DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Vet Center Inspection of Midwest District 3 Zone 1 and Selected Vet Centers

VCIP REPORT | REPORT #21-03231-38 | JANUARY 19, 2023

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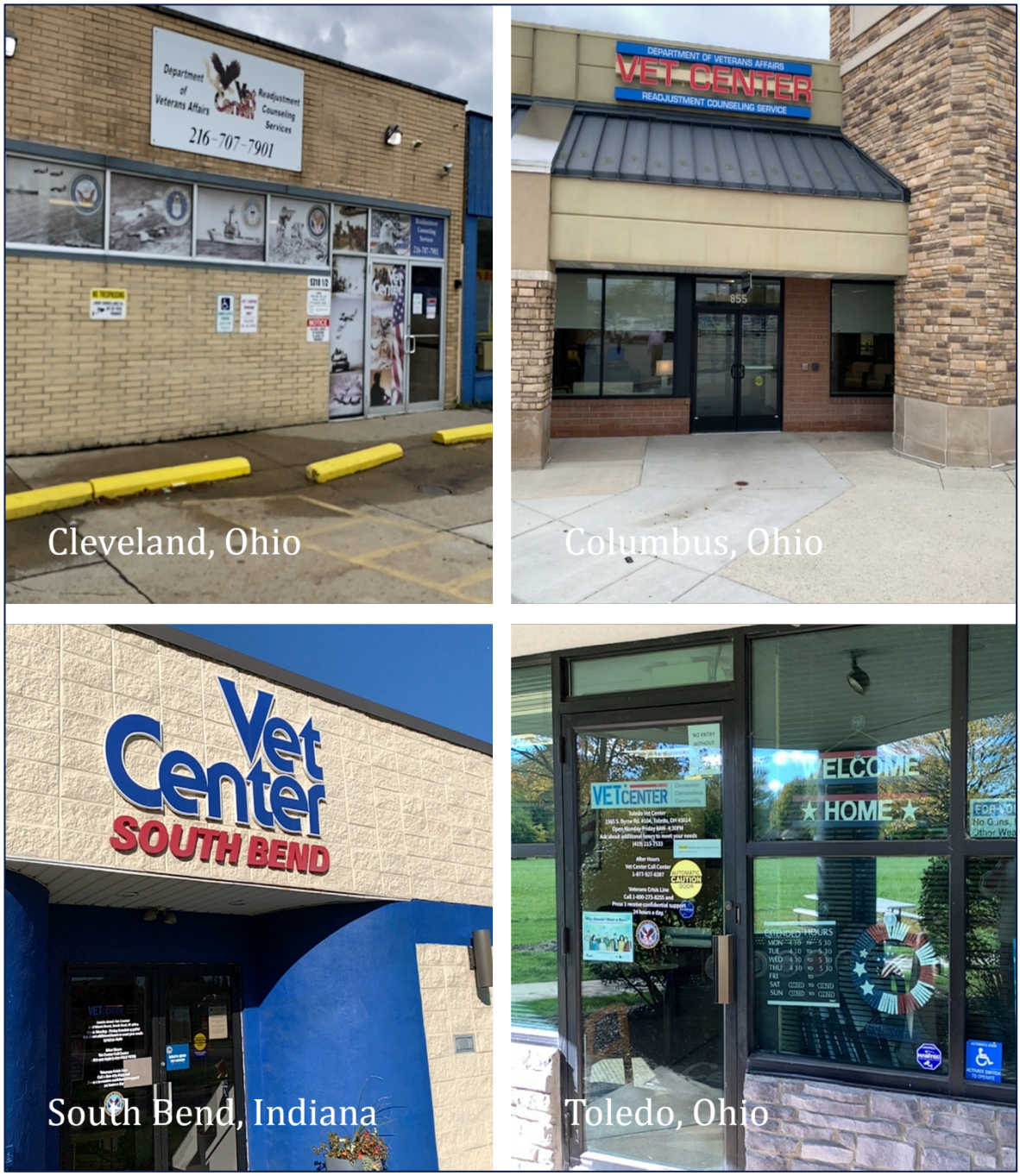

Figure 1. *Midwest District 3 Zone 1 Vet Centers inspected: (from top to bottom, left to right) Cleveland, Ohio;Columbus Ohio; South Bend, Indiana; and Toledo, Ohio.*
Source: VA OIG inspection team virtual visit photographs.

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 care delivered at vet centers.[1] 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 Midwest district 3 zone 1 and four selected vet centers: Cleveland, Columbus, and Toledo in Ohio; and South Bend in Indiana.[2]

VCIP inspections are one element of the OIG's oversight to ensure that the nation's veterans receive high-quality and timely mental health care and related Veterans Health Administration (VHA) services. The inspections cover key aspects of clinical and administrative processes associated with promoting quality care. The OIG selects and evaluates specific areas of focus each fiscal year.[3]

To examine risks or potential risks to clients, the OIG inspection focused on five review areas that influence the quality of client care and service delivery at vet centers:[4]

- Leadership and organizational risks
- Quality reviews
- Suicide prevention

[1] The Vet Center Inspection Program conducts routine and regular inspections of vet centers, whereas hotline inspections focus on fraud, waste, abuse or criminal activity generated from complaints by VA staff and the general public or requested by Congress.

[2] VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010, was in effect during the OIG's inspection period. It was rescinded and replaced by VHA Directive 1500, *Readjustment Counseling Service*, January 26, 2021, then again by VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021, and most recently by VHA Directive 1500(2), *Readjustment Counseling Service*, January 26, 2021, amended December 30, 2021. Unless otherwise specified, the requirements in the 2021 directive contain the same or similar language as the rescinded September 2010 handbook. 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 per zone.

[3] A fiscal year is a 12-month period from October 1 through September 30.

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

- Consultation, supervision, and training
- Environment of care

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

Inspection Results

Leadership and Organizational Risks

The leadership and organizational risks review is specific to the district 3 zone 1 leadership team. The team consists of the district director, deputy district director, associate district director for counseling, and associate district director for administration (see figure 2).[5]

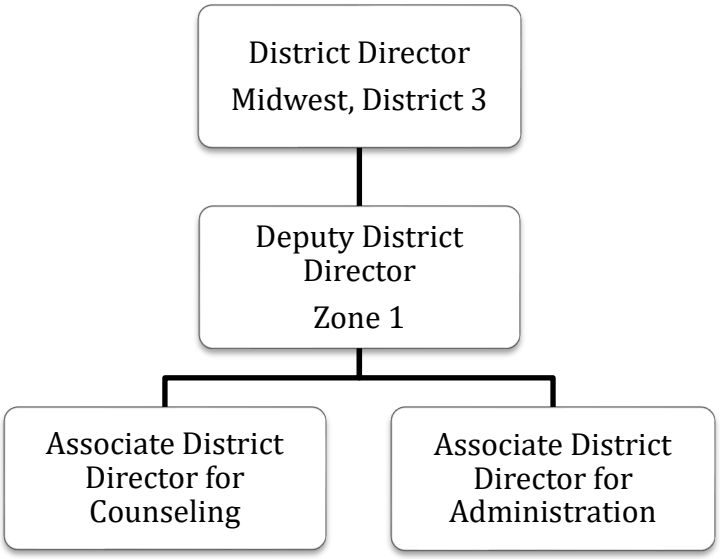

Figure 2. *Midwest district 3 zone 1 leaders.*
Source: VA OIG analysis of district organizational chart.

At the time of the inspection, the District Director had been in the role since 2016.[6] The Deputy District Director was assigned in March 2019, and the Associate District Director for

[5] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center* Administration; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). 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.

[6] 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.

Administration was assigned in September 2018. The associate district director for counseling position has been vacant since July 2021.

District leaders were generally knowledgeable about the basic concepts of, and their roles in, quality improvement. District leaders described quality improvement as a continuous process to sustain or exceed the standard, finding ways to provide better care and service, and analysis of practice and performance to improve operations and services. However, three of four district leaders reported not having enough time in a given week to support quality improvement activities.

District 3 zone 1 conducted required annual in-service training for vet center counselors; however, trainings were not provided for vet center directors (VCDs), veterans outreach specialists, and office managers.[7]

The VA All Employee Survey is an annual, voluntary survey of VA workforce experiences. District leaders provided examples of district wide initiatives implemented in response to feedback from the fiscal year 2020 VA All Employee Survey results.

Readjustment Counseling Service (RCS) requires a follow-up feedback survey for a client once a case is closed or a client has not been seen in the last 100 days and other select criteria are met. The results from the feedback survey provide district leaders and VCDs with feedback to evaluate the effectiveness of readjustment counseling and services provided. The OIG found district 3 zone 1 Vet Center Service Feedback results were below the RCS national veteran average in all areas except satisfaction with overall quality of services at the vet center. District leaders had limited knowledge as to the causation of the lower scores, but in response, the Deputy District Director noted several performance improvement actions.

The OIG found district leaders noncompliant with providing required annual in-service training to vet center directors, veteran outreach program specialists and office managers and issued one recommendation.

Quality Reviews

The OIG conducted an analysis of the required vet center clinical and administrative annual quality reviews, and morbidity and mortality reviews. Vet centers are required to have annual clinical and administrative quality reviews completed to ensure compliance with policy and

[7] Vet center staff must complete annual training specific to the duty assignments of each position. RCS district directors are responsible for planning and implementing the annual trainings.

procedures. RCS requires morbidity and mortality quality reviews for client safety events including clients with serious suicide or homicide attempts, and death by suicide or homicide.[8]

The OIG found the Associate District Directors of Counseling and Administration were compliant with requirements for completion of all clinical and administrative quality reviews for the zone. The Associate District Director for Administration completed all remediation plans for the zone; however, the Associate District Director for Counseling was noncompliant. The OIG reviewed documentation, evidence, and timely resolution of deficiencies at the four selected vet centers and found the Associate District Directors for Counseling and Administration were noncompliant. The OIG found the Associate District Director for Counseling noncompliant with completion of morbidity and mortality reviews for serious suicide attempts. The OIG issued seven recommendations: six to the District Director for quality reviews and one to the RCS Chief Officer specific to morbidity and mortality review.

Suicide Prevention

The suicide prevention review included a zone-wide evaluation of electronic client records and a focused review of suicide prevention activities at the four selected vet centers.[9]

The four selected vet centers inspected were compliant with required availability of nontraditional hours for appointments and had critical event plans. One VCD was compliant with the requirement of attending the support VA medical facility's mental health council meetings.[10]

Three of the four VCDs were not compliant with the requirement of reviewing the RCS High Risk Suicide Flag SharePoint site monthly.[11] Two of the four vet centers did not have a

[8] 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 morbidity and mortality review.

[9] An OIG hotline inspection was conducted at the South Bend Vet Center resulting in the following report, *Deficiencies in Suicide Risk Assessments, Continuity of Care, Bereavement Care, and Leadership at the South Bend Vet Center in Indiana*, Report No. 21-02511-28, January 19, 2023.

[10] Vet center staff are required to participate in all VA medical facility mental health councils and provide non-traditional hours to include evenings or weekends. VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). 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." VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

[11] Microsoft, Definition of SharePoint. "a secure place to store, organize, share, and access information from any device," accessed July 15, 2021. https://support.microsoft.com/en-us/office/what-is-sharepoint-97b915e6-651b-43b2-827d-fb25777f446f.

standardized communication process of collaboration with the support VA medical facility suicide prevention coordinators.[12]

The OIG issued a total of nine recommendations related to suicide prevention. Two recommendations were specific to the suicide prevention zone-wide evaluation of the psychosocial assessment, military history, and suicide risk assessments in the electronic client records. Three recommendations were made regarding consultation and collaboration with VA medical facilities and high risk for suicide clients. Two recommendations were made for completion of safety plans and consultation for clients rated as intermediate or high risk for suicide, with acute, chronic, or both risk levels. Two recommendations were specific to the four selected vet centers' suicide prevention and intervention processes.

Consultation, Supervision, and Training

The consultation, supervision, and training review evaluated the four selected vet centers with results and recommendations specific to those sites. The OIG found the four vet centers had at least one licensed and credentialed VHA-qualified mental health professional on staff, a clinical liaison who was also a mental health professional from the support VA medical facility, and an external clinical consultant who was an independent licensed mental health professional. [13] The four vet centers were noncompliant with the requirement for an external clinical consultant to provide at least four hours of consultation per month.

None of the VCDs were compliant with the requirement to provide regular and ongoing supervision to clinical staff and monthly auditing of electronic client records. Overall, staff at the four vet centers were noncompliant with completing training requirements.

The OIG issued four recommendations specific to the four selected vet centers.

Environment of Care

Environment of care reviews evaluated the four selected vet centers with results and recommendations specific only to those sites. The four vet centers inspected generally complied

[12] VHA Deputy Under Secretary for Health for Operations and Management memorandum, "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services," November 13, 2017, outlines responsibilities shared between RCS and the Office of Mental Health and Suicide Prevention. The OIG did not make recommendations for three suicide prevention deficiencies identified in this report as recommendations on the same matters were directed to the Under Secretary for Health, who has authority over both programs, in an OIG report, *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021.

[13] VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. VHA-qualified mental health professionals are mental health practitioners who have met the requirements, including licensure, set forth by the VA to provide mental health services independently. VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). Vet centers are required to maintain a reciprocal relationship with VA medical facilities to ensure clients receive quality care and needed services.

with environment of care requirements. However, one of the four vet centers was not compliant with the posting of Architectural Barriers Act Accessibility Standards tactile (braille) exit signs.[14] Three of the four vet centers were noncompliant with the requirement of having an updated emergency and crisis plan with all required components. The OIG made two recommendations.

Conclusion

The OIG conducted a detailed inspection across five review areas and issued a total of 2 recommendations for improvement to the District Director. 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 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 RCS Chief Officer and District Director concurred with recommendations 3–6, 9–18, and 20–23, and concurred in principle with recommendations 1, 2, 7, 8, and 19. An action plan was provided (see responses within the body of the report for full text of RCS comments, and appendixes D and E for the Chief Officer and District memorandums). Based on information provided, the OIG considers recommendation 1 closed. For the remaining open recommendations, the OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

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Assistant Inspector General
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[14] Architectural Barriers Act of 1968 (codified as amended at 42 U.S.C. § 4151 et seq.). Architectural Barriers Act (ABA) Standards (2015).

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.[2] Vet center staff assess and manage clients at risk for suicide, substance abuse, and other medical and mental health conditions.[3] Other services include bereavement support for families, referrals to the Veterans Benefits Administration, screening and assessment for employment, outreach, and referral coordination with VA and non-VA providers.[4]

Vet Center History

"RCS [Readjustment Counseling Service] is an autonomous organizational element in VHA [Veterans Health Administration] with direct line authority for administration of all RCS service delivery assets: Vet Centers, MVCs [mobile vet centers], the Vet Center Call Center, and the RCS CFF [Contract for Fee] program; and the provision of all readjustment counseling services."[5] Since opening vet centers in 1979, RCS was one of the first organizations to address

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[1] VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010, was in effect during the OIG's inspection period. It was rescinded and replaced by VHA Directive 1500, *Readjustment Counseling Service*, January 26, 2021, then by VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021, and then by VHA Directive 1500(2), *Readjustment Counseling Service*, January 26, 2021, amended December 30, 2021. Unless otherwise specified, the requirements in the 2021 directive contain the same or similar language as the rescinded September 2010 handbook. Vet centers provide counseling interventions for psychological and psychosocial readjustment problems related to specific types of military deployment stressors. RCS are "designed by law to be provided without a medical diagnosis." Therefore, those receiving readjustment services are not considered patients. To be consistent with RCS policy and terminology, the OIG refers to veterans receiving such services as clients in this report.

