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VETERANS HEALTH ADMINISTRATION

Inspection of Pacific District 5 Vet Center Operations

Vet Center Inspection	24-00390-41	January 8, 2025

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Report Overview

The purpose of the VA Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) is to provide a focused evaluation of organizational risk and the quality of care delivered at vet centers. Vet centers are community-based clinics that provide a wide range of psychosocial services to clients to support a successful transition from military to civilian life. This inspection focused on vet center operations in Pacific District 5 (district 5), evaluating four review areas that influence service delivery and the quality of care within the district.[1]

District review areas included

- leadership stability,
- morbidity and mortality reviews,
- high risk suicide flag (HRSF) SharePoint site, and
- safety plans.

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

Inspection Results

Leadership Stability

The OIG found Associate District Directors for Counseling covering vet center director (VCD) positions for extended periods, which limited their ability to provide effective oversight to the field.

[1] VHA Directive 1500(2), *Readjustment Counseling Service*, January 26, 2021, amended December 30, 2021, was in effect during part of the OIG's inspection period. It was amended and replaced by VHA Directive 1500(3), *Readjustment Counseling Service*, January 26, 2021, amended June 5, 2023, and most recently replaced by VHA Directive 1500(4), *Readjustment Counseling Service*, January 26, 2021, amended November 21, 2023. Unless otherwise specified, the requirements in the 2021 directives contain the same or similar language as the amended directives. As a result, the OIG references VHA Directive 1500(3) throughout this report. Readjustment Counseling Service is divided into five districts. Each district consists of two to four zones and 18–26 vet centers per zone; Readjustment counseling is provided by vet center counselors to assist with "psychological and psychosocial readjustment problems related to specific types of military service and deployment stressors such as combat theater trauma, military sexual trauma, or other military service-related traumas." 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.

To evaluate district 5 leadership stability, the OIG reviewed position vacancies and distributed a questionnaire to clinical staff. District leaders worked together for less than six months prior to the OIG inspection.[2] At the time of inspection, 18 of 70 (26 percent) VCD positions were vacant across the district. The OIG distributed questionnaires to all 257 district clinical staff to assess perceptions of central office and district leaders' knowledge of staff needs and responsiveness, Readjustment Counseling Service (RCS) suicide prevention and outreach activities, RCSNet, workplace culture, and workload.[3] The OIG shared the results from the 201 (78 percent) returned questionnaires with the District Director, who reported familiarity with staff's RCSNet concerns, discussed a need for improved communication across the district, and highlighted staff's identification of suicide prevention as one of RCS's top priorities.

All three Associate District Directors for Counseling were assigned to dual roles, providing long-term coverage for vacant VCD positions while simultaneously being responsible for oversight of vet centers. District leaders reported the VCD vacancy coverage plan resulted in role strain, competing priorities, and an inability to provide effective oversight for the Associate District Directors for Counseling. The OIG found that the coverage responsibilities may have contributed to morbidity and mortality and safety plan review deficiencies identified in this inspection. At the conclusion of the OIG inspection, the Associate District Directors for Counseling for all three zones reported no longer providing dual coverage.

The OIG issued one recommendation related to VCD vacancy coverage plans.

Additionally, in a December 2021 district 5 zone 2 inspection report, the OIG made a recommendation related to the process for resolution of administrative quality review deficiencies that remained open as of August 2024.[4] The District Director attributed the ongoing open recommendation to the vacant VCD positions and district leader turnover. Failure by district leaders to conduct administrative oversight and ensure deficiency resolution as required may affect quality of care and client safety at vet centers.

The OIG will continue to monitor the open recommendation until resolved.

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[2] For the purposes of this report, the term *district leaders* refers to a combination of two or more of the following: the District Director, Deputy District Director, and Associate District Director for Counseling. In the absence of current VA, Veterans Health Administration, or RCS 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).

[3] Vet center services are recorded in RCSNet, a system of records that is only viewable by RCS staff. RCSNet's independence from VA medical facilities and Department of Defense's electronic health record system allows vet centers to maintain secure and confidential records that are not disclosed to VA medical facilities, VA clinics, or the Department of Defense without a veteran's signed release of information.

[4] VA OIG, *Vet Center Inspection for Pacific District 5 Zone 2 and Selected Vet Centers*, Report No. 21-01804-56, December 20, 2021. Administrative quality reviews are conducted on an annual basis to ensure staff compliance with RCS policy and procedures.

Morbidity and Mortality Reviews

The OIG found all three zones noncompliant with completing timely morbidity and mortality reviews. In addition, the OIG found noncompliance with morbidity and mortality review process and completion requirements.

RCS requires morbidity and mortality reviews within 30 days following notification of all active client completed suicides, homicides, and serious suicide attempts.[5] Although district leaders completed morbidity and mortality reviews for the 10 applicable clients, one review was not completed within the new 120-day requirement and none were completed within 30 days as required during the review time frame.

The OIG also found that Deputy District Directors for zones 1 and 2 did not ensure morbidity and mortality reviews had the required panel members. Further, the Deputy District Director for zone 1 did not ensure completed morbidity and mortality review reports included all required components. For all three zones, Deputy District Directors did not inform the RCS Chief Officer about morbidity and mortality review completion delays. Additionally, the Associate District Directors for Counseling did not critically evaluate morbidity and mortality review reports for suicide prevention best practices or disseminate quarterly results as required.[6]

Lack of oversight from district leaders and failure to complete independent and timely reviews of deaths by suicide and homicide may delay the identification and communication of actions, practices, and policies that might prevent similar outcomes.

The OIG issued two recommendations related to morbidity and mortality reviews.

High Risk Suicide Flag SharePoint Site

The OIG was unable to conduct an HRSF SharePoint site review due to concerns with data accuracy because of duplication, inaccuracies, or missing data values. The OIG brought these concerns to the attention of the RCS Chief Officer in early 2023 and continues communication with RCS leaders regarding the matter.[7]

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[5] VHA Directive 1500(3). Morbidity and mortality reviews are conducted collaboratively between the vet center and a VA medical facility to evaluate the facts of the event and clinical services provided, identify opportunities for improvement and best practices, and determine if any alternative actions may have resulted in a different outcome. The OIG reviewed electronic client records and pertinent documents, and interviewed zone leaders to determine compliance with morbidity and mortality review requirements, and timeliness of completed morbidity and mortality reviews for suicide and homicide completions from October 1, 2022, through September 30, 2023. VHA Directive 1500(2) and VHA Directive 1500(3) were in place at the time of the OIG inspection. On November 21, 2023, RCS amended and published VHA Directive 1500(4), *Readjustment Counseling Service,* which changed requirements for morbidity and mortality reviews; specifically, reviews are required for suicide completions and the time frame was extended from 30 days to 120 days.

[6] VHA Directive 1500(3).

[7] VA OIG, *Inspection of Southeast District 2 Vet Center Operations*, Report No. 22-03941-144, April 18, 2024.

RCS requires VCDs to review the HRSF SharePoint site monthly to identify clients who receive or have received vet center services in the past 12 months. Vet center staff determine if client contact is needed, and as appropriate, complete follow-up. The VCD ensures client contacts and outcomes are documented in RCSNet and the HRSF SharePoint site within five business days of receiving the HRSF SharePoint list.[8]

RCS guidance describes the HRSF SharePoint site as part of a national process that ensures clients on the SharePoint site are not overlooked and allows for vet center staff to follow up with clients who are at risk based on clinical concerns.

In April 2024, the OIG made a recommendation to the RCS Chief Officer related to HRSF SharePoint site functionality. As of September 18, 2024, the HRSF SharePoint site functionality recommendation remained open; therefore, the OIG will continue to monitor the progress to closure and not make a new recommendation.[9]

Safety Plans

The OIG found that vet center staff in the three zones did not consistently complete and provide safety plans as required.

The safety plan review included zone-wide evaluations of RCSNet client records. The OIG evaluated whether staff completed safety plans for clients determined to be at intermediate or high suicide risk levels by RCS counselors.[10] RCS requires vet center counselors to develop a safety plan in collaboration with, and provide a copy to, the client.[11]

Additionally, in a December 2021 district 5 zone 2 inspection report, the OIG made a recommendation related to the completion of risk assessments on the first clinical visit that remained open as of August 2024.[12] The District Director identified challenges in evaluating compliance with this recommendation that included RCSNet functional errors such as entries not

[8] On May 11, 2020, RCS implemented a HRSF SharePoint site containing names of RCS clients who also receive services at a VA medical facility and have a high risk for suicide flag. According to RCS leaders, the SharePoint site was expanded in June 2021 to include Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) data. VA's REACH VET is a predictive analytics program developed to determine veterans who have a higher risk for suicide.

[9] VA OIG, *Inspection of Southeast District 2 Vet Center Operations.* In early 2023, the OIG identified problems with the HRSF SharePoint data that made it difficult to determine if staff were conducting follow-up with clients as required. The OIG notified RCS leaders of the data inaccuracies.

[10] VHA Directive 1500(3). Suicide risk assessments are divided into two interrelated categories: acute and chronic and counselors determine a self-harm level of low, intermediate, or high for both categories. Counselors, in conjunction with clients, to develop safety plans outlining coping techniques and sources of support for clients to use either before or during a suicidal crisis; VHA Directive 1160.07, *Suicide Prevention Program,* May 24, 2021. The intent of the plan is to provide a prioritized and predetermined list of interventions the client can use to help lower their risk of suicidal behavior.

