



US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Inspection of Select Vet Centers in Southeast District 2 Zone 1

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Abbreviations

AED	automated external defibrillator
BLS	basic life support
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



Report Overview

The VA Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) provides a focused evaluation of the quality of care delivered at vet centers. Vet centers are community-based clinics that provide a wide range of psychosocial services to clients, including eligible veterans, active-duty service members, National Guard members, reservists, and their families, to support a successful transition from military to civilian life. This inspection report focuses on six randomly selected vet centers throughout Southeast district 2 zone 1: Augusta, Marietta, and Savannah in Georgia; Johnson City, Tennessee; Charleston, South Carolina; and Bay County, Florida.¹

VCIP inspections are one element of the OIG's oversight that evaluates key clinical and administrative processes associated with promoting quality care and service delivery at vet centers:²

This VCIP inspection focused on four review areas:

- Suicide prevention
- Consultation, supervision, and training
- Outreach
- Environment of care

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

¹ VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021, was in effect during part of the OIG's inspection period. It was amended and replaced by VHA Directive 1500(2), *Readjustment Counseling Service*, January 26, 2021, amended December 30, 2021, 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*, amended November 21, 2023. Unless otherwise specified, the requirements in the December 2021 directive contain the same or similar language as the amended November 2023 document. Readjustment Counseling Service is divided into five districts. Each district consists of two to four zones. Each zone consists of 18–25 vet centers per zone.

² 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 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 Readjustment Counseling Service policy and terminology, the OIG refers to veterans receiving such services as clients in this report.

Review Topics and Inspection Results

Suicide Prevention

The OIG found three vet center directors (VCDs) were noncompliant with the requirement to provide licensed representation to attend the support VA medical facility's mental health executive council meetings.³ All six VCDs were compliant with the requirement to review and document actions taken for Readjustment Counseling Service (RCS) High Risk Suicide Flag (HRSF) SharePoint clients.⁴

The OIG issued one recommendation to select vet centers leaders specific to suicide prevention activities.

Consultation, Supervision, and Training

The OIG found all six vet centers had assigned clinical liaisons and an external clinical consultant who was independently licensed in mental health from a support VA medical facility; however, two vet centers were noncompliant with the requirement for an external clinical consultant to provide at least four hours of consultation per month for clinically complex cases. All six VCDs were compliant with auditing 10 percent of each counselor's electronic client records. Overall, staff at all six vet centers were noncompliant with completing training requirements.

The OIG issued two recommendations to select vet center leaders specific to consultation, supervision, and training.

Outreach

The OIG found outreach plans were not developed by outreach staff nor the VCD at one vet center.⁵ Of the five vet centers with a completed outreach plan, all five sites were missing one or more strategic components required in the outreach plan, and three of the five completed plans

³ VHA Directive 1500(2). RCS requires a licensed vet center staff member attend all support VA medical facility mental health executive council meetings to assist with care coordination and collaboration for clients; VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015, replaced by VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023. VA medical facilities are required to establish a mental health executive council that supports strategies, communication, and policies to improve mental health care.

⁴ The RCS HRSF SharePoint site lists names of RCS clients identified by VA medical facilities as high risk. VCDs review the HRSF SharePoint site monthly to identify clients who currently receive or have received vet center services in the past 12 months to determine if client contact is needed, and if appropriate, complete follow-up.

⁵ VHA Directive 1500(2). In addition to readjustment counseling, vet centers offer community-based interactions through outreach services to help eligible individuals overcome barriers to accessing resources. RCS requires each vet center to have an annual written outreach plan.

did not have tailored outreach activities specific to the cultural orientations that were identified in each plan.⁶

The OIG issued three recommendations to select vet center leaders specific to outreach.

Environment of Care

An environment of care inspection was not completed at one of the six vet centers due to the building being closed.⁷ Of the five vet centers inspected, the OIG found one noncompliant with completion of one of the following annual requirements: a risk and vulnerability assessment completed by VA police or local law enforcement, and servicing of fire extinguishers. Four vet centers did not have monthly fire extinguisher inspections. One vet center did not have an automated external defibrillator (AED) located on-site. The four vet centers with an AED on-site were compliant with having the AED serviced annually; however, one vet center did not have the AED on-site inspected monthly. One vet center did not have a desktop reference sheet, outlining basic steps staff would follow in an event of a mental health crisis and two sites lacked an emergency or crisis plan that was either current or comprehensive. An evacuation plan was posted in a communal area at five vet centers.

The OIG made seven recommendations to select vet center leaders specific to environment of care.

Conclusion

The OIG conducted a detailed inspection across four review areas and issued a total of 13 recommendations for improvement to the District Director and zone leaders in conjunction with select VCDs. 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 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.

⁶ VHA Directive 1500(2). Cultural orientation includes “ethnic, gender, occupational and generational” details.

⁷ The Marietta Vet Center building was closed on August 8, 2022, due to having a mold issue.

Comments

The RCS Chief Readjustment Counseling Officer and District Director concurred with the recommendations and provided an acceptable action plan (see appendixes B and C). Based on information provided, the OIG considers recommendations 1, 2, 4, and 6–13 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.