[2] 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."

[3] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol," January 25, 2019.

[4] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). VA, "Vet Centers (Readjustment Counseling): Vet Center Eligibility," accessed March 24, 2021, https://www.vetcenter.va.gov/Eligibility.asp.

[5] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; A Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). Readjustment counseling is a counseling service provided by readjustment counselors to assist with combat-related psychological and psychosocial readjustment. The Contract for Fee (CFF) Program provides readjustment counseling to eligible clients and their families who live at a distance from the vet center and provides services through contracted providers.

the psychological and social effects combat has on veterans before the American Psychiatric Association recognized posttraumatic stress disorder as an official diagnosis in 1980.[6]

While vet centers initially focused on Vietnam-era veterans, services are now offered to veterans of any combat theater, families, and active service members.[7] From 1979 through 1985, an estimated 305,000 clients received services at vet centers; an RCS clinical program analyst reported 117,033 clients received care at vet centers in fiscal year 2020 alone.[8] In an attempt to serve the growing veteran population, the number of vet centers expanded from 91 in 1979 to 300 as of December 2021.[9] Along with the increase in number of clients served, vet centers have undergone expansion to assist clients through a variety of services. Figure 3 shows a map of vet centers and vet center outstations.[10]

[6] VHA Handbook 1500.01.

[7] "Vet Centers (Readjustment Counseling): Who We Are," accessed January 7, 2020, https://www.vetcenter.va.gov/About_US.asp.

[8] Government Accountability Office, *Vietnam Veterans: A Profile of VA's Readjustment Counseling Program,* Report No. GAO/HRD-87-63, August 1987. Government Accountability Office, *1995 Readjustment Counseling Service: Vet Centers Address Multiple Client Problems, but Improvement Is Needed*, Report No. GAO/HEHS-96-113, July 1996. A fiscal year is a 12-month period that the federal government uses for accounting purposes running from October 1 through September 30.

[9] Arthur S. Blank Jr., "Apocalypse Terminable and Interminable: Operation Outreach for Vietnam Veterans." *Hospital and Community Psychiatry* 33, no. 11 (November 1982.): 913-918. VAST Snapshot-Vet Center Listing Fiscal Year 2022 Report, VHA Support Service Center (VSSC).

[10] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration,* November 23, 2010. VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). 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.

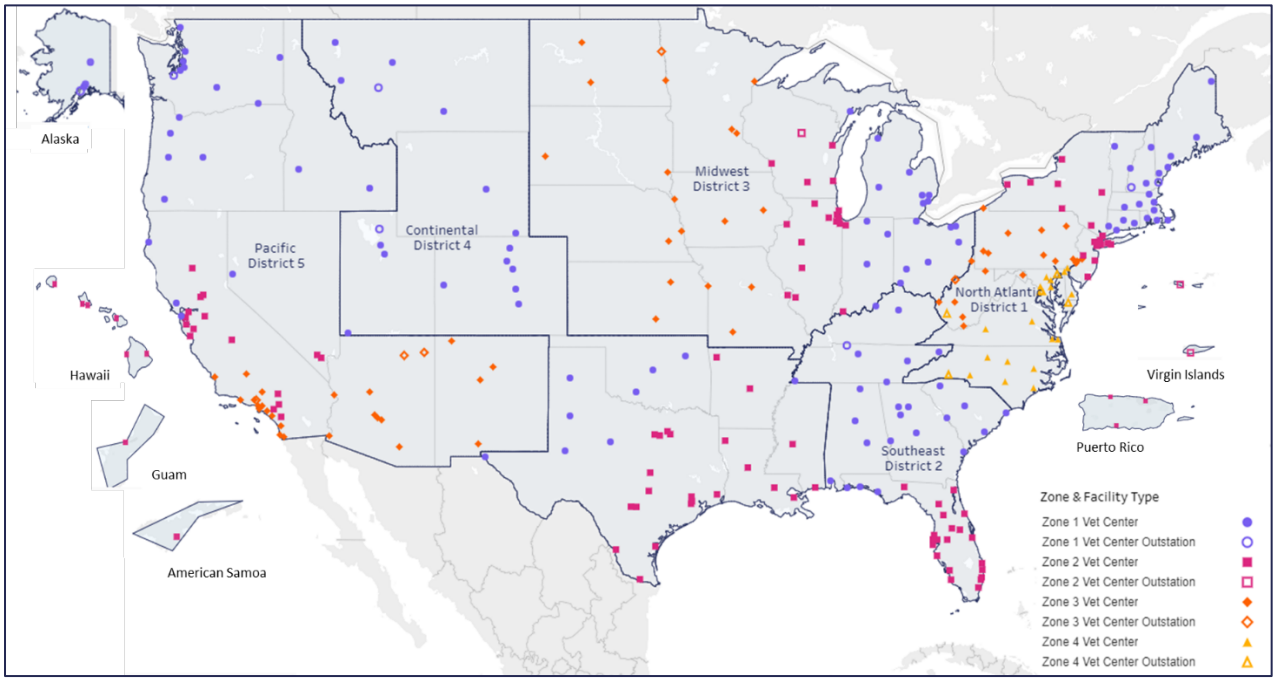

Figure 3. *Map of vet centers and vet center outstations. The placement of Alaska, American Samoa, Hawaii, Guam, Puerto Rico, and the Virgin Islands is not representative of their actual geographical locations. Source: VA OIG developed using VA Site Tracking (January 19, 2021) and RCS data (as of March 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 services 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.

Table 1. Vet Center Eligibility Expansion

Year	Vet Center Eligibility Expansion
1991	Veterans who served post-Vietnam
1992	Women veterans who experienced military sexual trauma
1994	Individuals who experienced military sexual trauma
1996	Veterans who served in World War II and Korean Combat Veterans*
2002	Bereavement counseling to surviving family members of veterans receiving VA services at the time of death and family members of active duty service members killed while on active duty

[11] "Vet Centers (Readjustment Counseling) – Who We Are," VA, 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.

Year	Vet Center Eligibility Expansion
2003	Veterans of Operation Enduring Freedom (OEF) Veterans of Operation Iraqi Freedom (OIF) Veterans of Global War on Terrorism (GWOT)
2011	Federally activated National Guard and Reserve forces who served in active military in Operation Enduring Freedom and Operation Iraqi Freedom or both
2013	Family members of deployed service members for support Crew members of unmanned aerial vehicles in combat operations or areas of hostility Providers of direct emergent medical care or mortuary services while serving on active military duty
2014	Amended VA's authority to provide counseling 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 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‡
2022	Reserve members of the Armed Forces with a behavioral health or psychological trauma§

Source: VA OIG analysis of vet center eligibility expansion information. Vet Center Eligibility, accessed January 12, 2022, https://www.vetcenter.va.gov/Eligibility.asp. National Defense Authorization Act for Fiscal Year 2013, Pub. L. No. 112-239 (2013).

**Armed hostile periods were expanded to include additional combat eras. Federal Register, Vol. 77, No. 49, Proposed Rules, March 13, 2012. Vet Centers (Readjustment Counseling) "Who We Are," accessed June 4, 2019, https://www.vetcenter.va.gov/About_US.asp.*

Vet Center Eligibility, accessed January 12, 2022, https://www.vetcenter.va.gov/Eligibility.asp. National Defense Authorization Act for Fiscal Year 2013, Pub. L. No. 112-239 (2013).

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

§VHA Directive 1500(2). The William M. (Mac) Thornberry National Defense Authorization Act, Pub. L. No. 116-283 (2021).

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.[12] The RCS Chief Officer reports directly to the VA Under Secretary of Health and is responsible for strategic planning, coordination of readjustment counseling services with VA services, serving as a policy expert for readjustment counseling, being the direct line authority for all RCS staff, coordinating with RCS

[12] "Vet Centers (Readjustment Counseling)," VA, accessed June 15, 2022, 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; VHA Directive 1500(1); VHA Directive 1500(2).

Consolidated Human Resources Management Office for hiring, and supervising six RCS national officers. The RCS Operations Officer is responsible for daily operations and providing supervision to the five district directors who oversee the districts. The RCS Operations Officer reports to the RCS Chief Officer. 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 is responsible for all vet center operations.[13]

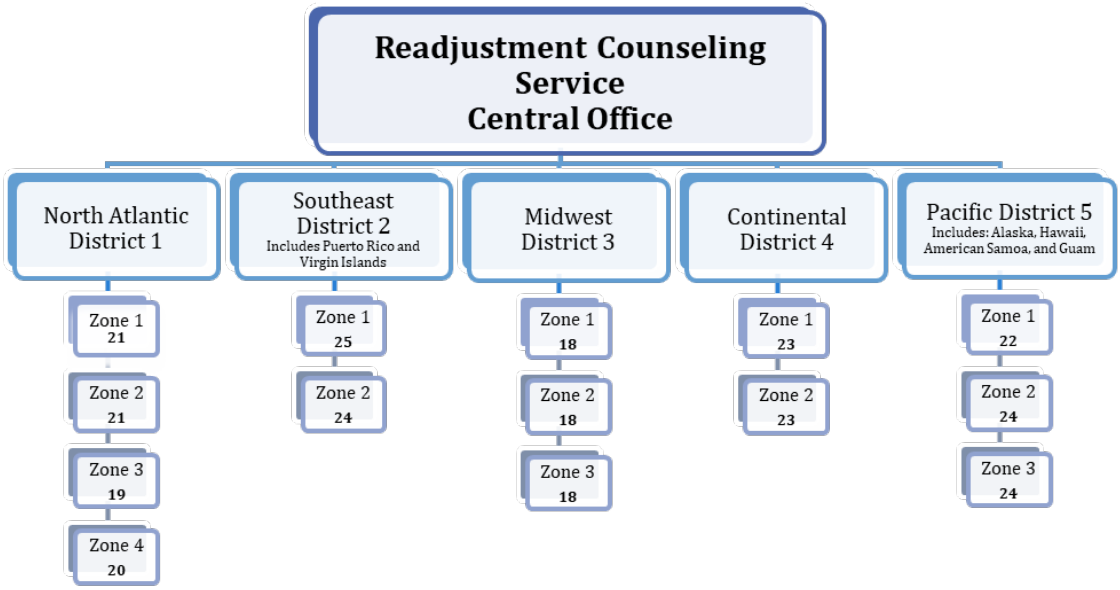

Figure 4. *RCS organizational district and zone structure.*
Source: VA OIG developed using analysis of RCS information.
Note: The number of vet centers in each zone is denoted below the respective zone. The OIG did not assess RCS data for accuracy or completeness.

Electronic Client Record

Vet center services are not required to be recorded in the client's VA electronic health record.[14] An RCS National Service Support leader noted that prior to fiscal year 2003, RCS used a paper record system to record client visits and data. In fiscal year 2003, a web-based software system called RCSNet was implemented to collect client information. On January 1, 2010, RCSNet 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

[13] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).
[14] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

facilities, VA clinics, or the Department of Defense unless there is a signed release of information.[15]

An RCS leader reported collaborating with Oracle Cerner and Electronic Health Record Modernization Integration Office to explore modernization of RCSNet; however, a determination has not been made.[16]

VA Medical Facilities

Vet centers are required to maintain a reciprocal relationship with VA medical facilities to ensure clients receive quality care and needed services.[17] The support VA medical facility director assigns a clinical liaison and an administrative liaison to aligned vet centers.[18] The VA medical facility clinical liaison coordinates services for shared clients, assists in suicide prevention activities, and supports morbidity and mortality reviews.[19] The VA medical facility administrative liaison provides support for procurement, engineering functions, commuter benefits, and fleet management for U.S. government vehicles.[20] 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.[21]

[15] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). 38 C.F.R. § 17.2000–816 (e). Vet centers cannot disclose clients' records unless a client authorizes release or there is a specific exemption.

[16] Per an RCS National Service Support leader, modernization of the RCSNet as the electronic client record system for vet centers was being considered and a determination had not been made. VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500 (2). "Federal Government," Oracle Cerner, accessed June 29, 2021, https://www.cerner.com/solutions/federal-government. Oracle Cerner is a corporation that promotes secure technology to improve healthcare operations of federal health organizations to assist in providing more connected healthcare.

[17] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[18] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). Support VA medical facilities are laterally aligned facilities identified to provide clinical collaboration to assist vet centers in better serving eligible individuals.

[19] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). For the purposes of this report, the OIG uses the term VA medical facility instead of VA medical center or VHA medical facility.

[20] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[21] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). Vet centers provide representation on root cause analysis investigations when a client completes suicide and is a shared client with a VA medical facility.

Purpose and Scope

The purpose of the VA Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) is to conduct routine oversight of vet centers providing readjustment services to clients.[22] The OIG inspection examined operations generally from October 1, 2020, through September 30, 2021. This report evaluates the quality of care delivered at vet centers and examines a broad range of key clinical and administrative processes for compliance with RCS policy. The OIG reports its findings to Congress and the Veterans Health Administration (VHA), so informed decisions can be made on improving care.

The OIG findings are a snapshot of a zone and vet centers' performance within 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).[23]

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

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

Methodology

The OIG announced the inspection to district leaders on October 25, 2021, and conducted virtual site visits from October 25, 2021, through November 5, 2021.[24] The OIG interviewed district

[22] The Vet Center Inspection Program conducts routine and regular inspections of vet centers, whereas hotline inspections focus on fraud, waste, abuse or criminal activity generated from complaints by VA staff and the general public or requested by Congress.

[23] The underlined terms are hyperlinks to a different section of the report. To return to the point of origin, press "alt" and "left arrow" keys.

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

leaders, three VCDs and one acting VCD at the selected vet centers. Due to travel restrictions during the COVID-19 pandemic, the inspection was conducted virtually.[25]

The OIG reviewed RCS policies and practices to evaluate compliance and identify potential discrepancies, validated client RCSNet record findings, explored reasons for noncompliance, and inspected select areas of care within vet centers. The OIG emailed two questionnaires: the first focused on leadership and quality improvement activities and was sent to district leaders, the second focused on quality improvement activities and was sent to all VCDs in the zone.

A VHA directive was issued in January 2021 (amended May 3, 2021, and December 30, 2021) during the OIG's inspection period of VCIP operations discussed in this report.[26] The OIG compared previously used guidelines and policies with the newly issued directive to identify changes. 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.

