthly chart audits of 10 percent of each counselor's caseload from March 1, 2020 through February 28, 2021 (12 months per counselor).

The OIG found the four vet centers were noncompliant in conducting case audits.

The Fresno VCD completed 58 of 58 audits and submitted documentation of monthly chart audits, including documentation of counselor caseload. However, of the 58 audits completed, 30 audits did not include the number of record reviews required to meet the 10 percent review of the counselor active case load and one audit did not include the active case load to determine if 10 percent of the audits were completed.

The High Desert VCD provided the OIG 44 of 50 audits; however, client caseload was provided for only 7 of the 50 audits to determine compliance with the 10 percent requirement. The Honolulu VCD submitted 16 of 24 audits, which were communicated to the counselors via email. However, the OIG was unable to determine if 10 percent were reviewed for 15 of the 16 audits submitted current client caseloads were not documented.

The Santa Cruz County VCD provided the OIG 26 of 26 audits, of which one met all OIG evaluation criteria for compliance. The OIG was unable to determine if 10 percent of the records were reviewed because the active client caseload was not documented. The Santa Cruz County VCD believed all audits were completed. However, the VCD stated if there were missed audits, it was due to a lack of time or entry error.

The Honolulu and Santa Cruz VCDs provided RCSnet audit reports as supplemental evidence to demonstrate compliance. However, after OIG reviewed the audit reports, both VCDs confirmed errors in the report including the number of active clients. Therefore, the OIG did not accept the RCSnet audit reports as evidence.

Recommendation 15

The District Director verifies and determines reasons for noncompliance with monthly RCSnet chart audits at the Fresno, High Desert, Honolulu, and Santa Cruz County Vet Centers, ensures chart audits are completed as required, and monitors compliance.

District Director response: Concur

Recent updates to RCSNet have made tracking this requirement easier and Vet Center Directors have been trained on the requirements associated with Chart audits. The District will monitor compliance.

Status: Ongoing

Target date for completion: July 2022

Staff Training

RCS requires completion of mandatory trainings for both clinical and non-clinical staff.[154] The OIG reviewed documentation for the four selected vet centers and found the High Desert and Santa Cruz County Vet Centers noncompliant with completion of annual suicide prevention training. The OIG found the Fresno, Honolulu, and Santa Cruz County Vet Centers noncompliant with military sexual trauma training for clinical staff.

Annual in-service training was provided for VCDs and office managers; all VCDs had evidence of completion of annual regional in-service training and documentation of completion was provided for two of the four office managers. One VCD stated the third office manager completed the training, but was unable to provide documentation of completion; the fourth vet center office manager was not employed when the training was offered. All four vet centers were

[154] VHA Directive 1115.01(1), *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017, amended May 8, 2020; VHA Directive 1071; SECVA Memorandum, *Agency-Wide Required Suicide Prevention Training* (VIEWS 3346983), October 15, 2020; VHA Handbook 1500.01, September 2010; VHA Directive 1500(1), 2021.

noncompliant with counselors and veteran outreach program specialists completing annual in-service training in fiscal years 2019 and 2020 (see table 7).[155] Three of four VCDs explained regional in-service training for counselors and veteran outreach program specialists was canceled during that time frame but were unable to provide evidence of cancelation.

District leaders stated because the fiscal year 2019 VA All Employee Survey results showed professional development (growth) was a top priority, counselors were permitted to coordinate their own community-based training while office managers and vet center directors took district training to meet annual in-service training requirements. District leaders told the OIG that community-based training for counselors was not tracked for completion. The Associate District Director for Administration stated a district coordinator was assigned Talent Management System trainings based on an RCS Central Office list of required trainings. The Associate District Director for Counseling reported VCDs were responsible for ensuring staff completed trainings, and the Associate District Director for Administration reported checking trainings during annual administrative quality visits.

Recommendation 16

The District Director determines reasons why trainings were not completed at the Fresno, High Desert, Honolulu, and Santa Cruz County Vet Centers, ensures all staff complete mandatory trainings, 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 assignment are established and monitored for compliance.

Status: Ongoing

Target date for completion: July 2022

Environment of Care

VHA defines environment of care as "the building or space, including how it is arranged and the special features protect patients [clients], 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, patients [clients], and anyone else who enters the environment, all of whom have a role in minimizing risks."[156] RCS requires that the interior layout and design of a vet

[155] All face-to-face training conferences were canceled in fiscal year 2020 due to COVID-19; alternate trainings were made available but were not required.