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Contents

Abbreviations	i
Report Overview	ii
Purpose.....	1
RCS Organizational Structure.....	2
Scope.....	3
District, Zone, and Vet Center Selection	3
Review Topics and Summary of Results	5
Suicide Prevention	5
Consultation, Supervision, and Training.....	7
Outreach	10
Environment of Care	12
Vet Center Results	15
Bay County Vet Center	15
Augusta Vet Center	19
Marietta Vet Center.....	22
Savannah Vet Center.....	26
Charleston Vet Center	29
Johnson City Vet Center	32

Results and Recommendations Summary.....35

 Suicide Prevention Results.....35

 Suicide Prevention Recommendation35

 Consultation, Supervision, and Training Results.....35

 Consultation, Supervision, and Training Recommendations.....36

 Outreach Results36

 Outreach Recommendations37

 Environment of Care Results37

 Environment of Care Recommendations38

Appendix A: District 2 Zone 1 Profiles40

Appendix B: RCS Chief Readjustment Counseling Officer Memorandum41

Appendix C: RCS Southeast District 2 Director Memorandum.....42

OIG Contact and Staff Acknowledgments51

Report Distribution52



Purpose

The purpose of the VA Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) is to conduct routine oversight of vet centers that provide readjustment services to clients.¹ The OIG reports findings to Congress and Readjustment Counseling Service (RCS) leaders so informed decisions can be made to improve care.

Background

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. Vet centers are community-based facilities that provide a wide range of psychosocial services to clients to support a successful transition from military to civilian life. RCS was one of the first organizations to address the psychological and social effects combat has on veterans before the American Psychiatric Association recognized posttraumatic stress disorder as an official diagnosis in 1980.²

While vet centers initially focused on serving Vietnam-era veterans, over the years, eligibility for vet center services has continued to expand to include veterans of any combat theater, active-duty service members, National Guard members, and their families.³ 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.⁴ In fiscal year 2022, RCS provided

¹ VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021, was in effect during part of the OIG's inspection period. It was amended and replaced by VHA Directive 1500(2), *Readjustment Counseling Service*, January 26, 2021, amended December 30, 2021, 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*, amended November 21, 2023. Unless otherwise specified, the requirements in the December 2021 directive contain the same or similar language as the amended November 2023 document.

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." VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010.

³ VHA Directive 1500(2); "Who We Are" (web page), Vet Centers (Readjustment Counseling), accessed June 4, 2019, https://www.vetcenter.va.gov/About_US.asp.

⁴ VHA Directive 1500(2); William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021, Pub. L. No. 116-283, 134 Stat. 3724 (2021) § 761.

counseling services to 286,907 clients, “totaling nearly 1.34 million visits and outreach contacts.”⁵

Vet center services include individual, group, and family counseling for mental health conditions related to military sexual trauma, posttraumatic stress disorder, and other military-related concerns. Vet center staff assess and manage clients at risk for suicide, substance abuse, and other mental health conditions.⁶ 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.⁷

Vet center services are recorded in RCSNet, a system of records that is only viewable by RCS staff.⁸ 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 are not disclosed to VA medical facilities, VA clinics, or the Department of Defense without a veteran’s signed release of information.⁹

RCS Organizational Structure

RCS is aligned under the VA Under Secretary for Health and has governance of 300 vet centers, 83 mobile vet centers (MVCs), 20 outstations, and the Vet Center Call Center.¹⁰ 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 on recruitment and selection of staff, and supervising six RCS national officers. The RCS Operations Officer, who reports to the RCS Chief Officer, is responsible for daily operations and supervision of five district directors who oversee the districts.¹¹ RCS has

⁵ "Vet Centers (Readjustment Counseling)" (web page) accessed February 7, 2023, <https://www.vetcenter.va.gov/index.asp>. A fiscal year is a 12-month period that the federal government uses for accounting purposes running from October 1 through September 30.

⁶ VHA Directive 1500(2).

⁷ VHA Directive 1500(2).

⁸ VHA Directive 1500(2).

⁹ VHA Directive 1500(2); 38 C.F.R. § 17.2000–816 (e).

¹⁰ VHA Directive 1500(2). Vet center outstations promote additional points of access for clients and are under the supervision of the nearest VCD. Outstations are distant from established vet centers, and while not having the same staffing requirements, outstations have at least one full-time counselor. The Vet Center Call Center, reached at 1-877-WAR-VETS or 1-877-927-8387, is a 24-hour per day, 7-day per week, confidential call center for eligible individuals and their families to receive support regarding their military experience or any other readjustment issue.

¹¹ VHA Directive 1500(2).

five districts, each with two to four zones. Each zone has a range of 18 to 25 vet centers. Each vet center has a vet center director (VCD) who is responsible for all vet center operations.¹²

Scope

The OIG inspection team examined vet center operations from October 1, 2021, through September 30, 2022.¹³ The inspection team evaluated the quality of care delivered at vet centers and examined a broad range of key clinical and administrative processes for compliance with RCS policy. Specifically, this OIG inspection focused on four review areas that influence the quality of client care and service delivery at six randomly selected vet centers:

- Suicide prevention
- Consultation, supervision, and training
- Outreach
- Environment of care

District, Zone, and Vet Center Selection

For this inspection, the OIG randomly selected district 2 for review. Within district 2, the OIG randomly selected six vet centers in zone 1: Bay County, Florida; Augusta, Marietta, and Savannah in Georgia; Charleston, South Carolina; and Johnson City, Tennessee.¹⁴ Zone 1 is noted in figure 1 below. See [appendix A](#) for the data profiles on the six selected vet centers.¹⁵

¹² VHA Directive 1500(2).

¹³ The review period was from October 1, 2021, through September 30, 2022, unless otherwise noted.