District and Zone Selection

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

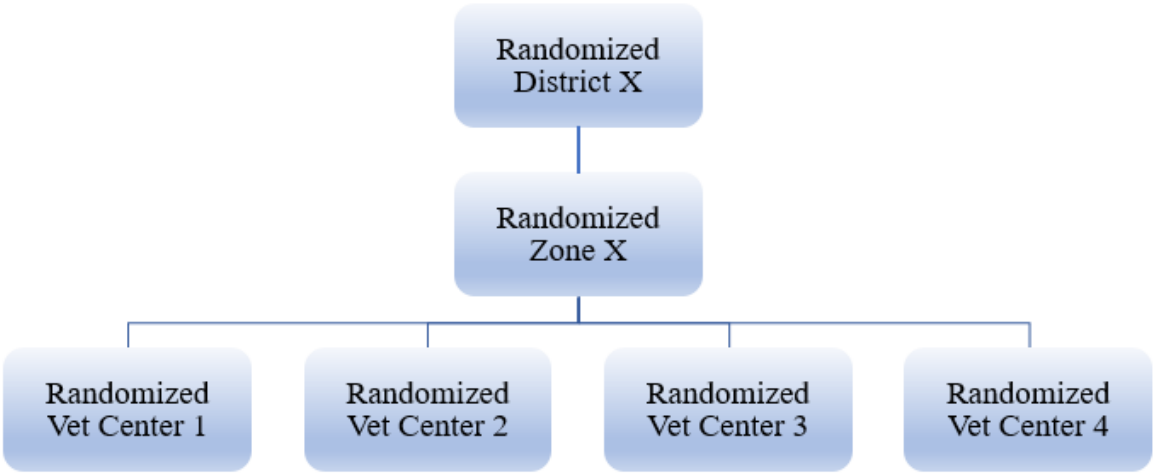

Figure 5. *Randomization and selection of inspection sites.*

[25] "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. The website has since been updated and has changed to "Domestic Travel During COVID-19."

[26] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). The OIG inspection period for this report is October 1, 2020, through September 30, 2021.

Source: VA OIG.

For this inspection, the OIG randomly selected district 3 zone 1. Within zone 1, the OIG randomly selected Cleveland, Columbus, and Toledo Vet Centers in Ohio; and the South Bend Vet Center in Indiana. Zone 1 is noted in figure 6 below. For demographic profiles of zone 1 and the four selected vet centers see appendixes B and C.[27] The OIG provided one-day notice to each vet center prior to formal evaluation.[28]

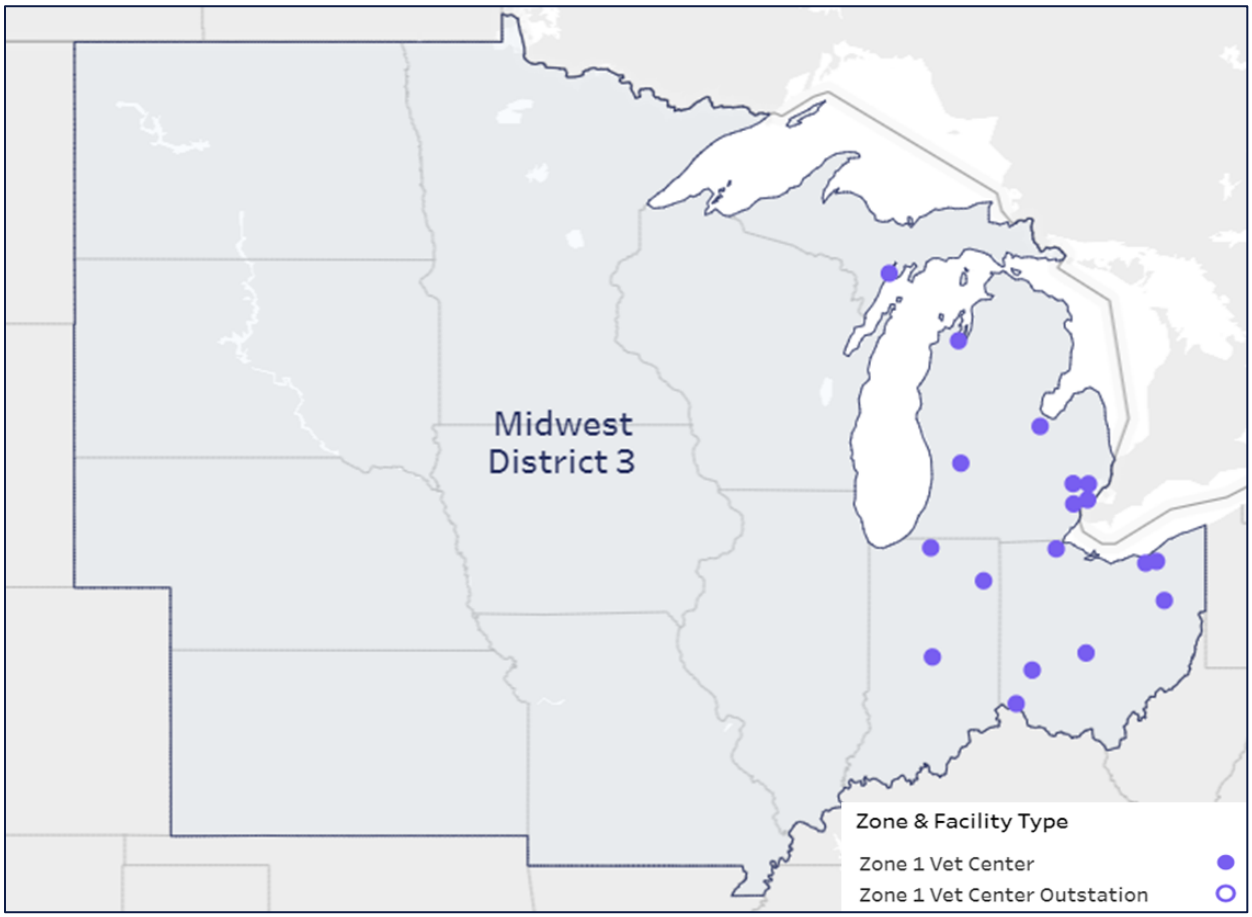

Figure 6. *Map of Midwest district 3 zone 1 vet centers.*
Source: Developed by VA OIG using VA Site Tracking.

The leadership and organizational risks review findings and recommendations are specific to the district and zone office and included interviews with district leaders and an assessment of

- leadership stability,

[27] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[28] Vet centers are comprised of small multidisciplinary teams. The OIG team provided the one-day notice for coordination of client care as needed.

- quality improvement activities,
- district annual in-service training,
- VA All Employee Survey,
- Vet Center Service Feedback Survey results, and
- response results obtained through a zone-wide questionnaire sent to all VCDs.

The assessment of quality reviews included interviews with district leaders with findings and recommendations specific to the district and zone office following an evaluation of

- vet center clinical and administrative oversight reviews for the zone,
- evidence and timely resolution of clinical and administrative deficiencies at the four randomly selected vet centers, and
- morbidity and mortality reviews.

The suicide prevention review included three zone-wide evaluations of RCSNet electronic client records with findings and recommendations specific to the District Director, and a focused review of the four selected vet centers with results and recommendations to the District Director.[29]

The consultation, supervision, and training review and the environment of care review evaluated the four selected vet centers with findings 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.

[29] For vet center clients shared with support VA medical facilities, the OIG also reviewed VHA electronic health records.

Results and Recommendations

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

Leadership and Organizational Risks

Leadership and organizational risks can affect a healthcare system's ability to provide safe and sustainable care.[30] Leadership is defined as the relationship between individuals who lead, and those who follow. Effective healthcare leadership is essential for achieving quality of care.[31]

As noted, the OIG assessed leadership and organizational risks for district 3 zone 1 by evaluating the following:

- District leadership position stability
- Quality improvement activities
- District annual in-service training
- VA All Employee Survey results (Employee Satisfaction)
- Vet Center Service Feedback Survey
- Leadership and organizational risk questionnaire results[32]

District Leadership Position Stability

The district directors oversee the deputy district directors who are responsible for an assigned zone (one deputy per zone). The deputy district directors supervise zone associate district directors. The associate district directors for counseling are responsible for providing guidance on all clinical operations, including clinical quality reviews and morbidity and mortality reviews. The associate district directors for administration are 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,

[30] Laura Botwinick, Maureen Bisognano, Carol Haraden. *Leadership Guide to Patient Safety*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2006.

[31] Danae F. Sfantou et al., *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.

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

administrative and fiscal operations, outreach events, community relations, hiring staff, and clinical programs.[33] Figure 7 shows the leadership organizational structure for district 3 zone 1.

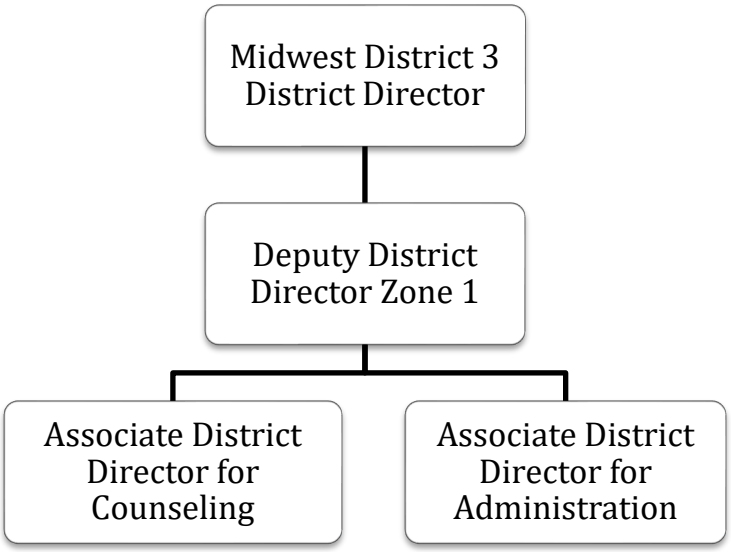

Figure 7. *District leaders.*
Source: VA OIG analysis of district organizational chart.

At the time of the OIG inspection, the District Director had been in the role since 2016. The Deputy District Director was assigned in March 2019, and the Associate District Director for Administration was assigned in September 2018. The associate district director for counseling position had been vacant since July 2021 with two acting Associate District Directors for Counseling assigned to provide coverage. At the time of inspection, it was reported the position was expected to be filled in November 2021.

During the 12 months prior to the inspection, two VCD positions were vacant: one for three months and one for four months. Both VCD positions were filled at the time of the OIG inspection. Two VCDs were on a reassignment from their primary VCD positions at the time of the inspection; however, the district office confirmed an acting VCD was assigned to each vet center.

The District Director stated there was a large degree of oversight responsibilities assigned to the Deputy District Director, including the supervision of VCDs and Associate District Directors for Counseling and Administration. Two of three district leaders agreed with the District Director's assessment including the impact this has on the ability of the Deputy District Director to provide training and coaching to staff. One district leader reported it was impossible to give VCDs the attention needed and was concerned that something would get missed.

[33] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

Quality Improvement Activities

The OIG sent questionnaires and interviewed district leaders to assess knowledge about healthcare quality improvement principles and practices. District leaders were generally knowledgeable about the basic concepts of, and their roles in, quality improvement. District leaders described quality improvement as a continuous process to sustain or exceed the standard, finding ways to provide better care and service, and analysis of practice and performance to improve operations and services. Three of four leaders did not feel they had enough time in a given week to support quality improvement activities.

District Annual In-service Training

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.[34] Vet center staff must complete annual training specific to the duty assignments of each position. RCS district directors are responsible for planning and implementing the annual trainings, using a wide variety of modalities, including face-to-face trainings or video conferencing.[35]

District 3 zone 1 conducted annual in-service trainings during the inspection period; however, it was only available to readjustment counselors. District leaders reported trainings were not developed for the vet center directors, veterans outreach specialists, and office managers due to the pandemic. District leaders were aware of who assigned the required VHA training to staff in Talent Management System but did not have a process to ensure required training was assigned and completed.

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 assessment of VA workforce experiences. Since 2001, the instrument has been updated "in response to operational inquiries by VA leadership on organizational health relationships and VA culture."[36] Although the OIG

[34] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[35] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[36] James L. Smith and Heather McCarren, "Developing servant leaders contributes to VHA's improved organizational health," *Organizational Health* 19, (Summer 2013): 1-2. "Healthy organizations are places where employees want to work and customers want to receive services." K. Osatuke, et al. (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.

recognizes that employee satisfaction survey data are subjective, the information can be (1) a starting point for discussions, (2) indicative of areas for further inquiry, and (3) considered along with other information for leaders' evaluation.

The OIG sent a questionnaire to district leaders that included questions related to the communication of, and changes implemented from, the All Employee Survey results. The District Director reported sharing the All Employee Survey results on a district-wide call and developing champion teams to address unique cohort results. As a result of the survey, the Deputy District Director reported offering leadership courses to address specific cohorts and increased communication with the field, including biweekly staff meetings with the district office, monthly meetings with Associate District Directors for Counseling and Administration, and zone phone lines in each office. The Acting Associate District Director for Counseling reported the establishment of biweekly VCD group calls where teams can obtain more information and ask additional questions. The Associate District Director for Administration noted the district made sharing a consistent message to the field a priority.

Vet Center Service Feedback Survey

RCS requires a follow-up feedback survey for a client once a case is closed or a client has not been seen in the last 100 days and other select criteria is met.[37] The results from the feedback survey allows district leaders and VCDs to evaluate the effectiveness of readjustment counseling and services provided.[38] On March 1, 2019, RCS National Service Support began maintaining all client survey feedback results and compiling the data into quarterly summary reports for RCS and district leaders.[39]

In July 2021, RCS changed the method of collecting client feedback and a new program called Veteran Signals (VSignals) was established.[40] The OIG reviewed the Vet Center Service Feedback Survey scores from fiscal year 2020 because a full year of results for scores were not available for fiscal year 2021.

[37] RCS Chief Officer memorandum, "Readjustment Counseling Service (RCS) Customer Feedback Procedures," February 1, 2019.

[38] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[39] Effective January 9, 2017, RCS National Service Support (NSS) Center undertook duties of mailing and collecting of RCS client feedback forms.

[40] VHA Directive 1003, *VHA Veteran Patient Experience*, April 14, 2020. VHA implemented use of Veteran Signals (VSignals) to solicit feedback from veteran stakeholders to be used with other tools to improve the patient experience. VSignals includes use of a "Digital Comment Card" that client stakeholders can utilize to provide feedback.

The OIG found district 3 zone 1 veteran client feedback results were below the national average in all areas except satisfaction with overall quality of services at the Vet Center as noted in table 2 below.

Table 2. District 3 Zone 1 Vet Center Service Feedback Survey Results October 1, 2019–September 30, 2020

Questions	District 3 Zone 1 Average Score*	RCS National Average Score*
I was treated in a welcoming and courteous manner by the Vet Center staff.	4.51	4.66
My appointments have been scheduled at a time that was convenient.	4.57	4.58
I would likely recommend the vet center to another Veteran, service member, or family member.	4.57	4.60
The Vet Center services were located conveniently in my community.	4.24	4.36
I feel better as a result of the services provided by the Vet Center staff.	4.38	4.40
How satisfied were you with the overall quality of services at the Vet Center?	4.50	4.50

Source: Developed by VA OIG based on RCS National Service Support data provided by Midwest District 3. The OIG did not assess VA's data for accuracy or completeness.
**Scoring 1=very dissatisfied, 2=dissatisfied, 3=neither satisfied nor dissatisfied, 4=satisfied, 5=very satisfied. Vet Center Service Feedback Survey results are divided into three client types: family member, service member, and veteran. The OIG used veteran type because it was most representative of clients served at vet centers.*

The District Director noted the scores were not far below the national average and did not indicate knowledge of factors that contributed to the lower performance. The Deputy District Director noted not having a lot of insight into client feedback scores due to being on leave for most of the year and not having visited each vet center. Additionally, in response to how responses gathered from the Vet Center service feedback forms were used, the Deputy District Director reported several vet centers had relocated, and the district utilized telehealth to mitigate staffing shortages.