[11] VHA Directive 1500(3).

[12] VA OIG, *Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers*.

being captured, prompts to nonclinical staff to complete risk assessments, as well as Wi-Fi outages for some sites. In August 2024, district leaders identified that staff at three vet centers were not completing risk assessments. District leaders reported implementing individualized plans to address concerns at each site.[13] The OIG closed this recommendation in October 2024.

Failure to complete a safety plan and provide a copy to the client may contribute to the client being less prepared to effectively cope before and during suicidal crises. When staff do not complete suicide risk assessments during a client's first clinical visit, they may fail to identify the potential risk of self-harm. Consequently, clients may not be offered additional services, such as the development of a safety plan.

The OIG issued two recommendations to the District Director.

Conclusion

The OIG conducted an inspection across four review areas and issued five recommendations for improvement to the District Director. Most recommendations targeted requirements designed to reduce the suicide risk of RCS clients and, in combination, demonstrate implementation of suicide prevention strategies. The number of recommendations should not be used as a gauge for overall quality of care within the district. The intent is for RCS and district leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues, as well as other less-critical findings that, if left unattended, may interfere with the delivery of quality care.

VA Comments and OIG Response

The Chief Readjustment Counseling Officer and District Director concurred with the recommendations and provided acceptable action plans (see appendixes E and F). Based on information provided, the OIG considers all recommendations open and will follow up on the planned actions until they are completed.

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Assistant Inspector General
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[13] VA OIG, *Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers*.

Contents

Abbreviations

HRSF	high risk suicide flag
MVC	mobile vet center
OIG	Office of Inspector General
RCS	Readjustment Counseling Service
VCD	Vet Center Director
VCIP	Vet Center Inspection Program
VHA	Veterans Health Administration

Introduction

The VA Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) staff conduct routine oversight of Readjustment Counseling Service (RCS) operations and delivery of care. RCS is an autonomous organizational element in the Veterans Health Administration (VHA) with authority and oversight of vet centers and all related provisions of readjustment counseling services, see appendix A for RCS background information.[1] Vet centers are community-based clinics that provide a wide range of psychosocial services to clients to support a successful transition from military to civilian life.[2]

Scope and Methodology

The OIG randomly selected Pacific District 5 (district 5) for inspection and examined RCS leadership stability and key operations from October 1, 2022, through September 30, 2023. This inspection focuses on four review areas that influence service delivery and the quality of client care within the district. District review areas included

a. leadership stability,

b. morbidity and mortality reviews,

[1] VHA Directive 1500(2), *Readjustment Counseling Service*, January 26, 2021, amended December 30, 2021, was in effect during part of the OIG's inspection period. It was amended and replaced by VHA Directive 1500(3), *Readjustment Counseling Service*, January 26, 2021, amended June 5, 2023, and most recently replaced by VHA Directive 1500(4), *Readjustment Counseling Service*, January 26, 2021, amended November 21, 2023. Unless otherwise specified, the requirements in the 2021 directives contain the same or similar language as the amended directives. As a result, the OIG references VHA Directive 1500(3) throughout this report. Readjustment counseling is provided by vet center counselors to assist with "psychological and psychosocial readjustment problems related to specific types of military service and deployment stressors such as combat theater trauma, military sexual trauma, or other military service-related traumas."; The underlined terms are hyperlinks to additional information. To return from the linked information, press and hold the "alt" and "left arrow" keys together.

[2] VHA Directive 1500(3). Vet centers provide "counseling interventions for psychological and psychosocial readjustment problems related to specific types of military service and 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 RCS policy and terminology, the OIG refers to veterans receiving readjustment services as *clients* in this report.

c. high risk suicide flag (HRSF) SharePoint site, and

d. safety plans.[3]

On March 18, 2024, the OIG announced the inspection to RCS leaders, and conducted virtual visits from April 15 through May 2, 2024.[4] The OIG interviewed district leaders, reviewed RCS practices and policies, conducted electronic record reviews, and distributed a questionnaire to all district 5 clinical staff.[5]

The OIG findings are a snapshot of a district's 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 are intended to help district leaders identify areas of vulnerability or conditions that, if addressed, could improve safety and quality of care.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

[3] The OIG evaluated morbidity and mortality reviews completed from October 1, 2022, through September 30, 2023, based on applicable directives during that time frame which required completion of morbidity and mortality reviews within 30 days of notification of all active client completed suicides, homicides, and serious suicide attempts. On November 21, 2023, VHA Directive 1500(4) was amended and published, changing requirements for morbidity and mortality reviews; specifically, requiring reviews only for completed suicides and extending the time frame for completion from 30 days to 120 days. Morbidity and mortality reviews are conducted collaboratively between the vet center and a VA medical facility to evaluate the facts of the event and clinical services provided, identify opportunities for improvement and best practices, and determine if any alternative actions may have resulted in a different outcome. On May 11, 2020, RCS implemented an HRSF SharePoint site containing names of RCS clients who also receive services at a VA medical facility and have a high risk for suicide flag. According to RCS leaders, the SharePoint site was expanded in June 2021 to include Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) data. VA's REACH VET is a predictive analytics program developed to identify veterans who have a higher risk for suicide.

[4] Prior to the district inspection, the OIG conducted on-site and virtual inspections of four vet centers in each zone in district 5 from January 29 through February 21, 2024. The vet center inspections generally examined operations from October 1, 2022, through September 30, 2023, and were focused on suicide prevention; consultation, supervision, and training; outreach; and environment of care. For full details of these reviews, see VA OIG, *Inspection of Select Vet Centers in Pacific District 5 Zone 1*, Report No. 24-00386-265, September 30, 2024; VA OIG, *Inspection of Select Vet Centers in Pacific District 5 Zone 2*, Report No. 24-00388-266, September 30, 2024; and *Inspection of Select Vet Centers in Pacific District 5 Zone 3*, Report No. 24-00389-267, September 30, 2024.

[5] For the purposes of this report, the term *district leaders* refers to a combination of two or more of the following: the District Director, Deputy District Director, and Associate District Director for Counseling. In the absence of current VA, VHA, or RCS 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).

District 5 Overview and Service Area Characteristics

The following table provides an overview from October 1, 2022, through September 30, 2023, of district 5 leader identified zone-specific highlights and challenges. See appendix B for the district client demographics, district profile, and organizational structure.

Table 1. District 5 Overview

Zone	Deputy District Director Identified Highlights	Deputy District Director Identified Challenges
Zone 1	Leaders used Milliman data to conduct targeted outreach in underserved communities on the Oregon and Washington border and Oregon coast.*	The zone is diverse with rural and urban areas that must be managed differently than the other zones in the district.
Zone 2	Maui Vet Center staff responded to the Lahaina fire, which included outreach, connecting veterans with resources, and collaborating with community partners to support the Maui veteran community.‡	The zone has staffing challenges due to difficulty providing competitive salaries and the high cost of living in some areas.
Zone 3	After a wave of suicides within a cohort, three vet centers located along the US and Mexico border expanded services to meet the needs of veterans who were formerly active duty but now serve in the US Border Patrol.	The zone has variability in VA medical facility support that negatively affected • safety and vulnerability assessments completion, • information technology infrastructure (telephone and data) needs, and • availability of automated external defibrillators at vet centers. Some vet centers, particularly those in tribal communities and New Mexico, are geographically distant from support VA medical facilities resulting in employees traveling hundreds of miles to complete personnel tasks.

Source: OIG interviews with district 5 zones 1, 2, and 3 Deputy District Directors.
**Milliman is a platform for warehousing data and healthcare analytics.*
‡Wildfires in Lahaina, on the island of Maui, Hawaii, occurred on August 8, 2023. The wildfires affected 2,200 structures and were one of the deadliest US wildfires in the past 100 years. "Maui Wildfires," United States Environmental Protection Agency, accessed July 3, 2024, https://www.epa.gov/maui-wildfires.

District leaders utilized mobile vet centers (MVCs) for outreach events, counseling, reaching rural areas for services, and in response to natural disasters.[6] MVCs were used for clinical services an average of 11.8 percent of the time across all three zones. The following figure depicts the location of all district 5 vet centers, those inspected by the OIG, and available MVCs.

[6] VHA Directive 1500(3). MVCs are mobile vehicles equipped "to provide direct readjustment counseling, outreach and access to other VA services for eligible individuals in communities that are distant from existing services."