¹⁴ The OIG completed a separate inspection and report with findings and recommendations for District 2 Zone 2. VA OIG, *Inspection of Select Vet Centers in Southeast District 2 Zone 2*, Report No. 22-03940-143, April 18, 2024. Additionally, throughout the report North Charleston is referenced as Charleston.

¹⁵ The underlined terms are hyperlinks to another section of the report. To return to the point of origin, press “alt” and “left arrow” keys.

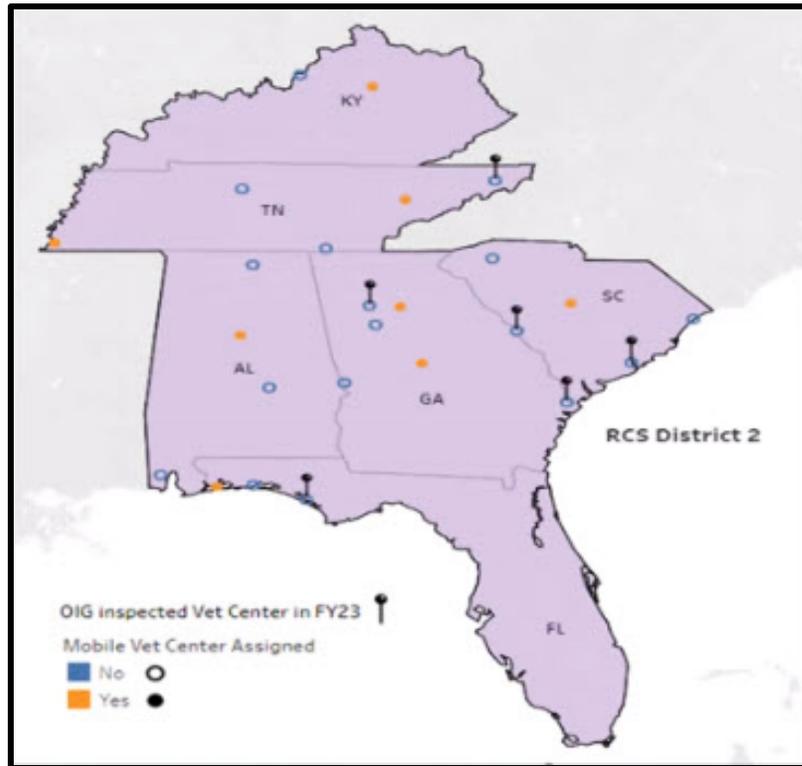


Figure 1. Map of Southeast district 2 zone 1 vet centers including sites visited and vet centers with MVCs.

Source: Developed by VA OIG using RCS vet center data.

The OIG announced the inspection to district leaders on October 24, 2022, and conducted on-site and virtual visits from October 25, 2022, through November 17, 2022, providing one-day advanced notification to each vet center inspected.¹⁶ The OIG interviewed VCDs and key staff at the selected vet centers, reviewed RCS practices and policies, and validated client record findings. Additionally, the OIG identified potential discrepancies, and explored reasons for noncompliance, when indicated.

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.

¹⁶ For the purposes of this report, district leaders refer to a combination of two or more of the following: District Director, Deputy District Director, Associate District Director for Counseling, and Associate District Director for Administration.

The OIG conducted this 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.

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).

Review Topics and Summary of Results

The following section is an overview of requirements and methodology for each review topic, including a summary table of results. For specific vet center results see [Vet Center Results](#) and for all results and recommendations see [Overall Results and Recommendations](#).

Suicide Prevention

The American Foundation for Suicide Prevention reports that suicide has no single cause, but “most often occurs when stressors and health issues converge to create an experience of hopelessness and despair.”¹⁷ The VA National Veteran Suicide Prevention Annual Report published in the fall of 2022, concludes that after “adjusting for population age and sex differences, the suicide rate for Veterans was 57.3 % greater than for non-Veteran U.S. adults” in 2020.¹⁸ 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.” VA 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.¹⁹

Approaches for reducing suicide among military service members, veterans, and their family members should be rooted in a strong public health framework that addresses the full range of risk and protective factors through evidence-based, interdisciplinary approaches, and balances the role of policy, program execution, engagement, and evaluation.²⁰

The OIG evaluated vet center staff’s compliance with the following requirements (see figure 2).

¹⁷ The American Foundation for Suicide Prevention is a voluntary health organization that supports suicide research and education. American Foundation for Suicide Prevention, “Risk factors, protective factors, and warning signs,” accessed August 23, 2023, <https://afsp.org/risk-factors-protective-factors-and-warning-signs>.

¹⁸ VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

¹⁹ VA Office of Mental Health and Suicide Prevention, *National Strategy for Preventing Veteran Suicide 2018 2028*, pp. 2, 4.

²⁰ White House, *Reducing Military and Veteran Suicide: Advancing a Comprehensive, Cross-Sector, Evidence-Informed Public Health Strategy*, 2021, p. 5.