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

center is welcoming and promotes access to readjustment counseling services and support in a non-institutional setting.[157]

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 the physical environment, general safety, and privacy.

Physical Environment

To assess compliance with environmental cleanliness, the OIG virtually inspected the exterior to assess if it appeared clean, neat, and presentable, and reviewed interior furnishings for cleanliness and to determine whether they were in good repair, serviceable, welcoming, and non-institutional. The OIG also assessed if the waiting area was large, comfortable, and able to accommodate clients and their families with an interior decorated with items depicting military appreciation.[158]

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.[159] Facilities subject to the Architectural Barriers Act must comply with the Architectural Barriers Act Accessibility Standard.[160] The OIG assessed whether vet centers were compliant with the Architectural Barriers Act Accessibility Standard for compliant entrances, designated parking spaces that are accessible to people with disabilities, and exit signs.[161]

Vet centers are also required to have a current emergency and crisis plan to address "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."[162] The OIG reviewed and assessed if crisis and emergency management plans were current.

[157] VHA Handbook 1500.01, September 2010.

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

[159] Architectural Barriers Act of 1968 (codified as amended at 42 U.S.C. § 4151 et seq.).

[160] 41 C.F.R. § 102–76.65(a).

[161] Architectural Barriers Act Accessibility Standard 2015 (codified at Appendices C and D to 36 C.F.R. part 1191).

[162] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010.

Privacy

According to RCS policy, "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."[163] 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.[164] Any documents or items displaying protected health information must be secured. Confidential records must be stored in a room that is double-locked and compliant with VHA security requirements.[165] The OIG virtually assessed each vet center's offices, group counseling rooms, and storage rooms to determine compliance with privacy requirements.

Environment of Care Findings and Recommendations

The OIG virtually inspected all areas within the designated vet centers and found general compliance with exteriors and interiors being clean and presentable. Interior designs were welcoming and non-institutional. Waiting areas were large and comfortable with clean, serviceable furnishings in good repair. The four vet centers complied with the Architectural Barriers Act Accessibility Standard for an accessible entrance and designated parking spaces that were accessible for people with disabilities. The OIG identified issues related to Architectural Barriers Act Accessibility Standard compliant exit signage. 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. Table 8 details the findings of the environment of care review.

[163] VHA Handbook 1500.01 September 8, 2010; VHA Directive 1500(1), 2021.

[164] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010.

[165] 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 8. District 5 Zone 2 Environment of Care

Review Elements	Findings			
	Fresno Vet Center	High Desert Vet Center	Honolulu Vet Center	Santa Cruz County 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				
Entrance Accessible for People with Disabilities	Compliant	Compliant	Compliant	Compliant
Designated Parking for People with Disabilities	Compliant	Compliant	Compliant	Compliant
Architectural Barriers Act Accessibility Standards Compliant Exit Signs	Compliant	**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
Personal Information Secured	Compliant	Compliant	Compliant	Compliant

Source: VA OIG analysis of environment of care inspections conducted from May 10, 2021, through May 26, 2021.

Architectural Barriers Act Accessibility Standards

The OIG found three vet centers noncompliant in one element of general safety. Specifically, RCS requires each vet center to follow Architectural Barriers Act Accessibility Standards which

requires each egress to have signage and "doors at exit passageways, exit discharge, and exit stairways shall be identified by *tactile* [braille] signs complying with 703.1, 703.2, and 703.5."[166] The OIG found three vet centers did not have tactile signs posted near exit doors.

Recommendation 17

The District Director evaluates and determines reasons for noncompliance with tactile (braille) signage at the High Desert, Honolulu, and Santa Cruz County Vet Centers and ensures all exit doors are compliant with Architectural Barriers Act Accessibility Standards requirements.

District Director response: Concur

The District will work with the RCS Central Office and RCS leasing POC [point of contact] to review compliance with the barriers act for the identified Vet Centers.

Status: Ongoing

Target date for completion: July 2022

[166] 36 C.F.R. § Pt. 1191, App. D.; Architectural Barriers Act (ABA) Standards (2015).