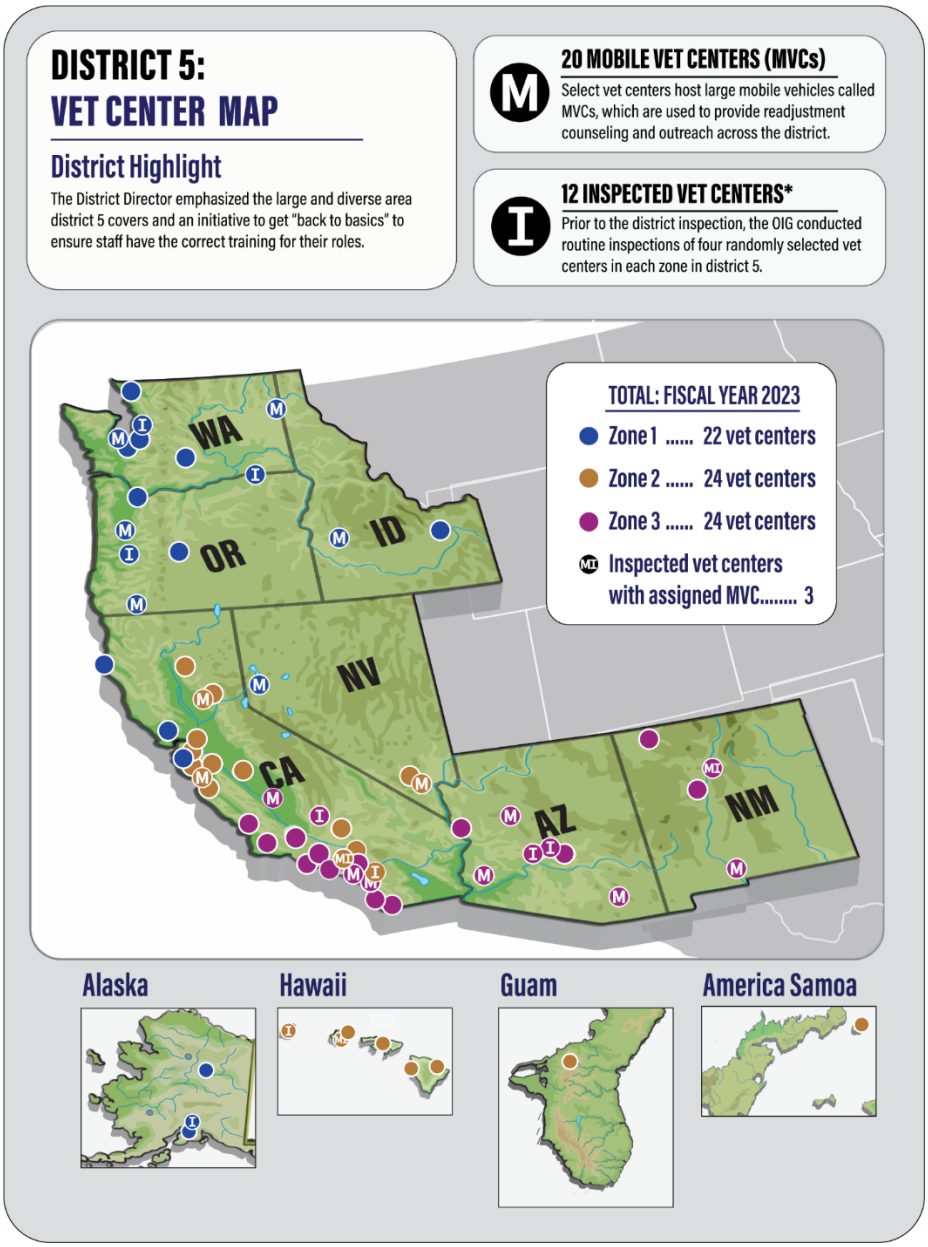

Figure 1. *Map of Pacific District 5 vet centers, sites inspected by the OIG, and MVC assignments.*
Source: OIG using RCS vet center data. VA OIG, Inspection of Select Vet Centers in Pacific District 5 Zone 1, Report No. 24-00386-265; VA OIG, Inspection of Select Vet Centers in Pacific District 5 Zone 2, Report No. 24-00388-266; and VA OIG, Inspection of Select Vet Centers in Pacific District 5 Zone 3, Report No. 24-00389-267.
Note: The Farmington Vet Center in New Mexico hosts 2 MCVs. Fiscal year 2023 was from October 1, 2022, through September 30, 2023.
**OIG-inspected vet centers: Anchorage, Alaska; Everette and Walla Walla, Washington; Eugene, Oregon; Temecula, Corona, and Antelope Valley, California; Kauai and Western Oahu, Hawaii; Phoenix and West Valley, Arizona; and Santa Fe, New Mexico. Inspections occurred from January 30, 2024, through February 21, 2024.*

Inspection Results

Leadership Stability Review

The OIG found Associate District Directors for Counseling covering for vacant vet center director (VCD) positions for extended periods, which limited their ability to provide effective oversight to the field.

To evaluate district 5 leadership stability, the OIG reviewed position vacancies across the district and distributed a questionnaire to clinical staff.[7] The OIG found district leaders worked together for less than six months prior to the inspection and 8 of 12 district staff started in their positions in the year prior to the inspection. The OIG identified 18 VCD vacancies in the 12 months prior to inspection. Two of the 18 vacancies were vacant for a year or more and one, filled during the review period, was vacant for almost three years.

Leadership Stability Review Results

Appendix C provides a detailed overview of district leader and VCD position stability.

District Leader Positions

At the time of the OIG inspection, the District Director had been in the role for just under 5 months. In the 12 months prior to the inspection, the district director position was vacant for 4 months, the zones 2 and 3 deputy district director positions were vacant for 6 and 4 months, respectively, and there were no vacancies in the associate district director for counseling positions. The District Director identified retirements and lack of candidate applications as reasons for district leaders' turnover and ongoing vacancies.

Additionally, in a December 2021 district 5 zone 2 inspection report, the OIG made a recommendation related to the process for resolution of administrative quality review deficiencies that remained open as of August 2024.[8] The District Director attributed the open recommendation to the vacant VCD positions and district leader turnover. In August 2024, the Deputy District Director reported implementing a plan to conduct in-person administrative quality reviews for fiscal year 2024. The District Director also discussed a newly implemented approach to monitor progress of open recommendations that included a weekly leadership meeting to address the identified deficiencies. The OIG will continue to monitor the open recommendation until resolved.

[7] To evaluate RCS leadership stability the OIG evaluated vacancies and coverage for district director, deputy district director, associate district director for counseling, and VCD positions.

[8] VA OIG, *Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers*, Report No. 21-01804-56, December 20, 2021. Administrative quality reviews are conducted annually to ensure staff compliance with RCS policy and procedures.

VCD Positions

At the time of the OIG inspection, 18 of 70 (26 percent) VCD positions were vacant across the district, including two VCD positions filled during the inspection. The 18 VCD vacancies included 6 of 22 (27 percent) in zone 1; 6 of 24 (25 percent) in zone 2; and 6 of 24 (25 percent) in zone 3. The District Director associated hiring challenges with staff turnover, recruitment issues, and a high cost of living in certain locations. The District Director reported that district leaders used retention, relocation, and recruitment initiatives, as well as special salary rates when available and approved by the VA medical facility leaders, to improve hiring efforts.

The OIG found that due to multiple VCD vacancies, Associate District Directors for Counseling were assigned dual roles, providing long-term coverage for vacant VCD positions while also responsible for zone oversight as Associate District Directors for Counseling. The zone 1 Associate District Director for Counseling reported providing VCD coverage for six months of the year prior to the OIG's inspection and noted the inability to effectively accomplish both roles. The zone 2 Associate District Director for Counseling described providing VCD coverage for the year prior to the inspection. The zone 3 Associate District Director for Counseling reported proving VCD coverage for two vet centers over a total of 10 months. The Deputy District Director for zones 2 and 3 described this coverage as unsustainable, stating that it limited the ability to complete oversight and created a conflict of interest in the oversight role.

The OIG found that the dual roles performed by the Associate District Directors for Counseling may have contributed to morbidity and mortality and safety plan review findings in this report. At the conclusion of the inspection, the Associate District Directors for Counseling for all three zones reported no longer providing dual coverage.

Vet Center Clinical Staff Questionnaire Responses

The OIG distributed 257 questionnaires and received 201 (78 percent) responses from district clinical staff to assess perceptions of RCS central office and district leaders' knowledge and responsiveness to staff needs, RCS suicide prevention and outreach activities, RCSNet, workplace culture, and workload.[9] Figure 2 shows an overview of the percentage of staff who disagreed, agreed, or remained neutral when asked specific questions within each topic area. For additional details and data related to the questionnaire, see appendix D.