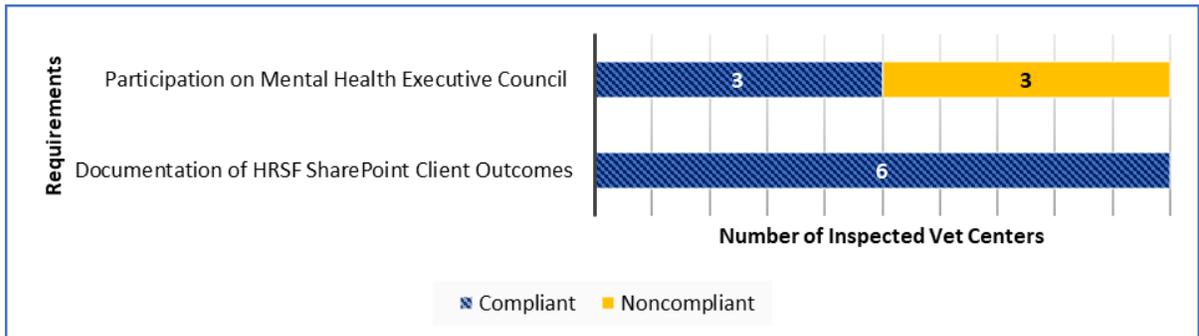


Figure 2. Suicide prevention review summary results across all vet centers inspected.
 Source: OIG analysis of VCIP results.

Mental Health Executive Council Participation

RCS requires a licensed vet center staff member to be assigned to actively participate on all support VA medical facility mental health executive council meetings to assist with care coordination and collaboration for clients.²¹ Each vet center aligns with a support VA medical facility to ensure access to clinical services and coordination of care for shared clients.²² VA medical facilities are required to establish a mental health executive council that supports strategies, communication, and policies to improve mental health care.²³

The OIG requested evidence of licensed vet center staff participation in VA medical mental health executive council meetings. The OIG reviewed attendance documentation to evaluate if required vet center staff attended mental health executive council meetings at an overall compliance rate of 90 percent for meetings held from October 1, 2021, through September 30, 2022.

High Risk Suicide Flag SharePoint Site

On May 11, 2020, RCS implemented a high risk suicide flag (HRSF) SharePoint site with names of RCS clients identified by VA medical facilities as high risk for suicide.²⁴ According to RCS leaders, the HRSF SharePoint site was later expanded to include clients with an increased predictive risk for suicide.²⁵ VCDs review the HRSF SharePoint site monthly to identify clients

²¹ VHA Directive 1500(2).

²² VHA Directive 1500(2).

²³ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

²⁴ RCS-CLI-006, April 27, 2020; Microsoft, *What is 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>.

²⁵ VA’s Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) program identifies veterans who have a higher risk for suicide through predictive analytics, Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 1, 2020.

who currently 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 follow-up. The VCD ensures documentation of actions taken is completed in RCSNet and the HRSF SharePoint site within five business days of receiving the HRSF SharePoint site list. Contacting high risk clients is an opportunity to provide unique resources while increasing communication and coordination with VA, all of which may reduce client risk for suicide.

To evaluate compliance at the six selected vet centers, the OIG performed a chart review of RCSNet documentation, assessing which clients still needed documentation in the HRSF SharePoint site on actions taken from October 1, 2021, through September 30, 2022.

Consultation, Supervision, and Training

Collaborative relationships between vet centers and VA medical facilities exist to improve veteran access to supportive health care for needs that go beyond the services that vet centers provide. Vet centers are assigned VA medical facility consultants, including a clinical liaison and external clinical consultant. Clinical liaisons assist in coordinating care, making referrals for shared VA medical facility clients, and coordinating suicide prevention activities. External clinical consultants provide consultation for clinically complex cases.²⁶

VCDs are responsible for all vet center operations, including the supervision of vet center staff.²⁷ One supervisory task performed by VCDs is monthly counseling record reviews to ensure thoroughness, accuracy, and compliance with RCS guidance and procedures.²⁸

“VHA required training is determined by the Under Secretary for Health to achieve the mission, goals and objectives of VHA.”²⁹ Required trainings are developed to ensure the information shared is targeted to the appropriate audience, limited in the time spent to reach the training goal, and evaluated annually to determine whether to keep the training as a requirement.

The OIG evaluated compliance with the following requirements (see figure 3).

²⁶ VHA Directive 1500(2).

²⁷ VHA Directive 1500(2).

²⁸ VHA Directive 1500(2).

²⁹ VHA Directive 1052, *Appropriate and Effective Use of VHA Employee Mandatory and Required Training*, June 29, 2018.

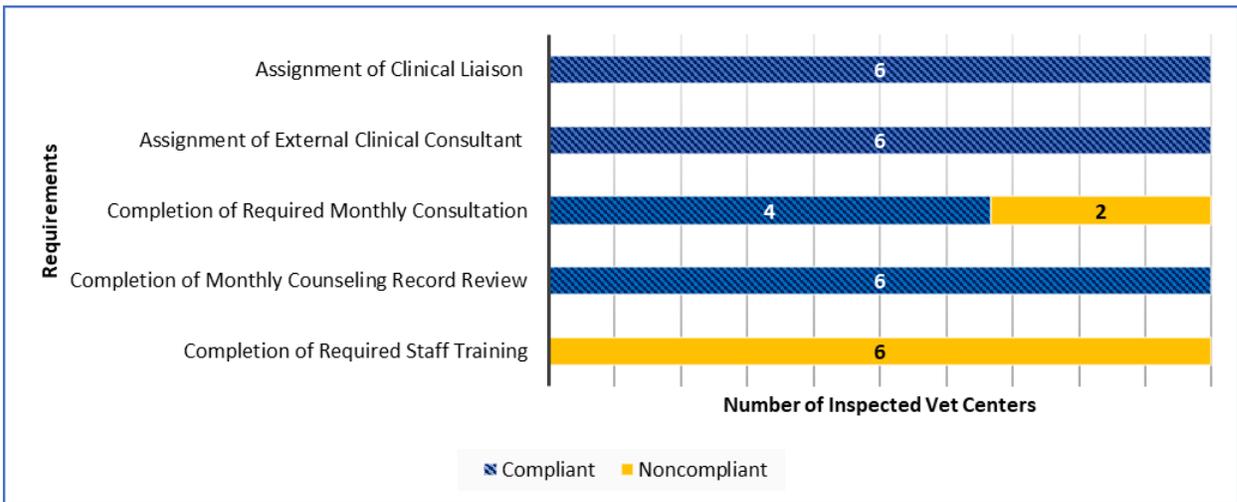


Figure 3. Consultation, supervision, and training review summary results across all vet centers inspected.
 Source: OIG analysis of VCIP results.