Leadership and Organizational Risks Questionnaire Results

The OIG distributed a leadership and organizational risks questionnaire to all district 3 zone 1 VCDs to evaluate perceptions about select quality improvement activities and organizational

health. The OIG sent 18 questionnaires to VCDs of which 14 were completed and returned.[41] The questionnaire consisted of 15 questions and collected both quantitative and qualitative data. The first 14 questions collected the quantitative data in the following areas: quality improvement, psychological safety, just culture and safety, and the All Employee Survey. The last question uses qualitative methodology to collect data by allowing VCDs to provide narrative responses related to quality improvement or to further explain any answers in the survey. All narrative responses were evaluated for immediate safety concerns or issues. The OIG did not validate respondent answers for accuracy.

Overall, VCDs indicated vet center staff speak up, offer ideas, and openly discuss concerns to find solutions. More than half of the respondents reported having processes in place at the vet center for reporting safety issues, errors, and concerns. VCDs indicated multiple barriers to implementing quality improvement activities such as district office not involving vet center staff in developing quality improvement processes, not receiving training on quality improvement requirements or processes, and not having adequate resources from the district. Other quantitative responses from the respondents included the following:

- Sixty percent disagreed or strongly disagreed when asked, "It is easy to ask district leaders for assistance when needed."
- Eighty percent disagreed or strongly disagreed when asked "District leaders ensure adequate resources (time, financial, training, etc.) to support quality improvement planning."
- Eighty-seven percent indicated not having enough time in a given week to support quality improvement activities due to a lack of tools and resources and competing priorities.

Leadership and Organizational Risks Findings and Recommendations

The district leadership team appeared stable across the district and zone, with sufficient coverage in place for the associate district director for counseling vacancy and reassigned VCDs. District leaders had a general understanding of quality improvement and perceived their role as important to driving and overseeing quality improvement activities. Questionnaire responses indicated 87 percent of district leaders and VCDs did not feel there was enough time to support quality improvement activities, and 60 percent of VCDs did not find it easy to ask district leaders for assistance when needed.

The OIG found district 3 zone 1 noncompliant with providing annual in-service training for vet center directors, veteran outreach program specialists, and office managers.

[41] Of the18 vet centers in district 3 zone 1, two VCDs were detailed out of the VCD position (Grand Rapids and South Bend Vet Centers), so they were excluded; therefore, only 16 VCDs were available for receipt of the questionnaire, of which, the OIG received 14 responses. Two VCDs did not respond.

Recommendation 1

The District Director determines reasons annual in-service training was not provided for vet center directors, veteran outreach program specialists, and office managers and ensures training is offered for all positions as required.

District Director Concur in Principle.

Annual training was not provided in FY21 due to the COVID 19 Pandemic. Annual training was provided to all roles via virtual sessions during Q4 of FY 2022. Vet Center Director (VCD) and Program Support Assistant (PSA) annual training was completed August 2-4, 2022. Veteran Outreach Program Specialist annual training was completed September 6-8, 2022, and counselor training was completed September 12-15, 2022. Annual Training for all roles is already in the planning stages for FY 2023. FY 2023 PSA training is tentatively scheduled for Q3, VCD training is tentatively scheduled in April 2023, veteran outreach program specialist training is tentatively scheduled in May 2023, and counselor training is tentatively scheduled for 3 separate weeks (cohorts by zone) in July, August, and September of 2023. All FY23 trainings are tentatively planned for in-person sessions. The Veteran Outreach Program Specialist Talent Management System (TMS) Course # is 131004917, Counselor TMS Course # 131004200 and VCD and PSA TMS Course is # 131004435.

Status: Closed

Target date for completion: N/A

OIG Response: The OIG considers this recommendation closed.

Quality Reviews

VHA leaders have articulated the goal to serve as the nation's leaders in delivering high-quality and veteran-centered care.[42] In its effort to ensure quality of care, client safety, and oversight, RCS policy outlines the use of various tools to monitor its wide range of psychosocial and psychological services to clients.[43]

Clinical and Administrative Quality Reviews

RCS requires an annual site visit, for both counseling and administrative services in all vet centers, to ensure compliance with RCS policies and procedures for management and delivery of

[42] VHA, "Blueprint for Excellence Fact Sheet," September 2014.

[43] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

readjustment counseling.[44] Based on objectives, the review is conducted by either the associate district director for counseling or the associate district director for administration.

Within 30 days of receiving the site visit report, the VCD, in conjunction with the associate district director for counseling or associate district director for administration, must develop a remediation plan to address all identified deficiencies.

Clinical quality reviews include multiple areas of evaluation:

- Vet center team composition
- Access to vet center services
- Readjustment counseling productivity
- Active client caseloads
- Customer feedback[45]

Administrative quality reviews include multiple areas of evaluation:

- Vet center key staff
- Vet center physical site
- Administrative operations
- Privacy and information security management
- Emergency and crisis management
- Fiscal management[46]

RCS policy requires deputy district directors to ensure vet center clinical and administrative quality reviews are conducted each fiscal year and are responsible for approving the quality reviews and remediation plans.[47] Associate district directors for counseling and administration conduct the quality reviews that result in written remediation reports.

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[44] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2) require clinical and administrative quality reviews to be completed annually. RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol" and RCS Chief Officer memorandum, "RCS Annual Oversight Assessments," October 7, 2021, further clarifies that clinical and administrative reviews are completed every fiscal year.

[45] RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

[46] RCS, *Administrative Site Visit (ASV)Protocol*. The OIG requested documentation related to administrative site visit protocol and the template was provided by RCS Central Office on October 7, 2021.

[47] RCS Chief Officer memorandum, "Vet Center Clinical and Administrative Site Visits," November 2, 2018; RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); RCS Chief Officer memorandum, "RCS Annual Oversight Assessments."

Within 30 days of receiving the clinical or administrative quality site visit 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.[48] Within 60 days from the date the deputy district director approves the remediation plan, the VCD is responsible for resolving all deficiencies.[49] 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.[50] Figure 8 depicts the vet center quality review remediation process.

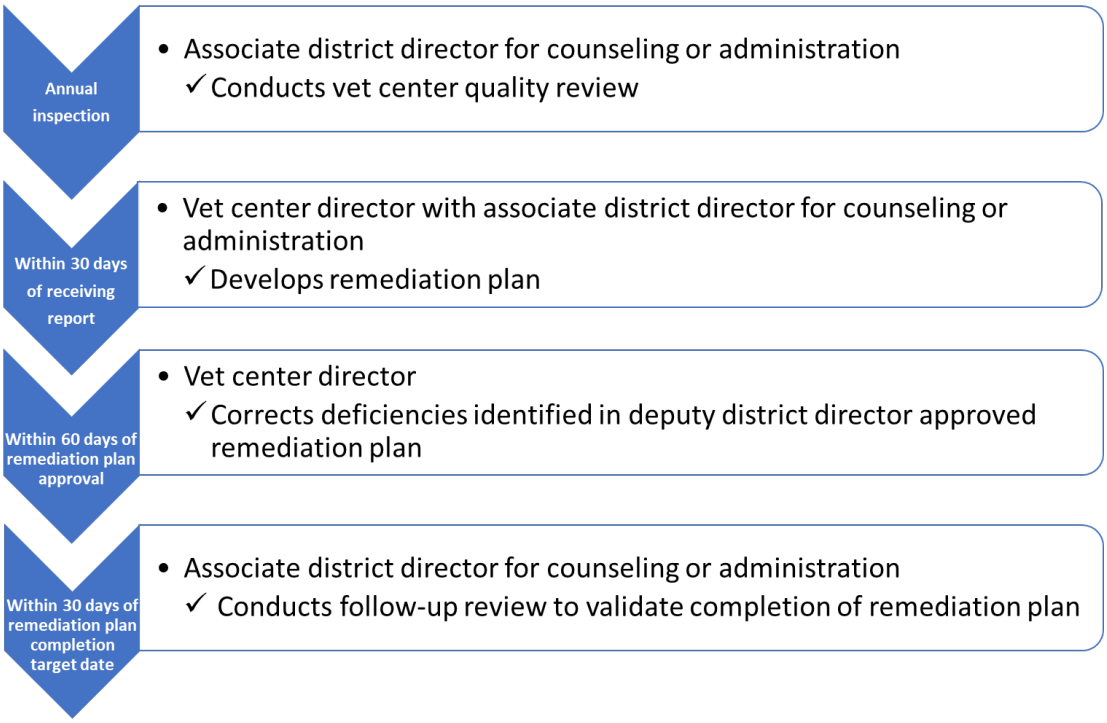

Figure 8. *Vet center quality review remediation process.*
Source: VA OIG developed using VA, Chief Officer RCS memo, "Vet Center Clinical and Administrative Site Visits." November 2, 2018, VHA Directive 1500; VHA Directive 1500(1); and VHA Directive 1500(2).

The OIG evaluation for the clinical and administrative review processes for district 3 zone 1 vet centers included interviewing district leaders and review of

- clinical and administrative site visit reports (zone wide),
- clinical and administrative remediation plans (zone wide),

[48] RCS Chief Officer memorandum, "Vet Center Clinical and Administrative Site Visits."
[49] RCS Chief Officer memorandum, "Vet Center Clinical and Administrative Site Visits." RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."
[50] RCS Chief Officer memorandum, "Vet Center Clinical and Administrative Site Visits."

- clinical and administrative deficiency resolution documentation and timeliness (four selected vet centers), and
- evidence of clinical and administrative deficiency resolution (four selected vet centers).[51]

Clinical and Administrative Quality Review Findings and Recommendations

The OIG found the Associate District Directors for Counseling and Administration compliant with the completion of clinical and administrative quality reviews for all 18 vet centers in district 3 zone 1. The Associate District Director for Administration was compliant with completion of required administrative remediation plans.

The OIG identified the following findings:

- Clinical quality review remediation plan incompletion (zone wide)
- Clinical quality review remediation plans did not include documentation of deficiency resolution and the timeframe of resolution (four selected vet centers)
- Insufficient evidence that clinical quality review identified deficiencies were resolved (four selected vet centers)
- Administrative quality review remediation plans did not include documentation of deficiency resolution and the timeframe for resolution (four selected vet centers)
- Insufficient evidence that administrative quality review identified deficiencies were resolved (four selected vet centers)

Zone-Wide Clinical Quality Reviews and Remediation Plans

Clinical quality reviews were completed for 18 vet centers. On average, clinical site visit reports were approved within 34 days of the site visit; 8 of the 18 reports exceeded the 30-day time frame.

The OIG found district 3 zone 1 noncompliant with completion of remediation plans for clinical quality reviews. Clinical quality reviews were primarily the responsibility of the Associate District Director for Counseling with the Deputy District Director responsible for the final

[51] The OIG requested documentation that each deficiency was resolved and evidence to support resolution. Examples of evidence include date and time stamped emails or invoices.

approval of the quality site visit report.[52] Of the 18 completed clinical quality site visit reports, 17 vet centers had clinical deficiencies identified; however, Grand Rapids and South Bend Vet Centers did not have approved remediation plans.

Vet Center Specific Clinical Remediation Plan and Deficiency Resolution

The OIG examined remediation plans and deficiency resolution for the clinical quality reviews conducted at the Cleveland, Columbus, Toledo, and South Bend Vet Centers. RCS requires a remediation plan for all deficiencies identified during quality reviews within 30 days following receipt of the site visit report. Deficiencies are expected to be resolved within 60 days following approval of the remediation plan.[53]

The OIG found the clinical remediation plans for the Cleveland, Columbus, and Toledo Vet Centers compliant in addressing all deficiencies identified in the clinical quality reviews.[54] One of the 31 identified deficiencies at the Cleveland, Columbus, and Toledo Vet Centers had documentation of resolution. None of the 31 identified deficiencies had documentation of timely resolution nor evidence of resolution. The South Bend Vet Center did not have an approved remediation plan for identified deficiencies and therefore, was noncompliant. Both acting Associate District Directors for Counseling told the OIG the remediation plan, submitted by the VCD, was not approved due to it lacking specific plans to address the identified deficiencies. The South Bend Vet Center was also noncompliant in documentation, evidence, and timely resolution of identified deficiencies.[55]

The OIG identified the following findings at the Cleveland, Columbus, and Toledo Vet Centers (see table 3):

- Absence of deficiency resolution documentation for 30 of 31 identified deficiencies.
- Insufficient evidence of deficiency resolution for all 31 identified deficiencies.
- No documentation of timely deficiency resolution for all 31 identified deficiencies.

[52] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); RCS Chief Officer memorandum, "Vet Center Clinical and Administrative Site Visits." RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

[53] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); RCS Chief Officer memorandum, "Vet Center Clinical and Administrative Site Visits."

[54] The OIG learned that the Associate District Director for Counseling had been detailed from the position in early April 2021 at which time coverage of the position was divided between two acting Associate District Directors for Counseling.

[55] Documentation of deficiency resolution is when the deficiency has been documented as resolved in the remediation plan. Evidence of resolution is the provision of requested documents to the OIG proving the deficiency has been resolved.

Table 3. Vet Center Clinical Remediation Plans and Deficiency Resolution for the Four Selected Vet Centers

	Cleveland	Columbus	Toledo	South* Bend
Number of Deficiencies Identified by the Associate District Director for Counseling	15	15	1	7
Number of Deficiencies Identified in the Remediation Plan	15	15	1	0
Number with Documentation of Resolution	1	0	0	0
Number with Evidence of Resolution	0	0	0	0
Number of Deficiencies with Documentation of Timely Resolution	0	0	0	0

Source: VA OIG analysis based on district 3 zone 1 documents.
Note: The OIG examined remediation plans and evidence of deficiency resolution that corresponded to Clinical Quality Reviews performed from October 1, 2020, through September 30, 2021.
**South Bend Vet Center did not have an approved remediation plan submitted from October 1, 2020, through September 30, 2021.*

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.[56] RCS requires deputy district director approval of remediation plans to establish the 60-day time frame for deficiency resolution.[57]

The OIG found that RCSNet did not have a location for remediation plans to record the deputy district director approval signature or date. District leaders explained the clinical quality review process includes deputy district director review of remediation plans, but approval could not be validated because it was not documented in RCSNet. The OIG was able to determine that there was 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 approval of the remediation plan.

[56] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); RCS Chief Officer memorandum, "Implementation of Automated Vet Center Clinical Site Visit (CSV) Operations," November 4, 2019.
[57] RCS Chief Officer memorandum, "Vet Center Clinical and Administrative Site Visits."

Recommendation 2

The District Director determines reasons clinical quality review remediation plans were not completed for the Grand Rapids and South Bend Vet Centers, ensures completion, and monitors compliance.

District Director Concur in Principle.

Clinical Quality Review remediation plans were not completed for FY20 or FY21 for the Grand Rapids or South Bend Vet Centers. Subsequent to this finding, a manual tracking system was developed for all clinical and administrative site visits that is completed and monitored by Associate District Director/Counseling (ADD/C), with oversight from the District Director (DD). Implementation of the Tracker began in October 2021 and has been consistently used since then for tracking Zone 1 clinical quality review remediations. Zone 1 remediation plans and actions will be completed for FY22 and beyond.

Status: Ongoing

Target date for completion: April 2023

Recommendation 3

The District Director determines reasons clinical quality review remediation plans at the four selected vet centers did not include documentation of deficiency resolution and the time frame of resolution, takes indicated actions to ensure completion, and monitors compliance.

District Director Concur.