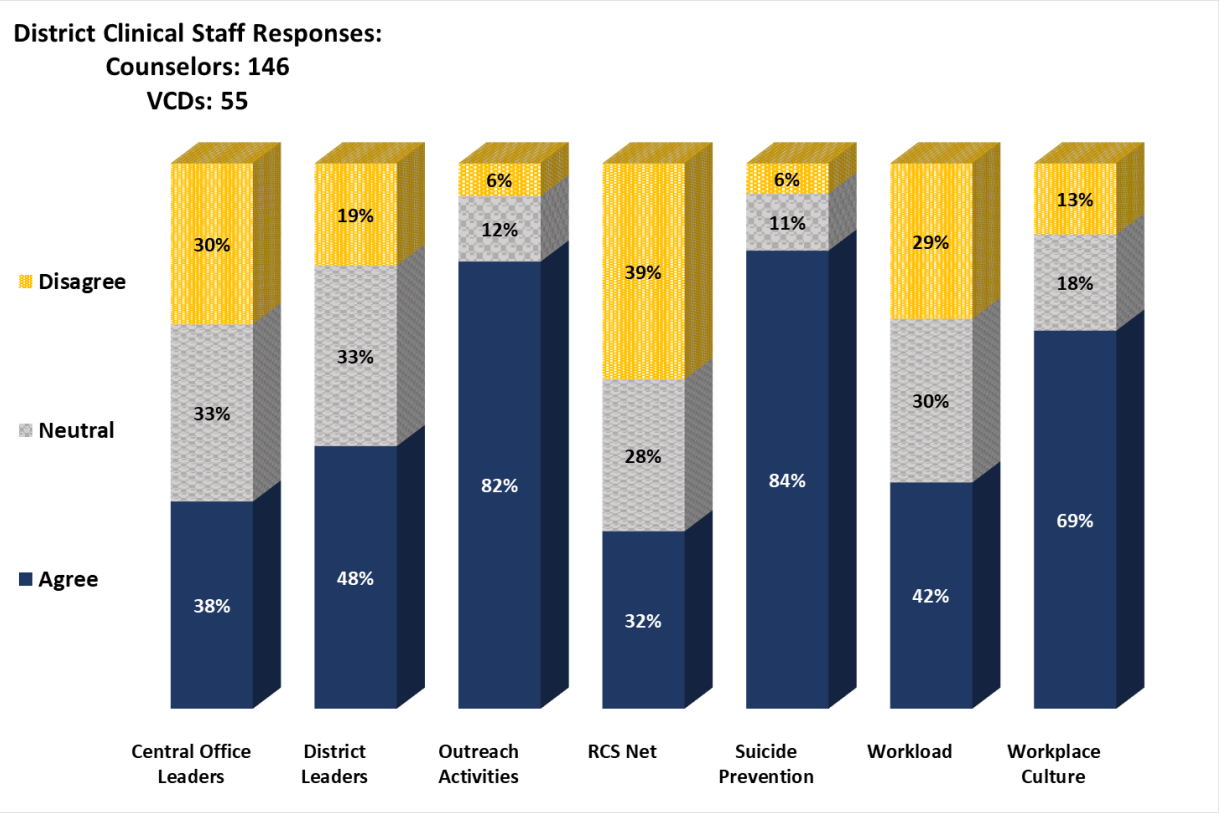

Figure 2. *Clinical staff questionnaire response results grouped by topic.*
Source: OIG analysis of VCIP questionnaire results.
Note: Agree responses refer to generally positive perceptions and disagree responses refer to generally negative perceptions by respondents to the questions asked in each topic area. Total percentages may not add up to 100 due to rounding.

The OIG team shared the clinical staff questionnaire results with the District Director, who reported familiarity with the RCSNet concerns, acknowledged a need for improved

[9] Vet center services are recorded in RCSNet, a system of records that is only viewable by RCS staff. RCSNet's independence from VA medical facilities' and the Department of Defense's electronic health record system allows vet centers to maintain secure and confidential records that are not disclosed to VA medical facilities, VA clinics, or the Department of Defense without a veteran's signed release of information.

communication across the district, and highlighted staff's identification of suicide prevention as one of RCS's top priorities.

Failure by district leaders to conduct administrative oversight and ensure deficiency resolution as required may affect quality of care and client safety at vet centers.

Leadership Stability Review Recommendation

Recommendation 1

The District Director, in conjunction with the Deputy District Director, develops a contingency coverage plan to ensure oversight during periods of vet center director vacancies.

Morbidity and Mortality Reviews

RCS Requirement

Morbidity and mortality reviews must be conducted within 30 days following notification of all active client completed suicides, homicides, and serious suicide attempts. Morbidity and mortality reviews are conducted collaboratively between the vet center and a VA medical facility to evaluate the facts of the event and clinical services provided, identify opportunities for improvement and best practices, and determine if any alternative actions may have resulted in a different outcome.[10]

The OIG found district leaders in all three zones did not complete morbidity and mortality reviews within 30 days following notification of suicides and homicides.[11] In addition, the OIG found noncompliance with morbidity and mortality review process and completion requirements.

Morbidity and Mortality Review Findings

The OIG reviewed electronic client records and pertinent documents, and interviewed zone leaders to determine compliance with morbidity and mortality requirements. Table 2 provides an overview of the timeliness of completed morbidity and mortality reviews for suicides and homicides from October 1, 2022, through September 30, 2023.

[10] VHA Directive 1500(2) and VHA Directive 1500(3) were in place at the time of the OIG inspection. On November 21, 2023, RCS amended and published VHA Directive 1500(4), *Readjustment Counseling Service*, which changed the requirements for morbidity and mortality reviews; specifically, reviews are required for suicide completions and the time frame was extended from 30 days to 120 days.

[11] The Deputy District Directors and Associate District Directors for Counseling from all three zones concurred that the Deputy District Director's signature signified completion of the morbidity and mortality review and the OIG used the signature date to evaluate completion.

Table 2: Zone 1, 2, and 3 Morbidity and Mortality Review Completion Timeliness October 1, 2022–September 30, 2023

Criteria for Morbidity and Mortality Review Required Within 30 days	Reviews Completed Within 30 days for Zone 1	Reviews Completed Within 30 days for Zone 2	Reviews Completed Within 30 days for Zone 3
Suicide Completions	0 of 6	0 of 2	0 of 1
Homicide Completions*	0 of 1	NA‡	NA‡

Source: OIG analysis of RCS district 5 documentation.

**Morbidity and mortality reviews are no longer required for homicides.*

‡The zone had no reported homicides.

The Associate District Directors for Counseling from all three zones reported morbidity and mortality reviews were not completed within the required 30 days of notification due to difficulties with both identifying a VA medical facility clinician review panel participant and coordinating a meeting time when all panel members were available. The Associate District Directors for Counseling reported providing additional time for staff bereavement prior to coordination of morbidity and mortality reviews, which also contributed to the delays.

The Deputy District Director for zone 1 reported a lack of VA medical facility staff availability for panel participation and a focus on prioritizing the reports' clinical accuracy and content over timely completion. The Deputy District Directors for zones 2 and 3 were hired after the morbidity and mortality reviews were completed and did not know why the reviews were not completed timely (see appendix C for hire dates).

On November 21, 2023, RCS changed the requirements for a morbidity and mortality review by eliminating reviews for serious suicide attempts and homicide completions and increasing the time to complete reviews of suicides from 30 to 120 days.[12] District leaders completed morbidity and mortality reviews for all required clients; however, 1 of the 10 reviews evaluated during the OIG inspection was not completed within the 120-day requirement and none were completed within 30 days as required during the review time frame. Morbidity and mortality reviews are no longer required for homicide completions; therefore, the OIG is not making a recommendation related to homicide completions.

[12] In the VA OIG 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 regarding the completion of morbidity and mortality reviews for serious suicide attempts. The OIG review period for this 2024 inspection included time when VHA was developing an action plan to respond to the 2021 recommendation; therefore, serious suicide attempts morbidity and mortality timeliness was not addressed in this report.

Additional Findings

Zones 1 and 2 Morbidity and Mortality Reviews Lacked Required Panel Members

RCS requires morbidity and mortality review panels have a minimum of three licensed mental health professionals, one support VA medical facility representative, and two RCS representatives from a vet center where the client did not receive services. An Associate District Director for Counseling from a neighboring zone serves as the chair of the review board and the Deputy District Director approves the assigned representatives.[13]

Deputy District Directors for zones 1 and 2 did not ensure morbidity and mortality reviews had required panel members. The OIG found that morbidity and mortality reviews conducted in zones 1 and 2 included clinical staff involved in the clients' care, either as a panel member or reviewer of the case. Additionally, for zone 1, one morbidity and mortality review did not have the required three panel members.

Associate District Directors for Counseling for zones 1 and 2 reported that the clinician and VCD who provided care to the clients were allowed to serve on the review panel and lacked awareness that their inclusion was contrary to policy. Deputy District Directors for zones 1 and 2 reported being unaware that staff involved in the client's care participated, as either panel members or reviewers, on morbidity and mortality reviews for multiple clients during the review period.

For zone 1, one homicide review included two of three required panel members. The Associate District Director for Counseling for zone 3 conducted the morbidity and mortality review and could not obtain a release of information from the client to include a VA medical facility panel member. The Deputy District Director for zone 1 reported reviewing the morbidity and mortality report for content and completion but not assigning panel members prior to signing it; and further stated the availability of VA mental health clinicians was limited, which may affect panel composition.

Zone 1 Morbidity and Mortality Reviews Incomplete

The Associate District Director for Counseling from a neighboring zone is responsible for morbidity and mortality review report preparation. The Deputy District Director must ensure morbidity and mortality reviews are completed and routed to the RCS Chief Officer.[14] Morbidity and mortality review reports are required to include components such as introductory

[13] VHA Directive 1500(3). Staff from the vet center where the client was receiving services are not part of the panel due "to the personal emotional impact of an eligible individual's suicide on the members of a close-knit small service delivery team."

[14] VHA Directive 1500(3).

information, presenting problem, counseling case summary, conclusions, and recommendations.[15]

The Deputy District Director for zone 1 did not ensure morbidity and mortality reviews were completed with required components. Of the seven morbidity and mortality reviews completed in zone 1, the OIG found three were missing either the introductory information or the conclusion.

The zone 2 Associate District Director for Counseling who completed the three zone 1 morbidity and mortality review reports conveyed being unaware of the missing components. The Deputy District Director for zone 1 reported ensuring morbidity and mortality reviews were clinically correct and thorough; however, reported the Associate District Director for Counseling completed the reports and missed populating sections.

Zones 1, 2, and 3 Morbidity and Mortality Completion Delays Not Reported

RCS requires that all delays in morbidity and mortality review completion be reported to the Deputy Chief Officer.