Consultation

The assigned clinical liaison must be a VA mental health professional, and the assigned external clinical consultant must be an independently licensed VA mental health professional who has completed the VA credentialing process.³⁰ The external clinical consultant is required to provide vet center counseling staff with four hours of monthly consultation for clinically complex cases.³¹

To evaluate compliance with RCS requirements for consultation, the OIG interviewed VCDs and conducted a document review to assess whether each vet center had an assigned clinical liaison and an external clinical consultant. To determine compliance with the requirement of four hours of monthly consultation from the external consultant, the OIG reviewed external clinical consultation hours documentation from October 1, 2021, through September 30, 2022, for a compliance rate of 90 percent or greater.

Supervision

VCDs must ensure a review of 10 percent of active counseling records monthly for each full-time counselor.³²

³⁰ VHA Directive 1500(2); VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. “Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care provider to provide care or services in or for the VA health care system.”

³¹ VHA Directive 1500(2).

³² VHA Directive 1500(2).

The OIG reviewed the VCDs' documentation of monthly counseling record reviews from July 1, through September 30, 2022. Specifically, the OIG evaluated if the VCDs reviewed 10 percent of active counseling records monthly for each full-time counselor for a 90 percent compliance rate.

Training

Vet center staff are required to complete specific trainings to ensure appropriate skills for assigned duties.³³ The OIG reviewed training records to determine vet center staff compliance with the following required trainings:³⁴

- Initial or annual S.A.V.E. training for nonclinical staff³⁵
- Initial or annual Skills Training for Evaluation and Management of Suicide for clinical staff³⁶
- One-time lethal means safety education and counseling for clinical staff³⁷
- One-time military sexual trauma training for clinical staff³⁸
- Bi-annual basic life support (BLS) certification for all staff³⁹

³³ VHA Directive 1500(2).

³⁴ Hire dates and departure dates were provided by VCDs to determine which trainings were required.

³⁵ VA Secretary, *Agency-Wide Required Suicide Prevention Training*, memorandum to Under Secretaries, Assistant Secretaries and Other Key Officials, October 15, 2020; VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training*, May 11, 2022. S.A.V.E. is the acronym for the Signs of Suicide, Ask about Suicide, Validate Feelings, and Encourage seeking help and expedited treatment training. Vet center nonclinical staff includes veterans outreach program specialist and program support assistant/office manager.

³⁶ VA Secretary, *Agency-Wide Required Suicide Prevention Training*; VHA Directive 1071, May 11, 2022. Skills Training for Evaluation and Management of Suicide is required within 90 days of hire for new clinical providers and annually for current clinical providers. VHA considers clinical staff to include psychologists, social workers, case managers, and vet center counselors.

³⁷ VHA memorandum, *Lethal Means Safety (LMS) Education and Counseling (VIEWS 7118915)*, March 17, 2022. Requirements for Lethal Means Safety (LMS) Education and Counseling training became effective on March 17, 2022. Lethal Means Safety (LMS) Education and Counseling training completion is required within 90 days of entering the position for new clinical providers or within 90 days of training assignment for current clinical providers.

³⁸ VHA Directive 1115.01 (1), *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017, amended May 8, 2020. Requirements for military sexual trauma training became effective on April 14, 2017. Military sexual trauma training completion is required within 90 days of entering the position for new clinical providers or within 90 days after training assignment for current clinical providers.

³⁹ The OIG reviewed vet center staffing spreadsheet, training records, or copy of BLS card. The OIG was informed by an RCS leader that all vet center staff are required to complete BLS on a bi-annual basis.

Outreach

In addition to readjustment counseling, vet centers offer community-based interactions through outreach services to help eligible individuals overcome barriers to accessing resources. Vet centers “conduct face-to-face outreach to contact, inform, engage, and bring local eligible individuals into the Vet Center for needed services.” Collaborative referral networks with VA medical facilities and community partners help vet centers ensure clients receive services and coordinated care.⁴⁰

“Culture competence is defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients.”⁴¹ The outreach plan reflects the unique sociocultural, geographic, and demographic variables of each veteran service area.⁴² Tailored community outreach can help improve outcomes, quality of care, and contribute to elimination of health disparities related to race and ethnicity.⁴³ RCS emphasizes culturally competent outreach through “contact with local eligible individual’s representative of all gender and ethnic cultural affiliations, class and occupational statuses, generational levels, and specific combat theater experiences.”⁴⁴

The OIG evaluated vet center staff’s compliance with the following requirements (see figure 4).

⁴⁰ VHA Directive 1500(2).

⁴¹ “Cultural competence in Health Care: Is it important for people with chronic conditions?” Georgetown University, McCourt School of Public Policy, Health Policy Institute, accessed January 18, 2023, <https://hpi.georgetown.edu/cultural/>.

⁴² VHA Directive 1500(2). Sociocultural variables are defined as “gender, ethnic, socioeconomic, and cultural orientations.”