Appendix A: Summary of Vet Center Inspection Program Recommendations

The intent of the recommendations is for VCDs to use them as a road map to help improve operations and clinical care. The 17 recommendations 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. Summary Table of Recommendations

Quality	Requirement	Recommendation
Quality Reviews	Annual vet center clinical quality review site visit	1. The District Director determines reasons for missing and incomplete clinical quality reviews, remediation plans, and resolution of deficiencies; ensures completion, and monitors compliance.
	Clinical deficiency resolution	2. The District Director evaluates the process for resolution of clinical quality review deficiencies and initiates action as necessary.
	Annual vet center administrative quality review site visit	3. The District Director determines reasons for missing and incomplete administrative quality reviews, remediation plans, and resolution of deficiencies; ensures completion and monitors compliance.
	Administrative deficiency resolution	4. The District Director evaluates the process for resolution of administrative quality review deficiencies and initiates action as necessary.
Suicide Prevention	**Requirement**	**Recommendation**
Intake Assessments	Completion of intake assessments within five visits	5. The District Director ensures intake assessments are completed and monitors compliance across all zone vet centers.
Lethality Risk Assessment	Completion of lethality risk assessments during the first clinical encounter	6. The District Director ensures lethality risk assessments are completed on the first clinical visit and monitors compliance across all zone vet centers.
Intake Assessment and Military History	Completion of psychosocial assessments within five visits	7. The District Director, in collaboration with Readjustment Counseling Service Central Office, evaluates the limitations of current tools and tracking methods including why completion dates are not visible in RCSnet and ensures compliance with standards for timely completion of intake assessments and lethality risk assessments.

Suicide Prevention and Intervention	High Risk Shared Client Care Coordination	8. The District Director ensures clinical staff consult and coordinate care with the shared support VA medical facility for clients with high risk for suicide flag placement and monitors compliance across all zone vet centers.
Intake Assessment and Military History	Following confidentiality requirements when coordinating care with VA medical facilities	9. The District Director ensures clinical staff follow confidentiality requirements when consulting and coordinating care with the support VA medical facility for shared clients at high risk for suicide and monitors compliance across all zone vet centers.
Suicide Prevention and Intervention Care Coordination and Collaboration with VA medical facility	Consultation following lethality status changes	10. The District Director ensures clinical staff consult with the vet center director, external clinical consultant, or suicide prevention coordinator following a lethality status change as required and monitors compliance across all zone vet centers.
	Completion of crisis reports	11. The District Director ensures clinical staff complete crisis reports as required and monitors compliance across all zone vet centers.
	Participation on VA medical facility mental health council	12. The District Director, in collaboration with the support VA medical facility clinical or administrative liaison, determines the reasons for noncompliance with staff participation on mental health councils at the Fresno, High Desert, Honolulu and Santa Cruz County Vet Centers, and takes action as required.
Consultation, Supervision, and Training	**Requirement**	**Recommendation**
External Clinical Consultation	Documentation of four hours of external clinical consultation per month	13. The District Director determines reasons for noncompliance with completing and tracking the required four hours of external clinical consultation per month, ensures that Vet Center Directors have processes to track consultation hours, and monitors compliance at the Fresno, High Desert, Honolulu, and Santa Cruz County Vet Centers.
Supervision	One hour weekly supervision with clinical staff members	14. The District Director determines reasons for noncompliance with staff supervision provided by the Vet Center Directors at the Fresno, High Desert, Honolulu, and Santa Cruz County Vet Centers, ensures staff supervision occurs as required, and monitors compliance.

External Clinical Consultation	Monthly 10 percent client record audit for each counselor	15. The District Director verifies and determines reasons for noncompliance with, monthly RCSnet chart audits at the Fresno, High Desert, Honolulu, Santa Cruz County Vet Centers, ensures chart audits are completed as required, and monitors compliance.
Training	Completion of all mandatory trainings	16. The District Director determines reasons why trainings were not completed at the Fresno, High Desert, Honolulu, and Santa Cruz County Vet Centers, ensures all staff complete mandatory trainings, and monitors compliance.
Environment of Care	**Requirement**	**Recommendation**
General Safety	All exit signage Architectural Barriers Act Accessibility Standards compliant	17. The District Director evaluates and determines reasons for noncompliance with tactile (braille) signage at the High Desert, Honolulu, and Santa Cruz County Vet Centers and ensures all exit doors are compliant with Architectural Barriers Act Accessibility Standards requirements.

Source: VA OIG.