For all three zones, morbidity and mortality review completion delays were not reported by district leaders to the RCS Deputy Chief Officer as required.

The Deputy District Director for zone 1 reported not having time to communicate delays. The Deputy District Directors for zones 2 and 3 were hired after the morbidity and mortality reviews, therefore, could not identify the reason(s) delays were not reported (see appendix C for hire dates).

Zones 1, 2, and 3 Morbidity and Mortality Reviews Findings Not Critically Assessed and Disseminated

Associate District Directors for Counseling are responsible for critically reviewing morbidity and mortality reports and subsequently disseminating suicide prevention best practices quarterly.[16]

For all three zones, Associate District Directors for Counseling did not critically review morbidity and mortality review reports nor distribute quarterly suicide prevention review best practices to VCDs. All three Associate District Directors for Counseling shared information sporadically with VCDs; however, the Associate District Directors for Counseling in zones 1 and 2 reported not completing the quarterly report due to competing priorities. The Associate District

[15] VHA Directive 1500(3). Morbidity and mortality reviews include introductory information, date of report, vet center veteran information form number, marital status, employment, education, date of suicide/attempt or harm to others with mode of death and military or current stressors, events immediately preceding suicide/attempt, presenting problem, counseling case variable, brief family and social history, military history, readjustment counseling service plan, counseling case summary, conclusions, and recommendations.

[16] VHA Directive 1500(3).

Director for Counseling in zone 3 reported being unaware of the quarterly dissemination requirement.

Lack of oversight from district leaders and failure to complete independent and timely reviews of deaths by suicide and homicide may delay the identification and communication of actions, practices, and policies that might prevent similar outcomes.

Morbidity and Mortality Review Recommendations

Recommendation 2

The District Director monitors district leaders' compliance with completion of morbidity and mortality reviews for client deaths by suicide, including timeliness, as required.

Recommendation 3

The District Director ensures district leaders are aware of the Readjustment Counseling Service policy requirements to provide oversight of morbidity and mortality review completion, including panel member assignments, participation of affected vet center staff, report completion, reporting of completion delays, and information dissemination.

HRSF SharePoint Site Review

RCS Requirement

VCDs have access to review the HRSF SharePoint site monthly to identify clients who receive or have received vet center services in the past 12 months. Vet center staff determine if client contact is needed, and if appropriate, complete the follow-up. The VCD ensures client contacts and outcomes are documented in RCSNet and the HRSF SharePoint site within five business days of receiving the HRSF SharePoint list.[17]

In early 2023, the OIG identified problems with the HRSF SharePoint site and issued the following recommendation:

> The Readjustment Counseling Service Chief Officer ensures the High Risk Suicide Flag SharePoint site functions as intended and includes accurate data.[18]

HRSF SharePoint data concerns persisted because of duplication, inaccuracies, or missing data; therefore, the OIG was unable to evaluate the HRSF SharePoint site dispositions in this review.

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

[18] VA OIG, *Inspection of Southeast District 2 Vet Center Operations*, Report No. 22-03941-144, April 18, 2024.

The OIG communicated these concerns to RCS leaders who, in April 2024, reported an HRSF SharePoint site redesign was in process to address identified issues (see table 3).

Table 3. Communication of HRSF SharePoint Site Concerns Timeline

Date	Concern
May 2023	The OIG initiated correspondence with RCS central office leaders to discuss HRSF SharePoint site concerns.
June 2023	RCS leaders notified the OIG that the identified concerns were addressed.
June 2023	The OIG identified ongoing concerns with data accuracy and notified RCS leaders.
July 2023	RCS leaders notified the OIG that a review and redesign of the HRSF SharePoint site was in process.
August 2023	RCS leaders notified the OIG that data issues were resolved; however, data prior to 2021 was unable to be corrected.
August 2023	The OIG continued to identify errors in HRSF SharePoint site data after 2021.
September 2023	The OIG was unable to access HRSF SharePoint site data at inspection time because of data inaccuracies.
April 2024	RCS leaders anticipate the HRSF SharePoint site to function with accurate data by August 30, 2024.

Source: OIG summary of electronic communications with RCS leaders.

The HRSF SharePoint site is part of a national process that ensures clients are not overlooked and allows for vet center staff to follow up with clients who are at risk based on clinical concerns.

As of September 18, 2024, the HRSF SharePoint site functionality recommendation remained open; therefore, the OIG will continue to monitor progress and not make a new recommendation.

Safety Plan Review

RCS Requirement

Vet center counselors are required to complete a suicide risk assessment at the initial counseling visit. For clients assessed at intermediate or high risk for suicide in either acute, chronic, or both categories, counselors must develop an individualized safety plan in collaboration with the client and provide the client a copy.[19]

The OIG found that vet center staff across all zones did not consistently complete and provide safety plans to clients assessed at intermediate or high risk for suicide, in either acute, chronic, or both categories, as required.

Safety Plan Findings

To evaluate compliance with RCS safety plan requirements, the OIG conducted zone-wide evaluations of RCSNet client records. The review was conducted for 49 clients in zone 1, 50 clients in zone 2, and 50 clients in zone 3 determined to be at an intermediate or high suicide risk level. Specifically, the OIG evaluated records to determine if staff completed all required components of a safety plan and if clients received a copy of the safety plan (see table 4).[20]

[19] VHA Directive 1500(3). 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. Counselors, in conjunction with clients, develop safety plans outlining coping techniques and sources of support for clients to use either before or during a suicidal crisis; VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. The intent of the plan is to provide a prioritized and predetermined list of interventions the client can use to help lower their risk of suicidal behavior.

[20] The OIG excluded one client for District 5, Zone 1 due to the client being urgently transferred to the hospital, which did not allow for completion of the safety plan.

Table 4. Estimated Safety Plan Compliance
October 1, 2022–September 30, 2023

Review Topic	Zone 1		Zone 2		Zone 3	
	Estimated Compliance (Percent)	Confidence Interval	Estimated Compliance (Percent)	Confidence Interval	Estimated Compliance (Percent)	Confidence Interval
Completed Safety Plan	32	(13, 52)	37	(21, 54)	43	(28, 58)
Safety Plan Provided to Client	18	(4, 36)	23	(10, 38)	14	(5, 26)

Source: OIG analysis of district 5 zones 1, 2, and 3 electronic client record reviews.
Note: A confidence interval is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95 percent confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time.

The OIG found that staff in all zones were noncompliant with safety plan requirements.

Explanations for safety plan completion deficiencies from the Associate District Directors for Counseling included the following:

- Associate District Directors for Counseling for zones 1 and 3 identified whether a safety plan was in a client's chart and did not review required safety plan sections for completion.
- The Associate District Director for Counseling for zone 2
    - was not reviewing safety plans, reporting difficulties fulfilling duties while providing vet center coverage;
    - believed completed safety plans were being provided to clients but that it was not documented in RCSNet; and
    - described RCSNet as not ideal since it does not allow printing of completed safety plans; therefore, counselors had to print a blank plan, handwrite the plan, and populate the plan in RCSNet.
- Associate District Directors for Counseling in all three zones acknowledged RCS policy contained a document that provided instructions for completing safety plans; however, Associate District Directors for Counseling for zones 1 and 2 were not aware of specifics in the document to be able to train staff and the zone 3 Associate District Director for Counseling, while being aware, did not provide the specifics when training staff.

The Deputy District Directors provided the following reasons why staff did not complete safety plans as required:

- The Deputy District Director for zone 1 identified the ability to save a partially completed safety plan in RCSNet, as well as frequent policy changes and a lack of time and bandwidth to ensure expectations were met.
- The Deputy District Director for zone 2 reported Associate District Directors for Counseling were not reviewing safety plans and RCSNet was unfriendly for the user when printing safety plans.
- The Deputy District Director for zone 3 reported RCSNet's lack of clinical reminders to complete safety plans could be a contributing factor and that the Associate District Directors for Counseling did not have time to oversee safety plan completion because of other responsibilities.

In addition to safety plan findings, the OIG also assessed progress on an open recommendation made within a December 2021 district 5 zone 2 inspection report. The recommendation was related to the completion of risk assessments on the first clinical visit and remained open as of August 2024.[21] The District Director identified challenges in evaluating compliance with this recommendation that included RCSNet functional errors such as lack of entry capture, nonclinical staff receipt of prompts to complete risk assessments, as well as Wi-Fi outages for some sites. In August 2024, district leaders informed the OIG that staff were not completing risk assessments at three vet centers. District leaders reported implementing plans to address concerns at each site.[22] The OIG closed this recommendation in October 2024.

Failure to complete suicide risk assessments on the first clinical visit may result in clients' unidentified risks for self-harm that would prompt clinical staff to provide additional resources, including the development of a safety plan with clients.[23] Failure to complete a safety plan and provide a copy to the client could leave the client less prepared to effectively cope before and during suicidal crises.

Safety Plan Review Recommendations

Recommendation 4

The District Director determines reasons vet center counselors did not complete safety plan components for clients assessed at intermediate or high suicide risk level in either acute, chronic,

[21] VA OIG, *Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers*.
[22] VA OIG, *Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers*.
[23] VHA Directive 1500(3).

or both categories; ensures completion of safety plans for all active clients assessed at intermediate or high suicide risk levels; and monitors compliance across all zone vet centers.