⁴³ “Cultural competence in Health Care: Is it important for people with chronic conditions?” Georgetown University, McCourt School of Public Policy, Health Policy Institute.

⁴⁴ VHA Directive 1500(2).

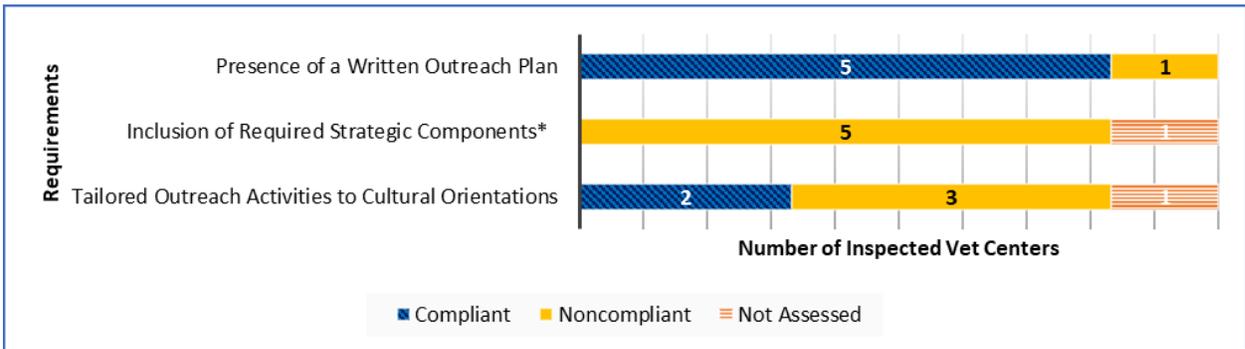


Figure 4. Outreach review summary results across all vet centers inspected.

Source: OIG analysis of VCIP results.

*Inclusion of required strategic components and tailored outreach activities were evaluated based on the five outreach plans evaluated.

Outreach Plan

RCS requires each vet center to have a written outreach plan, updated annually, that is developed by outreach staff under the supervision of the VCD.⁴⁵ The OIG requested the written outreach plan from each selected vet center and considered the vet center compliant if the written plan was active any time from October 1, 2021, through September 30, 2022.

Strategic Components of Outreach Plan

RCS policy requires each outreach plan include the following strategic components to target outreach services:⁴⁶

- Presence of a strategic map of the vet center veteran service area identifying local eligible population concentrations⁴⁷
- Inclusion of background information regarding cultural orientations of the local eligible communities⁴⁸
- Identification of personal points of contact for non-VA medical facility community service providers⁴⁹
- Identification of strategic VA medical facility partners including clinical and administrative liaisons, the external clinical consultant, the suicide prevention

⁴⁵ VHA Directive 1500(2).

⁴⁶ VHA Directive 1500(2).

⁴⁷ Strategic mapping can be in either narrative or visual format but must identify at least one eligible veteran population.

⁴⁸ VHA Directive 1500(2). Cultural orientation includes “ethnic, gender, occupational and generational” orientation.

⁴⁹ Personal points of contact were considered a specific person or role at an identified non-VA community agency.

coordinator, and the facility contact for prevention and management of disruptive behavior⁵⁰

- Inclusion of strategic coordination with MVC operations⁵¹

The OIG reviewed outreach plans that were active from October 1, 2021, through September 30, 2022, to determine if the plan contained the required strategic components. The OIG considered outreach plans with all required components to be compliant.

Tailored Outreach Activities

RCS requires that each outreach plan have activities tailored to the cultural background information identified in the plan.⁵² The OIG reviewed submitted outreach activities and interviewed VCDs to determine if outreach activities targeted specific cultural identities listed in the outreach plan. The vet center outreach plan was considered compliant if the plan demonstrated at least one activity tailored to cultural orientation.

Environment of Care

Environment of care refers to the physical environment, equipment and systems, and individuals who occupy a space. The environment should “support all Veterans’ dignity, privacy, safety, and security.”⁵³

The OIG evaluated compliance with the following requirements (see figure 5).

⁵⁰ VHA Directive 1500(2). The OIG reviewed the plan for the presence of all five required VA medical facility strategic partners and associated contact information.

⁵¹ VHA Directive 1500(2).

⁵² VHA Directive 1500(2).

⁵³ VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. VCDs are responsible for ensuring all environment of care requirements are met per the RCS, “RCS, Administrative Site Visit (ASV) Protocol,” provided to the OIG on October 7, 2021.