Appendix B: Zone Profile

Table B.1. District 5 Zone 2 Profile
October 1, 2019–September 30, 2020

Profile Element	District 5 zone 2	
Total Budget Dollars	$14,924,596.61	
Unique Clients	11,287	
New Clients	2,744	
Active Duty Clients	326	
Spouse/Family Clients	1588	
Bereavement Clients	65	
Position	**Authorized**	**Filled**
Total Full-time	162	147
District Leaders	4	4
Zone Staff	3	3
Vet Center Director	24	22
Clinical Staff	84	73
Veterans Outreach Program Specialist‡	22	21
Vet Center Office Staff	25	24
Contract Providers§	Not Applicable	5

Source: VA OIG analysis of information from District 5 Zone 2 leaders.
Note: *At the time of inspection, district 5 zone 2 reported 24 vet centers. District staff provided zone profile reports on the fiscal year, not the review period for inspection.*
Note: Zone staff include other zone 2 staff (not the four district leaders).
‡*Note: Veteran Outreach Program Specialists, who are responsible for vet center outreach services, conduct face-to-face outreach to contact, inform, engage, and bring local eligible individuals into the vet center for needed services.*
§*Note: Contract providers are not included in the authorized or filled totals*

Profile Summary. From October 1, 2019, through September 30, 2020, district 5 zone 2 operated on a total budget of $14,924,596.61 and served 11,287 unique clients; 2,744 new clients; 326 active duty service members; 1,588 spouses and family members; and 65 bereavement clients. There was a total of 162 positions, with 15 vacancies throughout the zone as of May 12, 2021.

Appendix C: Vet Center Profiles

The table below provides general background information for the district 5 zone 2 four selected vet centers.

Table C.1. Fiscal Year 2020 Vet Center Profiles

Profile Element	Fresno Vet Center	High Desert Vet Center	Honolulu Vet Center	Santa Cruz County Vet Center
Number of:				
• Unique Clients	995	450	385	395
• Bereavement Clients	3	3	0	3
• Active Duty Clients	7	5	43	10
• Spouse/Family Clients	160	87	45	47
• New Clients	180	87	176	71
Total Number of Positions (as of May 12, 2021)				
• Total Full-time Positions	9	8	5	6
• Total Part-time Positions	N/A	N/A	N/A	N/A
• Vet Center Director	1	1	1	1
• Clinical Staff	6	5	2	3
• Veterans Outreach Specialist	1	1	1	1
• Office Staff	1	1	1	1
• Other	3	N/A	4	1

Source: VA OIG analysis of information provided by district staff.
Note: The OIG did not assess VA data for accuracy or completeness.

Appendix D: RCS Chief Readjustment Counseling Officer Memorandum

Department of Veterans Affairs Memorandum

Date: November 24, 2021

From: Chief Readjustment Counseling Officer, RCS

Subj: Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers

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

Director, GAO/OIG Accountability Liaison (VHA GOAL Action)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Vet Centers Inspection Program-Pacific District 5 Zone 2. Readjustment Counseling Service (RCS) has reviewed the report and either concurred or concurs in principle with recommendations 1-17 and are submitting action plans to address all findings in the report.

2. RCS Vet Centers are essential to supporting Veterans, Service members and their families. As Vet Center eligibility broadens, RCS continues to modernize the organization and workforce to include improving staff training opportunities, automating functions, and updating policies and procedures. RCS staff continues to exceed the expectations of those served. RCS values the feedback provided by this review to continue our efforts to improve.

3. Comments regarding the contents of this memorandum may be directed to the RCS Action Group at VHA10RCSAction@va.gov.

(Original signed by:)

Michael Fisher
Chief Officer, RCS

Appendix E: Pacific District 5 Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 18, 2021

From: District Director, Pacific District 5 (RCS5)

Subj: Vet Center Inspection Program–Pacific District 5 Zone 2 and Selected Vet Centers

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers.

2. In reviewing the draft report, the District has addressed all identified recommendations and has either resolved or developed a plan to resolve all remaining items.

(Original signed by:)

Steven R. Reeves
District Director

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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 Matthew Baker, LCSW Sarah Levis, LCSW Ryan Mairs, MSW, LICSW Christine Micek, MSN, RN, CPPS Lauren Olstad, LCSW
Other Contributors	Josephine Andrion, MHA, RN Felicia Burke, MS Limin Clegg, PhD Brandon Leflore-Nemeth Dawn Dudek, LCSW Roy Fredrikson, JD Reynelda Garoutte MHA, BSN Kathy Gudgell, JD, RN Christopher Hoffman, LCSW, MBA Adam Hummel, MPPA Mahshid Lee, LCSW Bina R. Patel, PhD, LCSW Natalie Sadow, MBA Laura Savatgy, MPA Harold Stanek Robyn Stober, JD, MBA Rashiya Washington, JD

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