Recommendation 5

The District Director determines reasons staff did not document providing safety plans to clients, ensures all active clients assessed at intermediate or high suicide risk levels receives a safety plan, and monitors compliance across all zone vet centers.

Appendix A: RCS Background

With the congressional establishment of vet centers in 1979, RCS was one of the first organizations to address the psychological and social effects of combat on veterans before the American Psychiatric Association recognized post-traumatic stress disorder as an official diagnosis in 1980.[24]

While vet centers initially focused on serving Vietnam-era veterans, eligibility for vet center services has broadened over the years to include veterans of any combat theater, active-duty service members, National Guard members, and their families.[25] In 2022, eligibility expanded to allow reserve members of the Armed Forces with a behavioral health condition or psychological trauma to receive services from vet centers.[26]

In fiscal year 2023, RCS provided counseling services to 115,404 clients totaling nearly 1.3 million visits and an additional 162,291 outreach contacts.[27]

Vet center services include individual, group, and family counseling for mental health conditions related to military sexual trauma, post-traumatic stress disorder, and other military-related concerns. Vet center staff assess and manage clients at risk for suicide, substance abuse, and other medical and mental health conditions.[28] Vet center staff also provide bereavement support for families; referrals to the Veterans Benefits Administration; and screening and assessment for employment, outreach, and referral coordination with VA and non-VA providers.[29]

RCS Leadership Organizational Structure

In May 2015, the Advisory Committee on the Readjustment of Veterans recommended RCS realign from seven regions to five districts based on the MyVA reorganization. The purpose of this change was, "To promote full and effective coordination of services within VHA." The

[24] VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program,* September 8, 2010; "Vet Centers (Readjustment Counseling): Who We Are," VA, accessed June 4, 2019, https://www.vetcenter.va.gov/About_US.asp; Mayo Clinic, "Post-traumatic stress disorder (PTSD)," accessed September 24, 2024, 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 caused by an extremely stressful or terrifying event—either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event."

[25] "Vet Centers (Readjustment Counseling): Who We Are," VA; VHA Directive 1500(3).

[26] VHA Directive 1500(3); Public Law 116-283, January 1, 2021.

[27] "Vet Centers (Readjustment Counseling): Who We Are," VA; General Accounting Office *Vietnam Veterans: A Profile of VA's Readjustment Counseling Program*, Report No. GAO/HRD-87-63, August 26, 1987; "Vet Centers (Readjustment Counseling)," VA, accessed May 2, 2024, https://www.vetcenter.va.gov.

[28] VHA Directive 1500(3).

[29] VHA Directive 1500(3).

realignment resulted in RCS creating a new position for a district director and implementation of organizational transformations in fiscal year 2016.[30]

RCS is aligned under the VA Under Secretary for Health and, as of April 2022, has governance of 300 vet centers, 83 MVCs, and 20 outstations spanning 5 districts, in addition to the Vet Center Call Center.[31] The RCS Chief Officer reports directly to the VA Under Secretary for Health and is responsible for strategic planning, coordinating 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 human resources for hiring, and supervising six RCS national officers. The RCS Operations Officer, who reports to the RCS Chief Officer, is responsible for daily operations and providing supervision to the five district directors who oversee the districts.

RCS District Organizational Structure

Each district is led by a district director, who oversees zone deputy district directors. Each district is divided into two to four zones, with each zone encompassing 18–26 vet centers.[32] The deputy district director supervises the zone associate district director for counseling and associate district director for administration. The associate district director for counseling is responsible for providing guidance for all readjustment counseling service matters and conducting both counseling quality reviews and morbidity and mortality reviews within the zone. The associate district director for administration is responsible for providing guidance on administrative operations and conducting all administrative quality reviews within assigned zone. VCDs report to deputy district directors and are responsible for the overall vet center operations including administrative and fiscal operations, execution of outreach plans, supervision of staff, and community relations.[33]

[30] VA, *Response to the Advisory Committee on the Readjustment of Veterans,* May 2015 Recommendations, accessed March 16, 2023, https://www.va.gov/ADVISORY/Reports/ReportofReadjustMay2016.pdf. (The information had been removed when the website was accessed on December 19, 2024.)

[31] VHA Directive 1500(3). The Vet Center Call Center, reached at 1-877-WAR-VETS or 1-877-927-8387, is a 24-hour per day, 7 days per week, confidential call center for eligible individuals and their families to receive support regarding their military experience or any other readjustment issue.

[32] Total number of vet centers in each zone is based on most recent organization chart for each district.

[33] VHA Directive 1500(3).

Appendix B: District 5 Profile and Organizational Structure

Figure B.1 compares the district 5 client demographics across zones during fiscal year 2023.

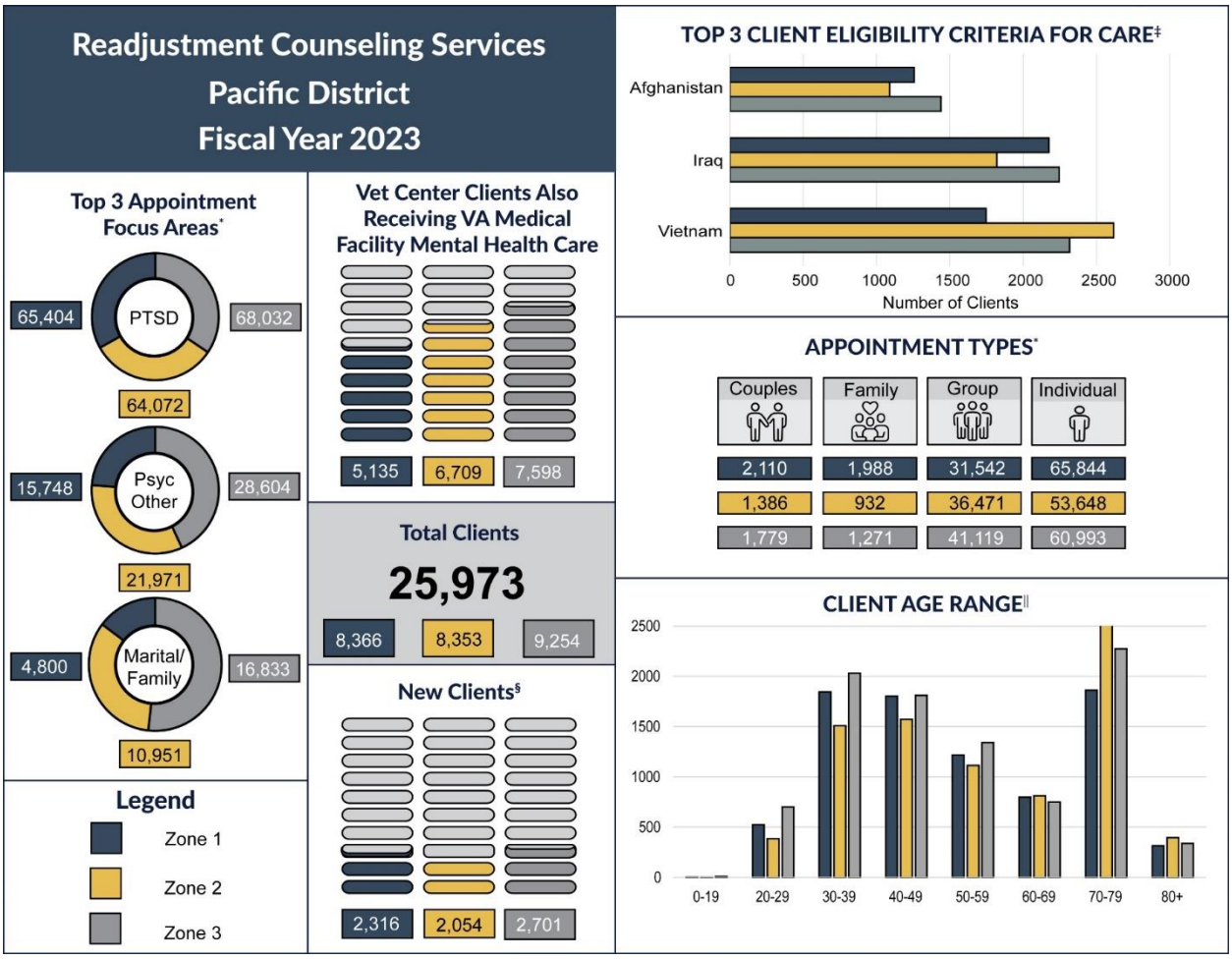

Figure B.1. *Client demographics across Pacific District 5 during fiscal year 2023, which spans from October 1, 2022, through September 30, 2023. Figures may not be exact replications of approximate percentages and numbers.*
Source: OIG created graphic utilizing RCSNet demographic data.
**Clients may be represented in more than one category.*
‡Top 3 Client Eligibility Criteria for Care represents the three most common circumstances for vet center service eligibility among vet center clients. For additional information on eligible categories see Appendix A.
§New clients are a subset of total clients.
||OIG calculated client age using RCS data and is the client's age on the last day of fiscal year 2023 (September 30, 2023).