District 3 is developing a new process to monitor clinical quality compliance, including training VCDs to include quality compliance review in regular supervision with staff. Documentation of progress on deficiency resolution will be included in the 90-day remediation actions of the Clinical Site Visit (CSV) report in RCSnet. Two online site visit dashboards have been created and made available to the DD and District staff to monitor compliance with psychosocial document and note entry outcomes. The CSV process is entered and tracked in RCSNet. The ADDC completes the report, and the Deputy District Director (DDD) approves the CSV. If a remediation plan is required, the VCD will develop the plan, the ADDC and the DDD will review and approve the final plan. A new process for addressing ongoing compliance is being initiated, wherein resolution of remediations is tracked and monitored in the Power-BI Dashboards and review of records in RCSnet by VCDs in collaboration with the ADDC and DDD, with a goal of deficiency resolution before the next clinical site visit.

Status: Ongoing

Target date for completion: April 2023

Recommendation 4

The District Director determines reasons for lack of evidence that clinical quality review deficiencies were resolved at the Cleveland, Columbus, and Toledo Vet Centers, takes indicated actions to ensure completion, and monitors compliance.

District Director Concur.

District 3 is implementing a new process for ongoing monitoring of clinical quality review deficiencies across Zone 1. Resolution of the clinical site and remediations will be tracked and monitored in the Power-BI Dashboards and review of records in RCSnet by VCDs in collaboration with the ADDC and DDD, with a goal of deficiency resolution before the next clinical site visit. The District Director will provide oversite to this new process and will ensure discussion with VCDs about all items that are deficient for consecutive clinical quality reviews.

Status: Ongoing

Target date for completion: April 2023

Zone-Wide Administrative Quality Reviews

The associate district director for administration is responsible for administrative quality reviews and the deputy district director is responsible for final approval of remediation plans.[58] The OIG found district 3 zone 1 to be compliant with requirements for administrative quality remediation plans.

For each vet center in district 3 zone 1, the Associate District Director for Administration completed an administrative quality site review. Of the 18 completed administrative quality site visit reports, 15 vet centers had administrative deficiencies identified; all vet centers with identified deficiencies had remediation plans.

Vet Center Specific Administrative Remediation Plan and Deficiency Resolution

The OIG examined remediation plans and deficiency resolution for the administrative quality reviews conducted at the Cleveland, Columbus, Toledo, and South Bend Vet Centers. RCS requires a remediation plan for all deficiencies identified during quality reviews within 30 days following receipt of the site visit report. Deficiencies are expected to be resolved within 60 days following approval of the remediation plan.[59]

The OIG found the administrative remediation plans for the Cleveland, Columbus, and South Bend Vet Centers compliant in addressing all deficiencies identified in the quality reviews. Seven of nine identified deficiencies at the Cleveland, Columbus, and Toledo Vet Centers had documentation of resolution. One of the identified deficiencies had evidence of resolution and one had documentation of timely resolution. During the OIG inspection period, the Toledo Vet Center did not have deficiencies in the administrative site review and therefore, did not require a remediation plan or deficiency resolution.

The OIG identified the following findings:

- Documentation of deficiency resolution was not available for two of eight deficiencies identified at the Columbus and South Bend Vet Centers.
- Evidence of deficiency resolution was not available for eight of nine deficiencies. identified at the Cleveland, Columbus, and South Bend Vet Centers.
- Documentation of timely deficiency resolution was not available for any of the eight deficiencies identified at the Columbus and South Bend Vet Centers.

[58] RCS Chief Officer memorandum, "Vet Center Clinical and Administrative Site Visits." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[59] RCS Chief Officer memorandum, "Vet Center Clinical and Administrative Site Visits." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

Table 4. Vet Center Administrative Remediation Plans and Deficiency Resolution for the Four Selected Vet Centers

	Cleveland	Columbus	Toledo*	South Bend
Number of Identified Deficiencies by the Associate District Director for Administration	1	6	0	2
Number of Deficiencies Identified in the Remediation Plan	1	6	0	2
Number with Documentation of Resolution	1	5	NA	1
Number with Evidence of Resolution	0	0	NA	1
Number of Deficiencies with Documentation of Timely Resolution	1	0	NA	0

Source: VA OIG analysis based on district 3 zone 1 documents.
Note: The OIG examined remediation plans and evidence of deficiency resolution that corresponded to administrative quality reviews performed from October 1, 2020, through September 30, 2021.
**During the OIG inspection period, the Toledo Vet Center did not have identified deficiencies in the administrative site review and therefore, did not require a remediation plan or deficiency resolution.*

Recommendation 5

The District Director determines reasons for lack of evidence for administrative quality review deficiency resolution for the Cleveland, Columbus, and South Bend Vet Centers, takes indicated actions to ensure completion, and monitors compliance.

District Director Concur.

District 3 is implementing a new process for ongoing monitoring of administrative quality review deficiencies across Zone 1. 10RCS has created an administrative site visit report in RCSnet, and as of FY23, paper processes will no longer be used. Resolution of the administrative site and remediations will be tracked and monitored by review of records in RCSnet by VCDs in collaboration with the Associate District Director for Administration (ADD/A) and DDD, with a goal of deficiency resolution before the next administrative site visit. The District Director will provide oversite to this new process and will ensure discussion with VCDs about all items that are deficient for consecutive administrative quality reviews.

Status: Ongoing

Target date for completion: April 2023

Recommendation 6

The District Director determines reasons administrative quality review remediation plans did not include documentation of deficiency resolution and the time frame of resolution for the Columbus and South Bend Vet Centers, takes indicated actions to ensure completion, and monitors compliance.

District Director Concur.

District 3 is developing a new process to monitor clinical quality compliance, including training VCDs to include administrative quality compliance review in regular supervision with staff. Documentation of progress on deficiency resolution will be included in the remediation plans of the administrative site visit report, now located in RCSnet.

Status: Ongoing

Target date for completion: April 2023

Morbidity and Mortality Reviews

VHA's National Patient Safety Improvement Handbook states 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.[60] RCS requires the VCD to complete a crisis report prior to close of business on the day of notification for a serious suicide or homicide attempt or when a client dies by suicide or homicide, with notification to district and the RCS Central Office leaders within 48 hours.[61]

Additionally, RCS requires completion of a morbidity and mortality review for client safety events including serious suicide or homicide attempts, and death by suicide or homicide.[62] RCS has established a specific protocol for conducting morbidity and mortality reviews to evaluate vet center policies and practices regarding client safety and staff actions during the provision of vet center services, and to make recommendations to improve the effectiveness of suicide prevention activities.[63]

[60] VHA Handbook 1050.01.

[61] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[62] VHA Handbook 1500.01. VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). Prior to the 2021 directive, RCS referred to morbidity and mortality reviews as critical incident quality reviews.

[63] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

To examine the quality oversight process, the OIG evaluated crisis reports and morbidity and mortality reviews completed for serious suicide or homicide attempts, death by suicide or homicide events that occurred during the inspection period, and interviewed district leaders.[64] In district 3 zone 1, the OIG identified seven crisis reports completed for serious suicide attempts and one for a client death by suicide.

Morbidity and Mortality Review Findings and Recommendations

The OIG found one death by suicide of an active client in district 3 zone 1. District leaders completed a morbidity and mortality review. The morbidity and mortality review evaluated actions taken and made recommendations for improvement of vet center suicide prevention activities related to the death by suicide. The OIG found morbidity and mortality reviews were not completed for the seven serious suicide attempts. District leaders did not have a process in place to complete morbidity and mortality reviews for serious suicide attempts.

Recommendation 7

The District Director determines reasons why morbidity and mortality reviews for serious suicide attempts were not completed, ensures completion, and monitors compliance.

District Director Concur in Principle.

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

Status: Ongoing

Target date for completion: April 2023

RCS Chief Officer Morbidity and Mortality Recommendation

Recommendation 8

The Readjustment Counseling Service Chief Officer defines "serious suicide attempt" and establishes criteria for when a morbidity and mortality review is required as well as a standardized process for completing the review.

[64] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). Crisis reports are used to document "suicide ideation (with inability to maintain safety), suicide attempt, and suicide completion" in RCSNet.

Chief Officer Concur in Principle.

Readjustment Counseling Service (RCS) is developing policy that will align RCS more consistently with larger Veterans Health Administration (VHA) to include replacing serious suicide attempt with self-directed violence.

Status: Ongoing

Target date for completion: April 2023

Suicide Prevention

The VA National Veteran Suicide Prevention Annual Report published in the fall of 2021 found that after adjusting for age and sex differences, the suicide rate was 52.3 percent greater in 2019, for veterans than for non-veteran adults.[65] 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." VHA supports a national goal to reduce suicide within the United States by 20 percent by the year 2025 through implementation of a public health model.[66] The American Foundation for Suicide Prevention reports that suicide has no single cause, but "most often occurs when stressors exceed current coping abilities of someone suffering from a mental health condition."[67]

In 2017, the VA identified RCS as an important part of the VA's overall suicide prevention strategy.[68] VHA requires a shared responsibility for suicide prevention between RCS, the Office of Mental Health and Suicide Prevention, and VHA suicide prevention coordinators. VHA recognizes that the unique community-based views of vet centers can help identify opportunities to better identify veterans' risk of suicide and thereby improve clinical outcomes of veterans under VHA care.[69] In 2017, a Memorandum of Understanding between the Office of Mental Health and Suicide Prevention and RCS defined operations for the identification, notification,

[65] VA Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, 2021. The suicide rate included in the report is adjusted for age and gender.

[66] 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.

[67] The American Foundation for Suicide Prevention is a voluntary health organization that supports suicide research and education.

[68] VHA Deputy Under Secretary for Health for Operations and Management memorandum, "Memorandum of Understanding between the VHA Office of Mental Health and Suicide Prevention and the VHA Readjustment Counseling Service."

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

and treatment of high risk or suicidal veterans, and quality reviews related to veteran suicides for active clients.[70]

VHA requires each supporting VA medical facility to establish a high-risk suicide list and develop a process to activate a patient record flag in each client's VA electronic health record.

On May 11, 2020, RCS implemented a SharePoint site for high-risk suicide flag clients organized by zone.[71] In June 2021, RCS informed the OIG that the SharePoint site was expanded to include the REACH VET data.[72] RCS requires vet center directors review the High-Risk Suicide Flag list monthly and document a disposition on the site for all clients seen at the vet center within the previous 12 months.[73] RCS requires the completion of a suicide risk assessment on the first visit during the intake process and subsequent counseling visits as indicated. The vet center counselor is required to develop an individualized safety plan for all risk assessment levels of intermediate or higher.[74]

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

- Psychosocial and suicide risk assessments *(zone wide)*
- Care coordination and collaboration with VHA–RCS and VA medical facility shared high risk for suicide clients *(zone wide)*
- Safety plans and consultation (*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)*
- Critical event plans *(four selected vet centers)*
- Root cause analysis participation and feedback *(four selected vet centers)*

[70] VHA Deputy Under Secretary for Health Operations and Management memorandum, "Memorandum of Understanding between the VHA Office of Mental Health and Suicide Prevention and the VHA Readjustment Counseling Service."

[71] Microsoft, Definition of SharePoint. "a secure place to store, organize, share, and access information from any device," accessed July 15, 2021. https://support.microsoft.com/en-us/office/what-is-sharepoint-97b915e6-651b-43b2-827d-fb25777f446f.

[72] Increased predictive risk for suicide was developed by VA's Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) program to determine veterans who have a higher risk for suicide through predictive analytics.

[73] RCS Chief Officer memorandum, "High Risk Suicide Flag Outreach*,"* April 27, 2020.

[74] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

The OIG team used a 90 percent benchmark to evaluate electronic client records for compliance with selected RCS requirements for psychosocial assessments (including intake and military histories) and suicide risk assessments, care coordination and collaboration with VA medical facilities, and safety plans and consultation.

Zone-Wide Psychosocial and Suicide Risk Assessment

RCS requires a psychosocial assessment including an intake and military history to be completed by the client's fifth visit unless there is documentation of an extenuating circumstance that would prevent completion of these portions in a timely manner.[75] Psychosocial assessments are used to gather information about a client's history including pre-military development, military history, war-related readjustment concerns, and level of functioning to complete a clinical evaluation.[76]

RCS also requires the completion of a suicide risk assessment during the first counseling encounter.[77] The assessment follows VA/Department of Defense Clinical Practice Guidelines by utilizing common terminology used for suicide risk evaluation and consultation practices that are familiar to other clinical providers.[78]

Electronic Client Record

The OIG used zone-wide data extracted from the RCSNet database to evaluate vet center staff compliance with completion of psychosocial and suicide risk assessments. The OIG randomly selected two samples of clients new to vet centers from October 12, 2020, through August 31, 2021.[79] The samples included 60 client records with five or more visits, and 40 clients with four or less visits.[80] The OIG reviewed the 60 client records with five or more visits and assessed clients only if there were five or more individual counseling visits. For the suicide risk assessment sample, the OIG reviewed the first clinical progress note for documentation of a completed suicide risk assessment by a clinical staff member. Exclusion criteria for both samples

[75] RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[76] VA, *RCS Guidelines and Instructions for Vet Center Client Records*, November 23, 2010; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[77] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[78] VA, *Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services (RCSNet)*, September 19, 2020.

[79] The sub-population size was randomly selected and weighted for the two samples. The one-year inspection period was shortened to match the launch date of the new suicide risk assessment.

[80] RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol." The OIG stratified the population sample given RCS requires completion of the intake and military histories by the fifth visit and suicide risk assessment by the first visit. The sample of 60 client records was reviewed for completion of the intake, military history, and suicide risk assessment. The sample of 40 client records was used to evaluate completion of the suicide risk assessment as this client group had four or less visits and therefore, completion of the psychosocial assessment was not required.

included clients not seen during the inspection period, bereavement cases, family member seeking services during client deployments, administrative visits only, and an "other" category requiring OIG team member concurrence.

The OIG reviewed RCSNet electronic client records to determine if intakes and military histories were completed and finalized within the required five visits. If the required intake assessment or military history was not completed, the OIG reviewed records for extenuating circumstances. The OIG reviewed client records to determine timely completion of suicide risk assessments by evaluating the first clinical note for reference to and completion of a suicide risk assessment.[81]

The OIG was able to determine intake and military history completion through a RCSNet record review. At the time of the inspection, due to RCSNet limitations, the OIG was unable to determine if intake and military history sections were completed by the fifth visit as required.

The OIG was able to determine suicide risk assessment completion through an RCSNet record reviews. However, the OIG was unable to determine if the risk assessment date in RCSNet or the database was the creation or completion date of the assessment despite the OIG having access to the database. Due to RCSNet limitations, the OIG reviewed the first clinical visit note for documentation that the clinician completed the suicide risk assessment.

Zone-Wide Psychosocial and Suicide Risk Assessment Findings

The OIG determined that district 3 zone 1 vet center clinicians completed 93 percent of military histories and were noncompliant with requirements for completion of intake and suicide risk assessments (see table 5).

[81] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). According to RCS, on October 12, 2020, a new risk assessment was implemented in the RCSNet individual intake procedural section. The risk assessment is divided into two groups: acute and chronic. Clinical staff determine level of risk as either low, intermediate, or high. For clients seen on or after October 12, 2020, the OIG reviewed electronic health records for completion of the new RCS risk assessment, assessing 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.