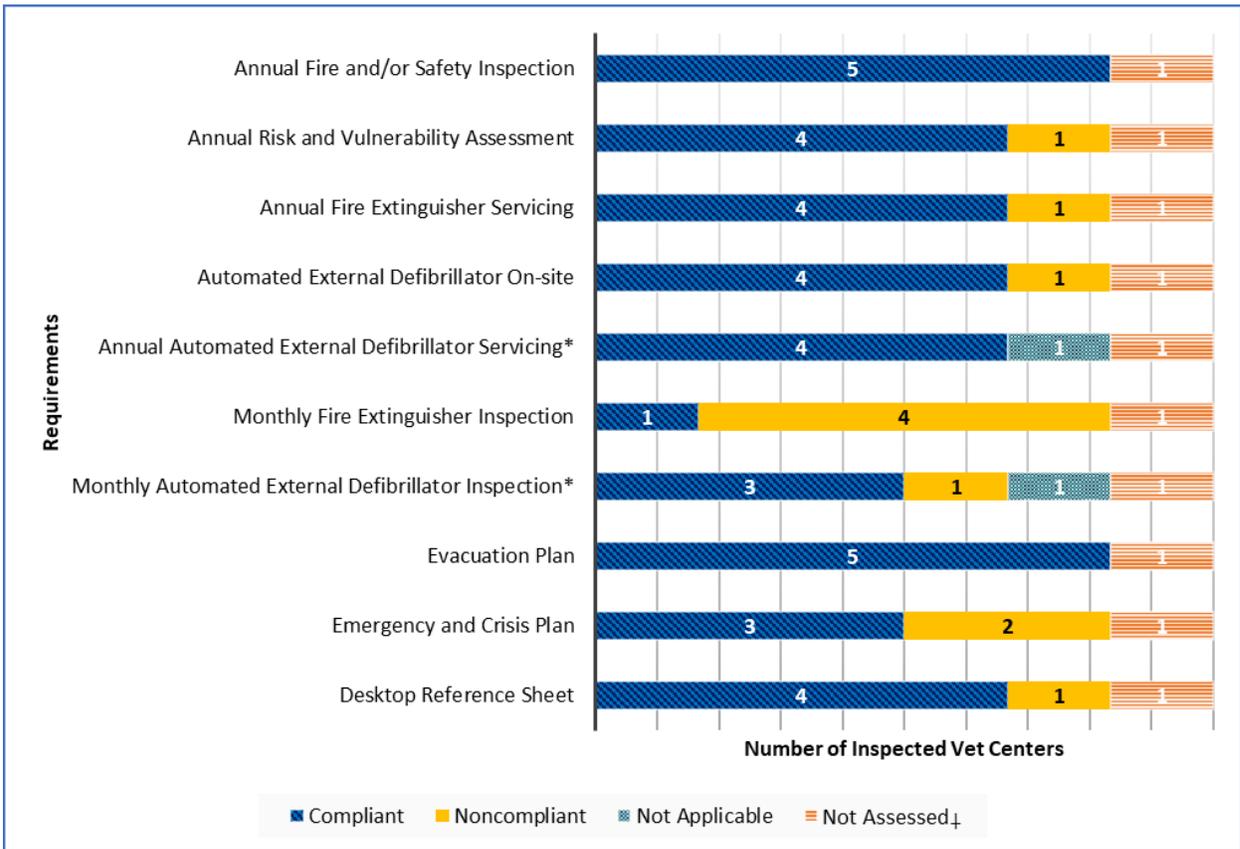


Figure 5. Environment of care review summary results across all vet centers inspected.

Source: OIG analysis of VCIP results.

*Monthly and Annual automated external defibrillator (AED)s not evaluated for the one site that did not have an AED.

†The OIG was unable to evaluate compliance with environment of care requirements at the Marietta Vet Center due to mold concerns resulting in closure of the site.

Physical Environment

Vet centers are required to have a fire and/or safety inspection and a risk and vulnerability assessment annually. The risk and vulnerability assessment must be completed by VA police or local law enforcement. Vet centers must also have fire extinguishers and an automated external defibrillator (AED) available for staff, both requiring annual servicing and monthly inspections to ensure proper functioning.⁵⁴ RCS requires vet centers to display an evacuation plan in a common area of the vet center for occupants to reference in the event of an emergency.⁵⁵

⁵⁴ The device can analyze the heart’s rhythm and then deliver an electrical shock, if necessary, to attempt to re-establish an effective rhythm. “What is AED?” accessed August 8, 2022, <https://www.redcross.org/take-a-class/aed/using-an-aed/what-is-aed>.

⁵⁵ “RCS, Administrative Site Visit (ASV) Protocol.”

The OIG evaluated the physical environment of each selected vet center through interviews, document reviews, and on-site inspections. During the on-site inspection, the OIG located and reviewed documentation the fire extinguishers, AEDs, and evacuation plans for compliance.⁵⁶ Documentation reviews included evaluation of annual fire and/or safety inspections and annual risk and vulnerability assessments.⁵⁷

General Safety

RCS requires a “community coordinated critical event plan, including a desktop reference sheet” outlining staff response to a suicidal or homicidal client, in person or on the phone.⁵⁸ Vet centers must also have a current emergency and crisis plan that includes contingencies for

- phone and computer disruptions;
- weather and natural disasters;
- site, facility, and building emergencies;
- site, facility, and building temporary relocation;
- management of disruptive behavior;
- violence in the workplace, including active shooter plan; and
- handling of suspicious mail and bomb threats.⁵⁹

The OIG evaluated the general safety of each selected vet center through interviews, document reviews, and on-site inspections. During the on-site inspection, the OIG reviewed desktop reference sheets for compliance. Documentation reviews included evaluation of current emergency and crisis plans.⁶⁰

⁵⁶ “RCS, Administrative Site Visit (ASV) Protocol.” RCS requires fire extinguishers and AEDs to be serviced annually and inspected monthly. For the yearly review elements, the OIG accepted documents from January 1, 2021, through the date of inspection. For the monthly review elements, the OIG reviewed the months of July, August, and September 2022.

⁵⁷ “RCS, Administrative Site Visit (ASV) Protocol.” RCS requires fire and/or safety inspections and risk and vulnerability assessments to be completed each calendar year. For these review elements, the OIG accepted documents from January 1, 2021, through the date of inspection.

⁵⁸ Vet Center Clinical Site Visit (CSV) Report: Procedural Background Information, accessed from internal RCS website on January 23, 2023.