Table B.1. Fiscal Year 2023 District Profile*
(October 1, 2022–September 30, 2023)

Profile Element	Zone 1		Zone 2		Zone 3	
Total Budget Dollars	$20,448,221.04		$20,320,982.26		$19,651,995.23	
Total Clients	8,359		8,341		9,234	
New Clients	2,307		2,043		2,687	
Veteran Clients	7,937		8,049		8,756	
Active Duty Clients	347		206		368	
Spouse/Family Clients	857		710		719	
Bereavement Clients	75		86		110	
Position‡	**Authorized**	**Filled**	**Authorized**	**Filled**	**Authorized**	**Filled**
Total Full-time	162	135	163	127	173	130
District Director and District Administrative Staff*	4	2	NA	NA	NA	NA
Zone Leaders (Deputy District Director, Associate District Directors for Counseling and Administration) and Zone Administrative Staff	4	4	4	2	4	4
Vet Center Director	22	22	24	21	24	19
Clinical Staff	86	86	89	67	94	61
Vet Center Outreach Program Specialist	26	22	21	17	28	25
Vet Center Office Staff	24	18	25	20	24	21
Contract Providers	0	0	0	0	0	0

Source: RCS data from District 5.

**District Director and Administrative staff work across all zones.*

‡Position information provided as of September 30, 2023.

Figure B.2 depicts the district 5 organizational structure and the vet center locations the OIG inspected.

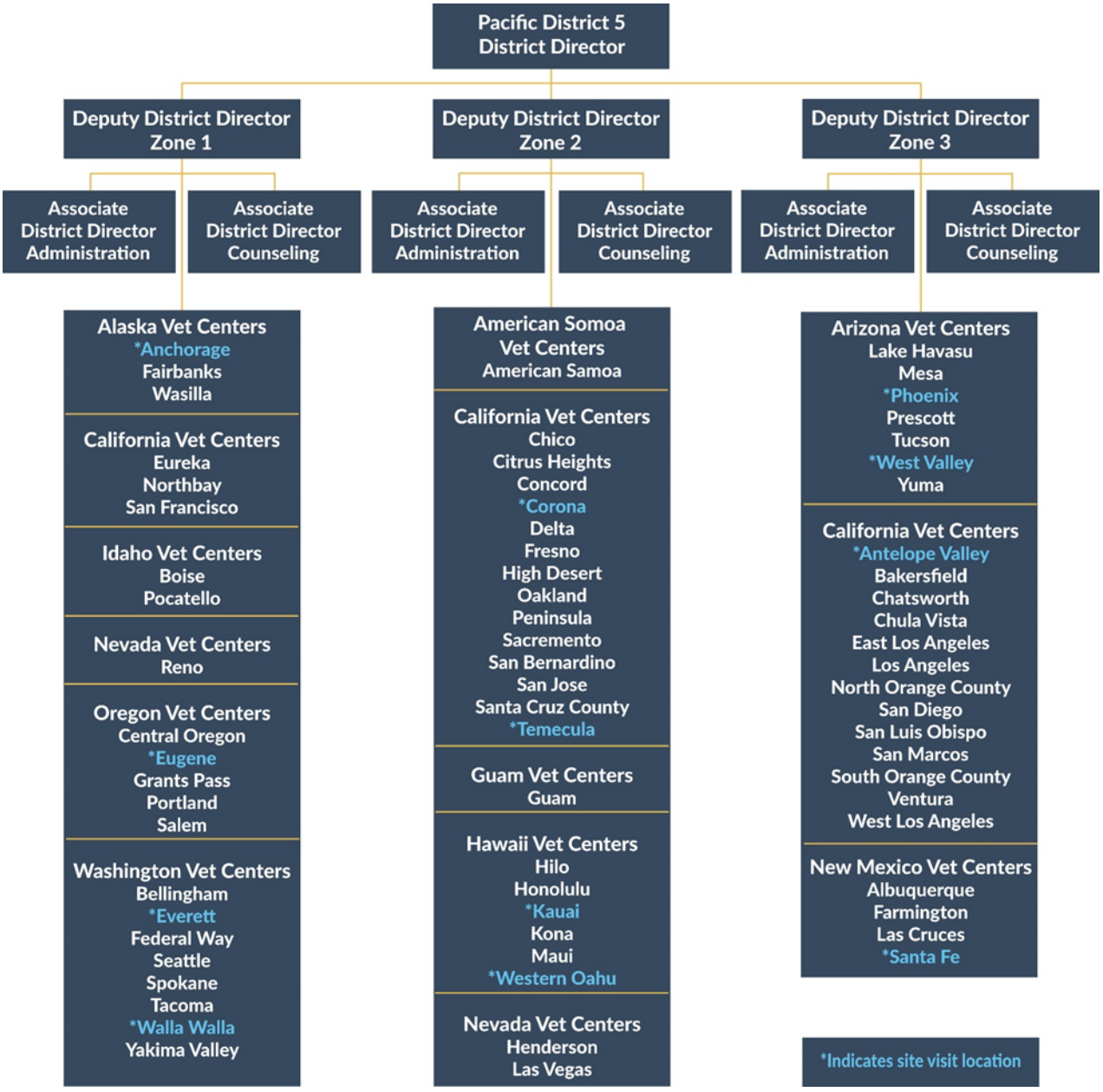

Figure B.2. *RCS organizational district and zone structure.*
Source: OIG-developed using analysis of RCS information.
Note: The OIG did not assess RCS data for accuracy or completeness.

Appendix C: District Leader and VCD Position Stability

Table C.1. District Leadership Positions

Position Title	Zone 1 Assignment Date*	Zone 2 Assignment Date*	Zone 3 Assignment Date*
District Director	November 5, 2023		
Deputy District Director	February 14, 2018	April 23, 2023‡	September 10, 2023
Associate District Director for Counseling	March 14, 2022	February 12, 2023	October 29, 2017
Associate District Director for Administration	June 6, 2022	December 31, 2023	December 9, 2018

Source: OIG-developed using analysis of RCS information.

**Leadership position assignment dates as of March 29, 2024.*

‡The Deputy District Director for Zone 2 started on April 23, 2023, but was not officially full-time in District 5 until the end of May 2023, per the District 5 Administrative Officer.

Table C.2. Zone 1, 2, and 3 Vet Center Director Position Hiring Status and Vacancy Length from March 29, 2023, through March 29, 2024

Vet Center Location	Date Position Filled	Length of Vacancy
Zone 1		
Anchorage Vet Center	January 7, 2019	NA
Fairbanks Vet Center	December 21, 2015	NA
Wasilla Vet Center	Vacant	1 month
Eureka Vet Center	August 2, 2021	NA
North Bay Vet Center	March 4, 2018	NA
San Francisco Vet Center	January 16, 2022	NA
Boise Vet Center	February 17, 2019	NA
East Idaho Vet Center	April 24, 2022	NA
Reno Vet Center	January 17, 2023	NA
Central Oregon Vet Center	September 10, 2023	7 months
Eugene Vet Center	February 14, 2022	NA
Grants Pass Vet Center	March 24, 2024	0 months
Portland Vet Center	September 12, 2021	NA
Salem Vet Center	June 25, 2017	NA
Bellingham Vet Center	March 24, 2024	2 months
Everett Vet Center	June 14, 2015	NA
Federal Way Vet Center	January 10, 2016	NA
Seattle Vet Center	September 16, 2019	NA
Spokane Vet Center	March 24, 2024	5 months
Tacoma Vet Center	December 10, 2018	NA
Walla Walla Vet Center	April 15, 2019	NA
Yakima Vet Center	June 5, 2023	1 month

Vet Center Location	Date Position Filled	Length of Vacancy
Zone 2		
American Samoa Vet Center	January 10, 2016	NA
Chico Vet Center	June 19, 2023	2 years, 11 months
Citrus Heights Vet Center	July 19, 2021	NA
Concord Vet Center	February 16, 2020	NA
Corona Vet Center	April 22, 2022	NA
Delta Vet Center	December 21, 2020	NA
Fresno Vet Center	November 7, 2022	NA
High Desert Vet Center	July 30, 2023	NA
Oakland Vet Center	April 21, 2024	1 year, 1 month
Peninsula Vet Center	February 4, 2018	NA
Sacramento Vet Center	Vacant	1 year, 4 months
San Bernadino Vet Center	July 12, 2015	NA
San Jose Vet Center	December 17, 2023	1 year
Santa Cruz Vet Center	February 12, 2023	NA
Temecula Vet Center	January 10, 2016	NA
Guam Vet Center	May 26, 2011	NA
Hilo Vet Center	December 5, 2021	NA
Honolulu Vet Center	February 4, 2018	NA
Kauai Vet Center	January 10, 2016	NA
Kona Vet Center	February 12, 2023	NA
Maui Vet Center	January 6, 2020	NA
Western Oahu Vet Center	October 10, 2010	NA
Henderson Vet Center	December 13, 2015	NA
Las Vegas Vet Center	July 31, 2023	2 months

Vet Center Location	Date Position Filled	Length of Vacancy
Zone 3		
Lake Havasu Vet Center	May 23, 2022	NA
Mesa Vet Center	December 21, 2015	NA
Phoenix Vet Center	July 5, 2022	NA
Prescott Vet Center	November 12, 2017	NA
Tucson Vet Center	April 21, 2024	2 months
West Valley Vet Center	Vacant	8 months
Yuma Vet Center	January 7, 2019	NA
Antelope Valley Vet Center	January 29, 2023	NA
Bakersfield Vet Center	December 19, 2022	NA
Chatsworth Vet Center	November 20, 2023	11 months
Chula Vista Vet Center	Vacant	7 months
East Los Angeles Vet Center	February 1, 2021	NA
Los Angeles Vet Center	June 8, 2008	NA
North Orange County Vet Center	Vacant	8 months
San Diego Vet Center	December 19, 2022	NA
San Luis Obispo Vet Center	January 10, 2016	NA
San Marcos Vet Center	March 14, 2022	NA
South Orange County Vet Center	December 6, 2012	NA
Ventura Vet Center	December 23, 2019	NA
West Los Angeles Vet Center	October 29, 2018	NA
Albuquerque Vet Center	August 17, 2020	NA
Farmington Vet Center	Vacant	7 months
Las Cruces Vet Center	May 11, 2020	NA
Santa Fe Vet Center	March 17, 2019	NA

Source: OIG-developed using analysis of RCS information.