Table 5. Estimated Compliance Rate for Psychosocial and Suicide Risk Assessments October 12, 2020–August 31, 2021

Electronic Client Record Section	Number of Client Records Reviewed*	Estimated Compliance (%) Completed Zone Wide	95% Confidence Interval†
Intake	59	19	(10, 29)
Military History	59	93‡	(86, 98)
Suicide Risk Assessment	99	43	(34, 53)

Source: VA OIG Analysis.

** One client was excluded from intake, military history, and suicide risk assessment sample for not being vet center eligible (only seen for humanitarian reasons).*

†Merriam-Webster.com Dictionary, "confidence interval," accessed January 21, 2021, https://www.merriam-webster.com/dictionary/confidence%20interval. 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."

‡ The estimated compliance rate for military history was 93 percent, where the OIG estimated with 95 percent confidence that the true compliance rate is between 86 percent and 98 percent.

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 suicide risk assessments with the first individual clinical visit.

Recommendation 9

The District Director ensures the intake portion of the psychosocial assessment is completed and monitors compliance across all zone vet centers.

District Director Concur.

The district team provided training to VCDs and Readjustment Counselors on completion and time-specific requirements of the intake portion of the psychosocial assessment in June of 2021. Additionally, they were provided training on methods for monitoring compliance for the VCDs including new monitoring tools such as the clinical compliance dashboards in September 2021. Compliance to be monitored through monthly chart audits and regular RCSNet report reviews by VCDs with support from ADDCs and other District staff.

Status: Ongoing

Target date for completion: April 2023

Recommendation 10

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

District Director Concur.

The district team provided training to the Vet Center Directors and Readjustment Counselors on electronic monitoring of risk assessment completed in FY 2021. The Vet Center Director and District leadership will monitor compliance through review of RCSnet data and monitoring tools such as the clinical compliance dashboards.

Status: Ongoing

Target date for completion: April 2023

Zone-Wide Care Coordination and Collaboration with VA Medical Facilities

RCS and VA Medical Facility Shared High Risk Clients

As outlined in the Memorandum of Understanding, there is a "shared responsibility for suicide prevention among the Office of Mental Health and Suicide Prevention (OMHSP), Suicide Prevention Coordinators (SPC), and Readjustment Counseling Service (RCS)."[82] Further, vet center counselors 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.[83] Vet center staff are required to follow confidentiality requirements when coordinating care with the support VA medical facility.[84]

[82] VHA Deputy Under Secretary for Health Operations and Management memorandum, "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service."

[83] VHA Deputy Under Secretary for Health Operations and Management memorandum, "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service. VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[84] 38 C.F.R. § 17.2000–816 (e).

Electronic Client Records

The OIG identified 42 RCS clients who were flagged as high risk for suicide by the support VA medical facility and who were seen at district 3 zone 1 vet centers from July 1, 2020, through July 31, 2021, following the placement of the high-risk flag.[85]

The OIG evaluated each client record for the following:

- Consultation and coordination of services with shared support VA medical facility within 60 days from placement of the high risk for suicide flag.
    - Adherence to confidentiality requirements if consultation and coordination occurred within 60 days.[86]
- Timely notification to the support VA medical facility suicide prevention coordinator if client posed a significant safety risk.[87]
    - Adherence to confidentiality requirements if notification occurred.

Zone-Wide Care Coordination and Collaboration with VA Medical Facilities Findings

The OIG found vet centers in district 3 zone 1 were not compliant with requirements for shared clients with the support VA medical facility related to suicide prevention and intervention. The OIG excluded 13 of 42 clients with closed cases during the high-risk flag episode.

The OIG found that of the 29 client records reviewed, 17 had documented coordinated care with support VA medical facilities as required. Of those 17, only 5 followed confidentiality requirements. Overall, 17 percent of records reviewed followed requirements for care coordination while maintaining confidentiality.

The OIG found 13 of 29 records reviewed had documented significant safety risks. Of the 13 records reviewed, 5 were compliant with providing timely notification to the support VA medical

[85] There was a total of 42 clients at high risk for suicide during this time period in zone 1. The OIG extracted all high risk for suicide (newly activated and reactivated) clients from all district 3 zone 1 vet centers associated with support VA medical facilities and cross referenced the clients with the RCSNet database to identify shared clients. The data extraction period was adjusted (two months before inspection period) to allow time for RCS clinical staff to complete required care coordination following high-risk flag placement.

[86] "The Vet Center supports prompt and open communication of readjustment counseling information with VA medical facility and other community providers by obtaining a voluntary written Release of Information (ROI) form from the eligible individual as required for client confidentiality." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[87] RCS policy does not define a significant safety risk. In the absence of an RCS definition of a significant safety risk, the OIG used suicidal ideation with intent and plan, preparatory suicidal behaviors, self-injurious or potentially self-injurious behaviors, and suicide attempts. For the purposes of this report, timely is defined as notification that should occur on the same day that the significant safety risk is identified. If a client had more than one significant safety risk during the review period, the team evaluated a randomly selected significant safety risk for the client.

facilities' suicide prevention coordinator within 60 days and only one of the five followed confidentiality requirements.[88] Overall, 8 percent of records reviewed followed the requirements for care coordination with suicide prevention coordinators while maintaining confidentiality.

The OIG identified the following findings:

- Vet center clinical staff did not consistently consult or coordinate with VA medical facilities on shared clients who were deemed high risk for suicide within 60 days.
- For clients where coordination occurred with VA medical facilities, vet center clinical staff did not consistently follow confidentiality requirements.
- For clients who posed a significant safety risk, vet center clinical staff did not consistently provide timely notification to suicide prevention coordinators at the VA medical facility.

Recommendation 11

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

District Director Concur.

The district team provided training to Vet Center Directors and Readjustment Counselors regarding the importance of collaborating and coordinating care with VA Medical Center (VAMC) providers on all shared clients, especially those with increased suicide risk. Compliance is monitored during monthly chart audits conducted by the VCDs, with ADDCs and other District staff available to support coordination efforts.

Status: Ongoing

Target date for completion: April 2023

Recommendation 12

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 Concur.

[88] The OIG identified only one vet center client records compliant with reporting significant safety risks. The OIG omits calculations for the electronic record review requirements when the number of clients is less than 11.

The district team provided training to Vet Center Directors and Readjustment Counselors, as a component of FY22 Annual trainings, on the importance of communicating the benefits of consultation and coordination of care with VAMC 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 monthly chart audits conducted by the VCDs and the RCSNet report provided to the ADD/C for oversight.

Status: Ongoing

Target date for completion: April 2023

Recommendation 13

The District Director ensures clinical staff make timely notification to the suicide prevention coordinator at the support VA medical facility for clients with significant safety risks and monitors compliance across all zone vet centers.

District Director Concur.

The counselor or VCD that is first notified of a suicide crisis notifies the ADDC or other District office staff of the incident, and initiates a Crisis Log in RCSnet. The Crisis Log is completed by the counselor or VCD in collaboration with the ADDC, and with consistent notification of progress provided to the DDD and District Director. Timely notification to the appropriate suicide prevention team is a component of the process, and RCSnet records are reviewed by District staff to ensure that all needed documentation associated with the crisis is entered.

Status: Ongoing

Target date for completion: January 2023

Zone-Wide Safety Plans and Consultation

RCS provides guidance to vet centers for assessment and management of individuals who are considered at risk for suicide.[89] Suicide risk assessments are divided into two interrelated categories, acute and chronic. Counselors determine a self-harm level of low, intermediate or high for both categories. Vet center counselors are required to complete a suicide risk assessment at the initial counseling visit and as professionally indicated following the initial session.[90]

[89] VA, *Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services (RCSnet)*, updated October 5, 2020; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[90] VA, *Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services (RCSnet)*, 2020; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

Counselors are also required to complete a safety plan and seek consultation for any client who is assessed at intermediate to high risk for suicide, in either acute, chronic, or both categories.[91]

Safety plans must be individualized and developed in conjunction with the client and vet center counselor. Completed safety plans are entered into the electronic client record and provided to the client.[92] Safety plans identify coping strategies and support resources a client can utilize to lower risk of suicidal behavior. Over time, individuals can experience fluctuating levels of suicidality and a safety plan is designed to break the cycle early, providing the client with tools to avoid re-entering a suicidal state.[93]

Consultation is required with the VCD, Associate District Director for Counseling, external clinical consultant, or other support VA medical facility mental health professionals including the suicide prevention coordinator within 30 days "for individuals assessed to be at intermediate to high risk either acute, chronic or both."[94]

Electronic Client Records

The OIG randomly selected 50 RCS clients who were assessed at intermediate to high risk for suicide, in either acute, chronic, or both categories, and were seen at district 3 zone 1 vet centers from October 12, 2020, through August 31, 2021.[95]

The OIG evaluated each client record for

- completion of a safety plan or documentation of client declining a safety plan, and
- documentation of consultation within 30 days.

Zone-Wide Safety Plans and Consultation Findings

Overall, the OIG found district 3 zone 1 vet centers noncompliant with requirements for completion of safety plans and consultation with a VCD, associate district director for counseling, external clinical consultant, or support VA medical facility mental health professional for clients assessed at intermediate or high, or acute or chronic, risk levels (see table 6).

[91] VA, *Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services (RCSnet),* 2020; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[92] VA, *Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services (RCSnet)*, 2020; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[93] VA, *Suicide Prevention Program Guide*, November 1, 2020.

[94] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). The OIG utilized 30 days as the time frame within which consultation should occur.

[95] For clients with multiple risk assessments on the same date, the OIG reviewed all valid documented risk assessments at intermediate or high suicide risk level in, either acute, chronic or both categories that were not duplicates or created in error.

In district 3 zone 1, the OIG found that 38 percent of records reviewed followed RCS requirements for completion of a safety plan and 26 percent followed RCS consultation requirements (noted in table 6 below).

Table 6. Estimated Compliance Rate for Safety Plans and Consultation October 12, 2020–August 31, 2021

Electronic Client Record Review Area	Number of Client Records Reviewed	Estimated Compliance (%) Completed Zone Wide	95% Confidence Interval
Safety Plans	50	38	(24, 52)
Consultation	50	26	(14, 38)

Source: VA OIG Analysis.

Recommendation 14

The District Director ensures clinical staff complete safety plans for clients who are assessed at intermediate or high suicide risk level in either acute, chronic, or both categories as required, and monitors compliance across all zone vet centers.

District Director Concur.

The district team provided training to Vet Center Directors and Readjustment Counselors as a component of Annual trainings on the importance of completing a safety plan when a client is assessed at intermediate or high, acute or chronic, risk level. The Vet Center Director and District leadership will monitor compliance via chart audits and RCSnet reports of records due.

Status: Ongoing

Target date for completion: April 2023

Recommendation 15

The District Director ensures clinical staff consult with the vet center director, external clinical consultant, associate district director for counseling, or support VA medical facility mental health provider to include the suicide prevention coordinator following a client's suicide risk assessment as required, and monitors compliance across all zone vet centers.

District Director Concur.

The district team provided training to Vet Center Directors and Readjustment Counselors on ensuring regular and ongoing consultation with either the VCD, the External Consultant, or the Suicide Prevention Coordinator when there are changes in risk levels as authorized by RCS privacy

rules. The Vet Center Director and District leadership will monitor compliance via chart audits and RCSnet reports of records due.

Status: Ongoing

Target date for completion: April 2023

Vet Center Specific Suicide Prevention

The remainder of the report provides inspection findings at the following randomly selected vet centers in district 3 zone 1:

- Cleveland Vet Center, Ohio
- Columbus Vet Center, Ohio
- South Bend Vet Center, Indiana[96]
- Toledo Vet Center, Ohio

Access

In the 2017 Memorandum of Understanding, RCS core values include providing veterans with appointments outside of regular business hours and consists of appointment availability in the mornings, evenings, and weekends at all of its vet centers.[97] 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.[98] The 2017 Memorandum of Understanding outlines the following responsibilities:

[96] The acting South Bend VCD reported being detailed to the position approximately three weeks prior to the VCIP inspection entrance on October 25, 2021. For the remainder of this report, the Acting South Bend VCD is referred to as the South Bend VCD. An OIG hotline inspection was conducted at the South Bend Vet Center resulting in the following report, *Deficiencies in Suicide Risk Assessments, Continuity of Care, Bereavement Care, and Leadership at the South Bend Vet Center in Indiana*, Report No. 21-02511-28, January 19, 2023.

[97] VHA Deputy Under Secretary for Health Operations and Management memorandum, "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service."

[98] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). VHA Handbook 1160.01. 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."

- Standardization of a communication process between RCS and VA medical facility suicide prevention coordinators
- Sharing lists of veterans at high risk for suicide between VA medical facilities and RCS
- Timely notification of clients with significant safety risks to suicide prevention coordinators[99]
- Training for RCS staff
- Dissemination of a list from the Office of Mental Health and Suicide Prevention to RCS identifying veterans at increased predictive risk of suicide
- Identification of veterans receiving RCS counseling services
- RCS qualified clinician on all root cause analysis procedures involving shared clients[100]

The OIG interviewed VCDs and requested the following:

- Evidence of the VCD's or designee's participation in VA medical facility mental health council meetings
- Evidence of client disposition from the four selected vet centers in the RCS High Risk Suicide Flag SharePoint site
- Evidence of vet center critical event plan with desktop reference
- 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.[101] RCS staff created a SharePoint site that is populated monthly with names of VA medical facility-identified high-risk suicide flag clients who currently receive or have received vet center services within the past 12 months.[102] As of May 11, 2020, VCDs are required to review the site monthly for clients seen at their vet center, determine if outreach is needed, and document a disposition. In June 2021, the

[99] RCS policy does not define timely notification; in the absence of a definition of timeliness, the OIG considered notification on the same day of a significant safety risk as timely.

[100] VHA Deputy Under Secretary for Health Operations and Management memorandum, "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service."

[101] RCS Chief Officer memorandum, "High Risk Flag Suicide Outreach."

[102] RCS Chief Officer memorandum, "High Risk Flag Suicide Outreach."

RCS Clinical Program and Training Analyst reported that the SharePoint site was expanded to include clients with an increased predictive risk for suicide.[103]

The OIG requested documentation of clients identified on the High Risk Suicide Flag SharePoint site from the district office and any documented disposition from October 1, 2020, through September 30, 2021, to evaluate compliance with RCS requirements for high risk clients.

Critical Event Plan

Vet centers are required to have a critical event plan. Critical event plans are coordinated with the community and include a desktop reference sheet for vet center staff, outlining how to respond when a client presents as suicidal or homicidal either on the phone or in person.[104]

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.[105] 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.[106] If a death by suicide occurs with a shared client and a root cause analysis is conducted, vet center staff should be included in the root cause analysis investigation and receive relevant outcome information from the support VA medical facility root cause analysis team when cases are reviewed.[107]

The OIG reviewed all clients who died by suicide from Veterans Integrated Service Network (VISN) 10 offices.[108] The list was cross referenced with RCS clients to determine shared clients between VA medical facilities and the four selected vet centers.

[103] Increased predictive risk for suicide was developed by VA's Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) program to determine veterans who have a higher risk for suicide through predictive analytics.

[104] RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

[105] VHA Handbook 1050.01. 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."

[106] VHA Handbook 1050.01.

[107] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration.* VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[108] VISN 10 is comprised of all the support VA medical facilities that collaborate with vet centers in district 3 zone 1.