Appendix D: Clinical Questionnaire Responses

Table D.1: District 5 Questionnaire Responses

RCS Central Office Leaders	Agree	Neutral	Disagree
1. RCS central office leaders are knowledgeable about the needs of vet centers and their staff	43%	31%	26%
2. RCS central office leaders are responsive to the needs of vet centers and their staff	33%	34%	33%
District Leaders	**Agree**	**Neutral**	**Disagree**
3. Policy changes and new requirements are communicated effectively to vet center clinicians	40%	31%	29%
4. District leaders are knowledgeable about the needs of vet centers and their staff	58%	31%	11%
5. District leaders are responsive to the needs of vet centers and their staff	46%	37%	16%
Organizational Assessment	**Agree**	**Neutral**	**Disagree**
Suicide Prevention			
6. Suicide prevention is a top priority for RCS	91%	6%	3%
7. RCS provides clinicians with the necessary tools for effective suicide prevention	77%	15%	8%
Outreach Activities			
8. Vet center outreach activities promote contact with the local eligible veterans with varying:			
• Genders	82%	11%	7%
• Backgrounds	83%	12%	5%
• Ethnic cultural affiliations	81%	13%	6%
RCSNet			
9. RCSNet is an effective electronic records management system that meets:			
• Clinical care needs	33%	30%	36%
• Documentation needs	37%	26%	36%
• Oversight needs	27%	27%	46%
Workplace Culture	**Agree**	**Neutral**	**Disagree**
10. I feel my unique background and identity are valued	70%	16%	14%
11. I am encouraged to offer ideas and ask questions to my leaders	74%	15%	11%
12. I am encouraged to bring concerns regarding vet center practices to my leaders	71%	17%	12%
13. My leaders take action when concerns regarding vet center practices are brought to their attention	53%	24%	22%
14. I am supported by my leaders during times of crisis	78%	16%	6%
Workload	**Agree**	**Neutral**	**Disagree**

15. I have enough time in a given week to complete all clinical documentation as required	42%	30%	28%
16. I feel my caseload is manageable	41%	30%	29%

Source: OIG clinical questionnaire.

Note: The OIG distributed questionnaires to all district clinical staff on March 25, 2024, for completion by April 5, 2024. Of the 257 questionnaires distributed to staff, 201 provided responses. Due to rounding some percent totals do not equal 100.

Appendix E: RCS Chief Readjustment Counseling Officer Memorandum

Department of Veterans Affairs Memorandum

Date: November 13, 2024

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

Subj: Inspection of Pacific District 5 Vet Center Operations

To: Director, Office of Healthcare Inspections, Vet Center Inspection Program (VC00)

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, *Inspection of Pacific District 5 Vet Center Operations*. I have reviewed the recommendations and submit action plans to address all findings in the report.

(*Original signed by*:)

Pedro Ortiz
Deputy Chief Officer, Readjustment Counseling Service
for
Michael Fisher
Chief Officer, Readjustment Counseling Service

[OIG comment: The OIG received the above memorandum from VHA on November 13, 2024.]

Appendix F: RCS Pacific District 5 Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 13, 2024

From: Debra Moreno, Pacific District 5 (RCS5)

Subj: Inspection of Pacific District 5 Vet Center Operations

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, Inspection of Pacific District 5 Vet Center Operations.

2. I reviewed the draft report and request closure of recommendations one and three. District 5 took immediate action to create and implement successful solutions that have resulted in a contingency coverage plan for Vet Center Director vacancies and the monitoring of morbidity and mortality reviews and oversight of their completions.

3. District 5 is actively working to resolve recommendations two, four and five.

4. 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*:)

Debra Moreno
District Director

[OIG comment: The OIG received the above memorandum from VHA on November 13, 2024.]

District Director Response

Recommendation 1

The District Director, in conjunction with the Deputy District Director, develops a contingency coverage plan to ensure oversight during periods of vet center director vacancies.

_X _Concur

____Nonconcur

Target date for completion: Requesting Closure

Director Comments

The District 5 Director and Deputy District Directors for each Zone have formulated a Vet Center Director (VCD) vacancy coverage plan which no longer relies upon Associate District Directors for Counseling (ADD/C) for this function. Instead, VCDs from within the District provide temporary VCD coverage. Additionally, District 5 has prioritized all VCD vacancies for human resource action to include the offering of recruitment incentives for those Vet Centers with difficult to fill VCD vacancies. At the time of inspection, 18 of 70 (26 percent) VCD positions were vacant across the District. As of November 1, 2024, 7 of 70 (10 percent) VCD positions were vacant across the District.

OIG Comments

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

Recommendation 2

The District Director monitors district leaders' compliance with completion of morbidity and mortality reviews for client deaths by suicide, including timeliness, as required.

_X _Concur

____Nonconcur

Target date for completion: May 13, 2025

Director Comments

District leadership was not consistently completing morbidity and mortality (M&M) reviews in a timely manner. In November 2023, VHA Directive 1500(4) was updated and stated that an M&M review will be completed within 120 days of notification by the Vet Center Director (VCD) of the eligible individual's suicide. District leadership modified their tracker to reflect the

120-day requirement to include sections that track the sending of a M&M panelist coordination e-mail within two weeks of the death by suicide event notification, convening the M&M panel within 60 to 90 days of the death by suicide notification, completing, and then uploading of the M&M report to the designated SharePoint site within 120 days of the death by suicide notification.

Recommendation 3

The District Director ensures district leaders are aware of the Readjustment Counseling Service policy requirements to provide oversight of morbidity and mortality review completion, including panel member assignments, participation of affected vet center staff, report completion, reporting of completion delays, and information dissemination.

_X _Concur

____Nonconcur

Target date for completion: Requesting Closure

Director Comments

The District Director, Deputy District Director, and ADD/C have reviewed and clarified policy and procedure documents and practices regarding the oversight of M&M review completion. All panels meet independently without the presence of affected Vet Center staff. The reporting of completion delays or any potential barriers to completion are promptly reported to the Deputy District Director. Deputy District Directors ensure that all M&M reviews are completed and routed in a timely manner with the aid of the District's modified M&M compliance tracker. During FY24, District 5 had eight events where a client died by suicide. Seven out of eight reports were completed within the prescribed timeline. The one late report was due to unforeseen circumstances involving an M&M panel member who was not available for report signature for an extended period of time.

OIG Comments

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

Recommendation 4

The District Director determines reasons vet center counselors did not complete safety plan components for clients assessed at intermediate or high suicide risk level in either acute, chronic, or both categories; ensures completion of safety plans for all active clients assessed at intermediate or high suicide risk levels; and monitors compliance across all zone vet centers.

_X _Concur

____Nonconcur

Target date for completion: March 1, 2025

Director Comments

Vet Center counselors were not consistently completing all components of a safety plan for clients assessed at intermediate or high suicide risk levels. Zone leadership provided education to VCDs and counselors, as well as ongoing reminders to meet this requirement. Safety plan training occurred at District 5 VCD sequesters for all Zones in FY24. Post-sequester follow-up e-mails to include training materials were sent to all District 5 VCDs as reinforcement of that training and as reminders to provide ongoing safety plan monitoring as well as training to their counseling staff. In that training, District 5 leadership highlighted the consistent monitoring of safety plans using the District's quality assurance compliance tracker which each VCD completes monthly. An additional feature will be added to the quality assurance compliance tracker to better monitor that each safety plan component is being completed. This new feature of the quality assurance compliance tracker will take effect December 1, 2024.

Recommendation 5

The District Director determines reasons staff did not document providing safety plans to clients, ensures all active clients assessed at intermediate or high suicide risk levels receives a safety plan, and monitors compliance across all zone vet centers.

_X _Concur

____Nonconcur

Target date for completion: March 1, 2025

Director Comments

Vet Center counselors were not consistently documenting the provision of safety plans to all active clients assessed at intermediate or high suicide risk levels. Zone leadership provided education to VCDs and counselors, as well as regular reminders to meet this requirement through Zone meetings and e-mails. Safety plan training occurred at VCD sequesters for all Zones in FY24. Post-sequester follow-up e-mails to include training materials were sent to all District 5 VCDs as reinforcement of that training and as reminders to provide ongoing safety plan monitoring as well as training to their counseling staff. District 5 added the monthly monitoring of safety plans to the District's quality assurance compliance tracker which each VCD completes monthly. An additional feature will be added to the quality assurance compliance tracker to better monitor that safety plans are being provided to clients and that safety plan provision actions are documented in a progress note. This new feature of the quality assurance compliance tracker will take effect on December 1, 2024.

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