Vet Center Specific Suicide Prevention Findings and Recommendations

The OIG found the vet centers complied with nontraditional hours allowing clients easier access to services. All four vet centers had critical event plans that included a desktop reference sheet. 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 in root cause analysis investigations. The OIG found issues related to

- vet center participation in mental health council meetings,
- monthly review of the High Risk Suicide Flag SharePoint site, 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 comprised of essential mental health disciplines and specialty programs. VA medical facilities "are encouraged to include representation from Readjustment Counseling Centers (Vet Centers) in this Council."[109] The mental health councils are responsible for

- proposing program improvement and innovation,
- coordinating communication, and
- evaluating mental health policy impact.[110]

RCS requires a licensed vet center staff member to participate on all VA medical facility mental health council meetings. Participation is required to reinforce vet center and support VA medical facility partnerships, assist with care coordination for clients receiving vet center and VA medical facility services, and aid in critical responses and suicide prevention.[111] The OIG did not find a policy or guidance specifying how attendance was tracked and requested evidence of attendance.

The OIG found the Columbus, South Bend, and Toledo Vet Centers did not have evidence of representation at all meetings. The Columbus VCD reported sending a staff member, but did not have documents to support attending all meetings. The South Bend VCD stated an alternate designee was not identified when the VCD was unable to attend and client care was prioritized

[109] VHA Handbook 1160.01.

[110] VHA Handbook 1160.01.

[111] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*. VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

over mental health council attendance. The Toledo VCD reported missing some meetings due to client care and did not find information presented at the meetings pertained to vet centers.

Recommendation 16

The District Director, in collaboration with the support VA medical facility clinical or administrative liaisons, determines the reasons for noncompliance with staff participation on the mental health council for the Columbus, South Bend, and Toledo Vet Centers and takes actions as indicated to ensure compliance with Readjustment Counseling Service requirements.

District Director Concur.

The district team provided training to Vet Center Directors on ensuring regular participation in Mental Health Council meetings. VCDs are to participate monthly and document their participation in the RCSnet oversite tracker in addition to any separate tracking system they may maintain. Compliance is reviewed by ADDCs and discussed with VCDs.

Status: Ongoing

Target date for completion: April 2023

RCS High Risk Suicide Flag SharePoint

RCS requires VCDs to review a national SharePoint site monthly that lists clients designated as high risk for suicide by VHA facilities and clients at increased predictive risk for suicide who were active at vet centers within the previous 12 months. Once reviewed, VCDs were responsible for determining a plan of action for clients on the list and documenting a disposition on the SharePoint site. All four VCDs reported reviewing the site monthly and dispositioning clients; however, the Columbus, South Bend, and Toledo Vet Centers each had clients with incomplete dispositions in the database.

Recommendation 17

The District Director determines reasons for noncompliance with High Risk Suicide Flag SharePoint site requirements and the tracking of continuity of care for clients with a high risk-suicide flag or clients with an increased predictive risk for suicide at the Columbus, South Bend, and Toledo Vet Centers, takes action to ensure requirements are met, and monitors compliance.

District Director Concur.

Training has been completed for Vet Center Directors and Readjustment Counselors on the requirements associated with the High-Risk Suicide Flag (HRSF) lists which come out each

month. Since June 2021, Vet Center Directors have been responding to the monthly HRSF list. VCDs are working in collaboration with District staff to monitor completion of these lists on a monthly basis.

Status: Ongoing

Target date for completion: April 2023

Standardized Communication Process

In the 2017 Memorandum of Understanding, RCS was identified as a crucial entity in the VA's suicide prevention strategy. Standardizing communication between suicide prevention coordinators and vet center staff was a component of the memorandum that sought to formalize the relationship with the Office of Mental Health and Suicide Prevention, suicide prevention coordinators, and RCS.[112]

The OIG found while each of the vet centers inspected had informal contact with the suicide prevention coordinators at the support VA medical facility, only the South Bend and Toledo Vet Centers had a standardized communication process established: either a local memorandum of understanding or standard operating procedure outlining the process.

In its VCIP report, *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021, the OIG made a recommendation related to standardized communication between suicide prevention coordinators and vet center staff 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 Readjustment Counseling Service Memorandum of Understanding, and initiates action as necessary.

Therefore, the OIG did not make a recommendation related to standardized communication and collaboration processes between suicide prevention coordinators and vet centers in this report.[113]

[112] VHA Deputy Under Secretary for Health Operations and Management memorandum, "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service."

[113] VA OIG, *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014, September 30, 2021. RCS leaders informed the OIG that the 2017 Memorandum of Understanding was discontinued on March 22, 2022.

Consultation, Supervision, and Training

Each vet center is assigned a clinical liaison and an external clinical consultant from the support VA medical facility.[114] Clinical liaisons help coordinate care for clients with the support VA medical facility, whereas external clinical consultants provide guidance on clinically complex cases.[115]

Vet centers are comprised of small multidisciplinary teams, are community-based, and traditionally located outside of VA medical facilities. Vet center teams consist minimally of at least four staff: a VCD, an office manager, a counselor, and an outreach program specialist.[116] Vet centers are required to have at least one VHA-qualified licensed mental health professional on staff.[117]

VCDs provide staff supervision, maintain VA and community partnerships, and are accountable for the clinical and administrative oversight of readjustment counseling services that include specific therapies:

- Individual and group counseling
- Family counseling for military-related issues
- Bereavement counseling for family members or caregivers
- Counseling for conditions related to military sexual trauma[118]

In February 2016, the VHA Under Secretary for Health stated the need for continued review and certification of suicide prevention training annually for VHA clinicians. Following the initial mandated training, staff were required to complete the corresponding refresher courses for their positions.[119] On October 15, 2020, VHA updated the suicide prevention training course and refresher requirements for all staff.[120]

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[114] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[115] RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[116] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[117] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[118] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). The VCD is responsible for vet center operations including staff supervision, administration, and clinical programs.

[119] VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017. VA Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*. An average of 18 veterans died by suicide daily in 2018. Of those 18 veterans, seven had recently used a VA medical facility in the year of, or the year prior to, their death.

[120] VA Secretary memorandum, Agency-Wide Required Suicide Prevention Training (VIEWS 3346983), October 15, 2020.

RCS requires annual training specifically focused on all background knowledge and skill sets for vet center staff to perform administrative and counseling duties specific to each vet center staff position.[121]

Military sexual trauma is reported to VA providers at a rate of 1 in 3 for women and 1 in 50 for men. RCS clinical staff are required to complete military sexual trauma training.[122]

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

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

Consultation

Clinical Liaison

The clinical liaison is a mental health professional appointed from the support VA medical facility.[123]

External Clinical Consultation

External clinical consultants are assigned from the support VA medical facility to provide a minimum of four hours per month of consultation. The external clinical consultants must be VHA-qualified mental health professionals who are licensed and credentialed through the support VA medical facility. If the VA medical facility is unable to provide an external clinical consultant, the vet center is authorized to seek services from the private sector. External clinical consultants provide consultation when a client presents as suicidal or homicidal to assess the probability of suicide or homicide and develop an intervention. External clinical consultants also complete peer case reviews and assist vet center clinicians in the treatment of complex veteran cases.[124]

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[121] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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

[123] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[124] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

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

- Vet center staffing spreadsheets[125]
- Documentation demonstrating external clinical consultation of four hours a month

VHA-Qualified Mental Health Professional

Each vet center is required to maintain one licensed and credentialed VHA-qualified mental health professional.[126] 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 October 1, 2020, through September 30, 2021.
2. If the vet center had more than one VHA-qualified mental health provider on staff,
    a. the OIG randomly selected one individual, and
    b. requested credentialing documentation of that individual from RCS's Consolidated Human Resource Management Office.

Supervision

VCDs are to provide individual supervision to all vet center staff on an ongoing basis.[127] If the VCD is not a VHA-qualified mental health professional, a licensed clinical designee will assist with the supervision of clinical staff.[128] VCDs must also complete a monthly chart audit of 10 percent of every full-time counselor's active client records.[129]

The OIG evaluated supervision through interviews with the four VCDs and reviewed documentation of weekly supervision from July 1, 2021, through September 30, 2021, and monthly chart audits from October 1, 2020, through September 30, 2021, for all full-time counselors on staff.[130]

[125] A staffing spreadsheet was requested from each vet center to provide information on appointed liaisons, consultants, and their associated service lines.

[126] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[127] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

[128] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

[129] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

[130] District leaders informed the OIG the expectation in zone 1 is to conduct weekly individual clinical supervision.

Staff Training

In December 2017, VHA clinical staff (including RCS clinical staff) were mandated to complete Suicide Risk Management Training for Clinicians within 90 days of entering their position and annually thereafter. Additionally, non-clinical staff were required to complete the S.A.V.E. training within 90 days of entering their position or as an annual refresher.[131] In October 2020, VA updated requirements for all clinicians implementing Skills Training for Evaluation and Management of Suicide to be completed within 90 days of hire or as an annual refresher training.[132]

All VA medical facilities and vet centers provide military sexual trauma services. Vet center clinical staff are required to complete VHA military sexual trauma training within 90 days of entering their position.[133] All vet center staff, regardless of position, are required to complete in-service training annually.[134]

To determine compliance the OIG requested training records and proof of attendance for required training completed for all staff employed from October 1, 2020, through September 30, 2021.

Consultation, Supervision and Training Findings and Recommendations

The OIG found all four vet centers had the required clinical liaison and external clinical consultant, who is licensed in mental health, and assigned from the support VA medical facility. All four vet centers had at least one licensed and credentialed VHA-qualified mental health professional on staff. The OIG identified issues related to

- external clinical consultation,
- supervision,
- monthly chart audits, and
- staff training.

[131] VHA Directive 1071. S.A.V.E. refers to "Signs," "Ask," "Validate," "Encourage," and "Expedite," and is a training video collaboration with VA and PyschArmor Institute.

[132] VA Secretary memorandum, Agency-Wide Required Suicide Prevention Training.

[133] VHA Directive 1115.01.

[134] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

External Clinical Consultation

RCS requires four hours of external clinical consultation monthly.[135] The OIG found all four VCDs documented consultation hours; however, they did not meet the required four hours of external clinical consultation per month for the inspection period. The Cleveland Vet Center provided evidence of external clinical consultation occurring all months of the inspection period but did not meet the four-hour requirement for two months. The VCD indicated the lack of documentation was related to being out on leave and some responsibilities not being assumed by covering personnel. The VCD also described a process where external clinical consultation is done in collaboration with another vet center to share information and better utilize the external clinical consultant. The Columbus Vet Center had consultation every month and met the four-hour requirement four months out of the inspection period. The VCD reported that the consultants were on leave or had other VA medical facility obligations and meetings were not held. The South Bend VCD provided outlook calendar invites, but no documentation of meetings occurring and was unable to speak to meetings prior to being detailed. The Toledo Vet Center had consultation every month, but only met the four-hour requirement two months of the inspection period. The VCD reported various reasons including three months' worth of meeting minutes may have been shredded and the consultant being on leave.

Recommendation 18

The District Director determines reasons a process for completing and tracking four hours of external clinical consultation per month did not occur at Cleveland, Columbus, South Bend, and Toledo Vet Centers, ensures vet center directors implement processes, and monitors compliance.

District Director Concur.

The district team provided training to the VCD's on the importance of external consultation. VCDs are to participate with their teams in 4 hours of monthly consultation and document their participation in the RCSnet oversite tracker in addition to any separate tracking system they may maintain. Compliance is reviewed by ADDCs and discussed with VCDs to ensure the appropriate meeting time is established and that there is team participation.

Status: Ongoing

Target date for completion: April 2023

[135] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

Supervision

RCS policy requires ongoing supervision to help with staff cohesion, problem solving, client case coordination, and coordination of services with external VA partners. RCS does not specify how supervision is tracked to ensure completion.[136] District leaders stated an expectation of weekly clinical supervision and all four VCDs reported that supervision was to be completed weekly.

The OIG found all four VCDs did complete supervision, but were noncompliant with the provision of weekly staff supervision. The Cleveland VCD reported having experienced clinicians with limited supervision needs and did not have a lot to discuss. The Columbus VCD reported supervision was missed due to leave and that make-up sessions were not held; rather, supervision was rolled into the following week. The South Bend VCD reported being unable to determine why supervision was not completed prior to being detailed but did comment that scheduling supervision weekly is very difficult to do without rescheduling client care. The Toledo VCD reported that missed supervision was due to leave or staff being out and found it challenging to make up supervision.

Recommendation 19

The District Director determines reasons for noncompliance with staff supervision provided by vet center directors at the Cleveland, Columbus, South Bend, and Toledo Vet Centers, ensures staff supervision occurs as required, and monitors compliance.

District Director Concur in Principle.

The VHA Directive 1500(1) which was published on January 26, 2021, indicates that the VCD is responsible for "providing individual supervision to all Vet Center staff, counselors, outreach workers, and office managers on an ongoing basis." VCDs will track supervision of staff, and oversite of supervision compliance will be provided by District staff.

Status: Ongoing

Target date for completion: April 2023

Monthly Chart Audits

Oversight is one of the main responsibilities of a VCD to ensure quality clinical services. A methodology used to complete oversight is chart audits.[137] RCS policy requires VCDs to

[136] RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[137] RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

complete a monthly 10-percent audit of each full-time counselor's active client caseload. [138] The OIG found that all four VCDs were noncompliant in conducting case audits.

The Cleveland and Toledo VCDs completed audits for all months in the inspection period; however, a 10-percent review was not completed every month for each counselor on staff. The Cleveland VCD reported rounding down when completing monthly audits and not receiving training on how to complete chart audits. The Toledo VCD provided audit records, but the records were missing caseload numbers. The Toledo VCD subsequently provided the RCSNet audit report but told the OIG that there were inconsistencies with the caseload numbers on the RCSNet audit report. The Toledo VCD did not believe that the RCSNet audit report caseload numbers coincided with when the VCD pulled caseload numbers for audit completion. Both VCDs reported using the RCSNet master client caseload report when completing audits. The Columbus VCD had missing audits and reported using an inaccurate report in RCSNet to complete audits up until two months prior to the inspection. The South Bend VCD was unable to explain the noncompliant months; however, beginning in July 2021, monthly audits were completed for all counselors on staff.

Recommendation 20

The District Director verifies and determines reasons for noncompliance with monthly RCSNet chart audits at the Cleveland, Columbus, South Bend, and Toledo Vet Centers; ensures chart audits are completed as required; and monitors compliance.

District Director Concur.

Recent updates to RCSnet have made tracking this requirement easier and Vet Center Directors have been trained on the requirements and the importance of conducting monthly Chart audits. The district team will monitor compliance.

Status: Ongoing

Target date for completion: April 2023

Staff Training

RCS requires completion of mandatory trainings for both clinical and non-clinical staff.[139] All four vet centers' clinical staff were compliant with completing military sexual trauma training. However, the OIG found one clinical and all non-clinical staff at the Columbus Vet Center were noncompliant with completion of annual suicide prevention and refresher trainings. The VCD

[138] RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[139] RCS, *Administrative Site Visit (ASV) Protocol.*

reported multiple stressors including the pandemic, the vet center moving locations, and community unrest contributing to the training not being completed.

Annual in-service training is required for all staff.[140] Staff at all four vet centers were noncompliant with completing annual in-service training in fiscal year 2021. All four VCDs reported that annual in-service trainings were not offered to VCDs, veterans outreach specialists, and office managers.

Recommendation 21

The District Director determines reasons staff at the Cleveland, Columbus, South Bend, and Toledo Vet Centers did not complete required trainings, ensures all staff complete mandatory trainings, and monitors compliance.

District Director Concur.

A new process is in development to establish guidelines for the assignment, tracking and follow-up of mandatory trainings. The district team 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: April 2023

Environment of Care

VHA defines environment of care as "the built environment, including how it is arranged and the special features that protect patients, visitors, and staff; equipment and systems used to support patient care or to safely operate the building or space; and people, including those who work within the hospital, patients, and anyone else who enters the environment, all of whom have a role in minimizing risks by ensuring that these environments support all Veterans' dignity, privacy, safety, and security."[141] RCS requires that the office space promotes interaction amongst eligible clients and their families and facilitates access to readjustment counseling services.[142]

The environment of care review evaluated compliance at the four selected vet centers. The OIG completed virtual inspections, conducted virtual interviews, and reviewed relevant documents. The OIG evaluated the physical environment, general safety, and privacy.

[140] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[141] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, June 21, 2021.

[142] RCS, *Administrative Site Visit (ASV) Protocol*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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 to determine if they were clean and in good repair. The OIG also assessed each vet center for a welcoming or non-institutional environment decorated with military appreciation items, including an informal space for clients and families to interact.[143]

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.[144] Facilities subject to the Architectural Barriers Act must comply with the Architectural Barriers Act Accessibility Standards.[145] The OIG evaluated if vet centers were compliant with Architectural Barriers Act Accessibility Standards related to people with disabilities including entrances, parking spaces, and exit signs.[146]

Vet centers are also required to have a current emergency and crisis plan that addresses "contingencies for phone and computer disruptions, weather/national disaster emergency plan, site/facility/building emergency plan, site/facility/building temporary relocation plan, management of disruptive behavior plan, violence in the workplace (including active shooter plan), and handling of suspicious mail and bomb threats."[147] The OIG reviewed and assessed if emergency and crisis plans were comprehensive and current.

Privacy

According to RCS policy, vet centers provide a safe and confidential place for eligible clients to talk about military and traumatic experiences in an environment that is less stigmatizing than traditional medical settings.[148] Any documents or items displaying confidential or sensitive information must be secured. RCS requires vet centers to have space for group counseling and ensures auditory privacy when sensitive client information is discussed. The OIG virtually assessed each vet center's offices, group counseling rooms, and storage rooms to determine compliance with privacy requirements.

[143] RCS, *Administrative Site Visit (ASV) Protocol*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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

[145] 41 C.F.R. § 102–76.65(a).

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

[147] RCS, Administrative Site Visit (ASV) Protocol.

[148] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

Environment of Care Findings and Recommendations

The OIG virtually inspected all areas within the designated vet centers and found general compliance with the exterior and interior being clean, and the interior design being welcoming and non-institutional. The vet centers had furnishings that were clean and in good repair. All four vet centers had sound-proofed counseling spaces and a space for informal social interaction for clients and their families. All four vet centers complied with the Architectural Barriers Act Accessibility Standards for an accessible entrance and designated parking spaces for people with disabilities.

The OIG found deficiencies in the following:

- Architectural Barriers Act compliant exit signage
- Current and comprehensive emergency and crisis plans

Architectural Barriers Act Accessibility Standards

RCS requires that each vet center follow the Architectural Barriers Act Accessibility Standards and each egress have signage and "doors at exit passageways, exit discharge, and exit stairways shall be identified by *tactile* signs complying with 703.1, 703.2, and 703.5."[149] The OIG found the Cleveland, Columbus, and South Bend Vet Centers compliant; however, the Toledo Vet Center did not have a tactile (braille) sign posted by the front or rear exit discharges at the time of the environment of care virtual inspection. The VCD reported ordering the appropriate signage during the inspection and provided evidence of the front exit door with appropriate signage but did not provide evidence for the rear exit.

Recommendation 22

The District Director evaluates and determines reasons for noncompliance with tactile (braille) signage at the Toledo Vet Center and ensures all exit doors are compliant with Architectural Barriers Act Accessibility Standards.

District Director Concur.

The district team will work with the RCS leasing point of contact to have the braille signage added to the identified Vet Centers.

Status: Ongoing

Target date for completion: April 2023

[149] 36 C.F.R. § Pt. 1191, App. D.

Emergency Plan

RCS requires vet centers to have a current and comprehensive emergency and crisis plan.[150] The OIG found the Columbus Vet Center compliant, but the Cleveland, South Bend, and Toledo Vet Centers were noncompliant. The Cleveland emergency plan was current but did not contain provisions for telephone disruptions. The South Bend emergency plan did not have contingencies for phone and computer disruption. The Toledo Vet Center crisis plan was dated December 2010 and not current. The VCD reported the plan is updated when district office sends information and the VCD had not received any updates. The VCD reported not being aware of requirements to keep the emergency and crisis plans current.

Recommendation 23

The District Director reviews reasons for noncompliance with maintaining a current and comprehensive emergency and crisis plan at the Cleveland, South Bend, and Toledo Vet Centers and ensures all emergency and crisis plans are comprehensive and updated as required.

District Director Concur.

VCDs have been trained on the need to have a comprehensive emergency and crisis plan. Review of crisis plans is completed by District staff, and any missing information or documents are discussed with VCDs.

Status: Ongoing

Target date for completion: April 2023

[150] RCS policy does not define current emergency and crisis plans; in the absence of an RCS definition of a current emergency and crisis plan, the OIG considered the plan to be current if updated within two years from the date of inspection.

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 23 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 of Vet Center Inspection Program Recommendations

Leadership and Organizational Risk	Requirement	Recommendation
District Training	Annual in-service training	1. The District Director determines reasons annual in-service training was not provided for vet center directors, veteran outreach program specialists, and office managers and ensures training is offered for all positions as required.
Quality Reviews	**Requirement**	**Recommendation**
Clinical and Administrative Quality Reviews	Clinical quality review remediation plans	2. The District Director determines reasons clinical quality review remediation plans were not completed for the Grand Rapids and South Bend Vet Centers, ensures completion, and monitors compliance.
		3. The District Director determines reasons clinical quality review remediation plans at the four selected vet centers did not include documentation of deficiency resolution and the time frame of resolution, takes indicated actions to ensure completion, and monitors compliance.
		4. The District Director determines reasons for lack of evidence that clinical quality review deficiencies were resolved at the Cleveland, Columbus, and Toledo Vet Centers, takes indicated actions to ensure completion, and monitors compliance.
	Administrative quality review remediation plans	5. The District Director determines reasons for lack of evidence for administrative quality review deficiency resolution for the Cleveland, Columbus, and South Bend Vet Centers, takes indicated actions to ensure completion, and monitors compliance.

		6. The District Director determines reasons administrative quality review remediation plans did not include documentation of deficiency resolution and the time frame of resolution for the Columbus and South Bend Vet Centers, takes indicated actions to ensure completion, and monitors compliance.
Morbidity and Mortality Reviews	Completion of morbidity and mortality reviews for all serious suicide attempts of active clients	7. The District Director determines reasons why morbidity and mortality reviews for serious suicide attempts were not completed, ensures completion, and monitors compliance.
		8. The Readjustment Counseling Service Chief Officer defines “serious suicide attempt” and established criteria for when a morbidity and mortality review is required as well as a standardized process for completing the review.
Suicide Prevention (Zone-Wide Electronic Record Review)	**Requirement**	**Recommendation**
Intake Assessment	Completion of psychosocial assessments within five visits	9. The District Director ensures the intake portion of the psychosocial assessment is completed and monitors compliance across all zone vet centers.
Suicide Risk Assessment	Completion of suicide risk assessments during the first clinical encounter	10. The District Director ensures suicide risk assessments are completed on the first clinical visit and monitors compliance across all zone vet centers.
Care Coordination and Collaboration with VA Medical Facilities	Flagged High Risk for Suicide care coordination	11. The District Director ensures clinical staff consult and coordinate care with the support VA medical facility for shared clients flagged as high risk for suicide and monitors compliance across all zone vet centers.
	Following confidentiality requirements when coordinating care with VA medical facilities and timely notification to the suicide prevention coordinator	12. 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.
	Timely notification to VA medical facility suicide prevention coordinators following a significant safety risk	13. The District Director ensures clinical staff make timely notification to the suicide prevention coordinator at the support VA medical facility for clients with significant safety risks and monitors compliance across all zone vet centers.
Safety Plans and Consultation	Safety plans	14. The District Director ensures clinical staff complete safety plans for clients who are assessed at intermediate or high suicide risk level in either acute, chronic, or both categories as required, and monitors compliance across all zone vet centers.

	Consultation following intermediate or high suicide risk level in either acute, chronic, or both categories	15. The District Director ensures clinical staff consult with the vet center director, external clinical consultant, associate district director for counseling, or support VA medical facility mental health provider to include the suicide prevention coordinator following a client's suicide risk assessment as required, and monitors compliance across all zone vet centers.
Suicide Prevention (Vet Center)	**Requirement**	**Recommendation**
Suicide Prevention and Intervention (Vet Center)	Mental Health Council participation with VA medical facilities	16. The District Director, in collaboration with the support VA medical facility clinical or administrative liaisons, determines the reasons for noncompliance with staff participation on the mental health council for the Columbus, South Bend, and Toledo Vet Centers and takes actions as indicated to ensure compliance with Readjustment Counseling Service requirements.
	Monthly review and documentation in RCS High Risk Suicide Flag SharePoint Site	17. The District Director determines reasons for noncompliance with High Risk Suicide Flag SharePoint site requirements and the tracking of continuity of care for clients with a high-risk suicide flag or clients with an increased predictive risk for suicide at the Columbus, South Bend, and Toledo Vet Centers, takes action to ensure requirements are met, and monitors compliance.
Consultation, Supervision and Training	**Requirement**	**Recommendation**
External Clinical Consultation	Documentation of four hours of external clinical consultation per month	18. The District Director determines reasons a process for completing and tracking four hours of external clinical consultation per month did not occur at Cleveland, Columbus, South Bend, and Toledo Vet Centers, ensures vet center directors implement processes, and monitors compliance.
Supervision	Supervision with clinical staff members	19. The District Director determines reasons for noncompliance with staff supervision provided by vet center directors at the Cleveland, Columbus, South Bend, and Toledo Vet Centers, ensures staff supervision occurs as required, and monitors compliance.
Monthly Audit	Monthly 10 percent active client record audit for each full-time counselor	20. The District Director verifies and determines reasons for noncompliance with monthly RCSNet chart audits at the Cleveland, Columbus, South Bend, and Toledo Vet Centers; ensures chart audits are completed as required; and monitors compliance.

Training	Completion of all mandatory trainings	21. The District Director determines reasons staff at the Cleveland, Columbus, South Bend, and Toledo Vet Centers did not complete required trainings, ensures all staff complete mandatory trainings, and monitors compliance.
Environment of Care	**Requirement**	**Recommendation**
General Safety	All exit signage Architectural Barriers Act standards compliant	22. The District Director evaluates and determines reasons for noncompliance with tactile (braille) signage at the Toledo Vet Center and ensures all exit doors are compliant with Architectural Barriers Act Accessibility Standards.
	Updated emergency and crisis plan	23. The District Director reviews reasons for noncompliance with maintaining a current and comprehensive emergency and crisis plan at the Cleveland, South Bend, and Toledo Vet Centers and ensures all emergency and crisis plans are comprehensive and updated as required.

Appendix B: District 3 Zone 1 Profile

Table B.1. Zone 1 Profile
(October 1, 2020–September 30, 2021)

Profile Element	District 3 Zone 1	
Total Budget Dollars		$2,444,132.77
Unique Clients*		4,782
New Clients		1,261
Active Duty Clients		97
Spouse/Family Clients		3,605
Bereavement Clients		335
Position	**Authorized**	**Filled**
Total Full-time	121	111
District Director and District Administrative Staff	3	3
Zone Leaders (Deputy District Director, Associate District Directors for Administration//Counseling) and Zone Administrative Staff	4	3
Vet Center Director	18	18
Clinical Staff	64	56
Veterans Outreach Program Specialist‡	17	16
Vet Center Office Staff	18	18
Contract Providers	N/A	

Source: VA OIG analysis of information from district 3 zone 1.
**Unique clients are the number of clients seen at the vet center during the inspection period and could include bereavement, active duty, or spouse/family clients.*
† Total full-time excludes the district director and district administrative staff.
‡Veteran Outreach Program Specialist are responsible for vet center outreach services. Veteran Outreach Program Specialists conduct outreach in order to educate, engage, and encourage eligible individuals to obtain needed services at the vet center.

Profile Summary: From October 1, 2020, through September 30, 2021, district 3 zone 1 operated on a total budget of $2,444,132.77 and served 4,782 unique clients, 1,261 new clients, 97 active duty, 3,605 spouses and family members, and 335 bereavement clients. There was a total of 121 authorized positions, with 10 vacancies throughout the zone as of October 27, 2021.

Appendix C: Vet Center Profiles

The table below provides general background information for the four selected zone 1 vet centers.

Table C.1. Fiscal Year 2021 Vet Center Profiles

Profile	Cleveland Vet Center	Columbus Vet Center	South Bend Vet Center	Toledo Vet Center
Total Budget Dollars	$109,600.00	$103,047.40	$124,235.89	$118,887.00
Unique Clients*	424	350	347	330
Bereavement Clients	16	38	13	47
Active Duty Clients	4	8	6	5
Spouse/Family Clients	205	148	744	41
New Clients	125	101	45	36
Total Number of Positions	**Cleveland Vet Center**	**Columbus Vet Center**	**South Bend Vet Center**	**Toledo Vet Center**
Total Authorized Full-time Positions	7	7	7	7
Total Filled Positions	7	5	6	7
Total Vacancies	0	2	1	0
Total Part-time Positions	0	0	0	0

Source: VA OIG analysis of information provided by district 3 zone 1.
Note: The OIG did not assess VA's data for accuracy or completeness.
**Unique clients are the number of clients seen at the vet center during the inspection period and could include bereavement, active duty or spouse/family clients.*

Appendix D: RCS Chief Readjustment Counseling Officer Memorandum

Department of Veterans Affairs Memorandum

Date: November 1, 2022

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

Subj: Vet Center Inspection of Midwest District 3 Zone 1

To: Office of the Under Secretary for Health (10N)
Director, GAO/OIG Accountability Liaison (VHA 10B 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-District 3 Zone 1*. I have reviewed the recommendations and submit action plans to address all findings in the report.
2. Comments regarding the contents of this memorandum may be directed to the Readjustment Counseling Service action group at VHA10RCSAction@va.gov.

(Original signed by:)

Michael Fisher
Chief Officer, Readjustment Counseling Service

Appendix E: RCS Midwest District 3 Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 25, 2022

From: Joseph Dudley, Acting District Director, District 3

Subj: OIG Draft Report, Vet Center Inspection Program-District 3 Zone 1

To: Chief Readjustment Counseling Officer, RCS (VHA 10 RCS Action)
Director, GAO/OIG Accountability Liaison (VHA 10B 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-District 3 Zone 1.
2. I have reviewed the draft report and request closure of recommendation one since annual trainings were completed for all disciplines in Fiscal Year 2022. I concur with the other recommendations and comments and action plans are provided in the attachment.
3. Please express my thanks to the team for their professionalism and assistance to us in our continuing efforts to improve the care we provide to our Veterans.

(Original signed by:)

Joseph J Dudley
Acting District Director

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