⁵⁹ “RCS, Administrative Site Visit (ASV) Protocol.”

⁶⁰ The OIG evaluated ‘current’ as being reviewed or updated within two years of the date of inspection. “RCS, Administrative Site Visit (ASV) Protocol.”

Vet Center Results

The following section provides an overview of each vet center inspected, along with detailed results specific to each element reviewed. For an overview of all results see [Overall Results and Recommendations](#).

Bay County Vet Center

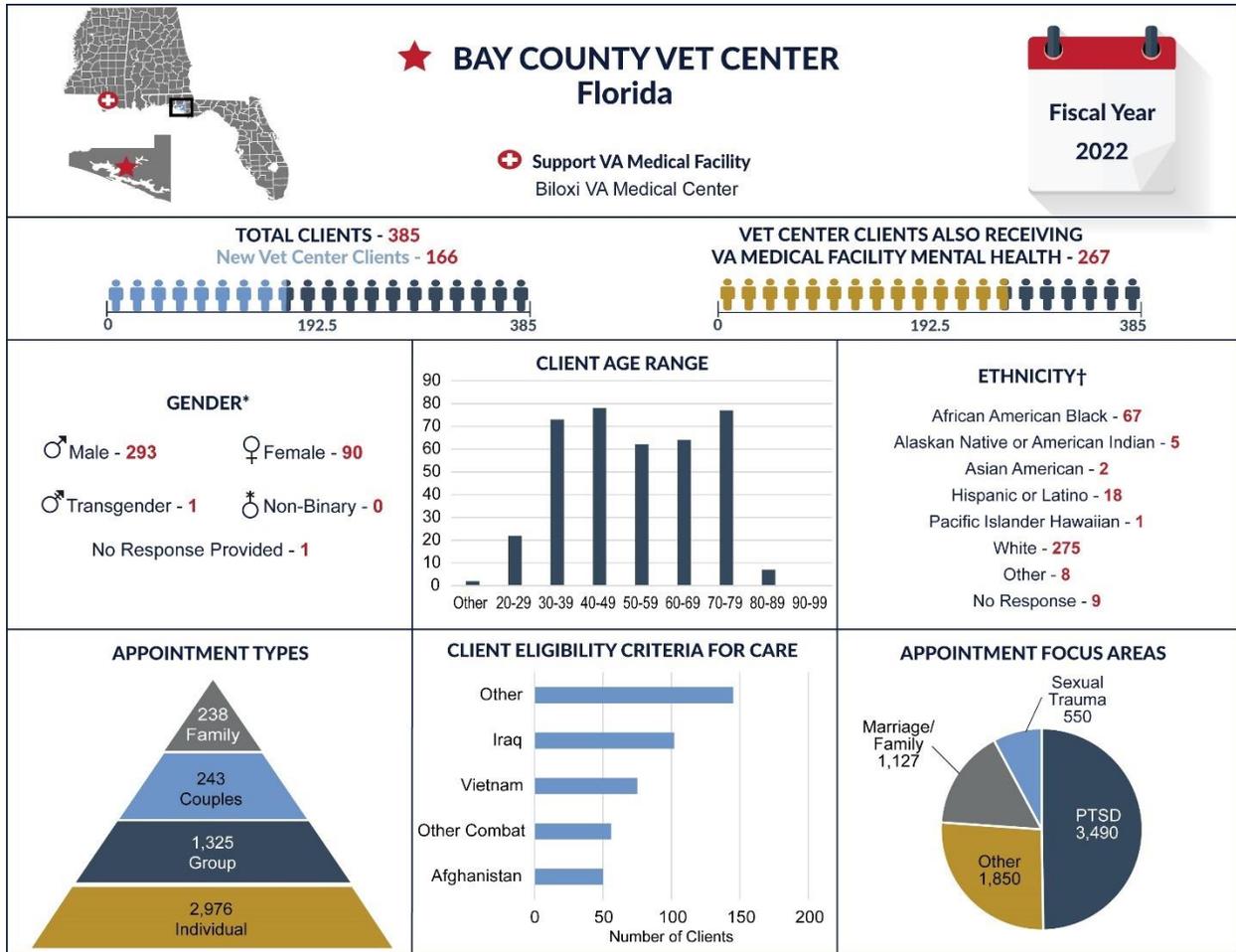


Figure 6. Client demographics across Bay County Vet Center during fiscal year 2022.

Source: OIG created graphic utilizing RCS demographic data. Figures may not be exact replications of approximate percentages.

*Gender is self-reported by RCS clients according to an RCS leader.

†RCSNet functionality allows for the selection of one ethnicity category per client according to an RCS leader.

‡Age represents “age at date of last visit” according to an RCS leader.

The Bay County Vet Center has approximately 58,000 veterans residing within the veteran service area spanning six counties in Florida and an additional five counties in Alabama, which also includes military bases: Tyndall Air Force Base, Naval Support Activity Panama City, and

Fort Rucker.⁶¹ The Bay County Vet Center is supported by the Biloxi VA Medical Center, which is approximately 248 miles from the vet center.

The VCD reported the closest MVC was located at the Pensacola Vet Center. The VCD denied using the MVC during the last fiscal year and noted that, if an MVC was needed, an attempt to coordinate would be made. Bay County Vet Center staff participated in 315 outreach events during fiscal year 2022.

At the time of the inspection, the VCD reported in addition to themselves, the vet center employed three readjustment counselors, a veteran outreach program specialist, and an office manager. The VCD had been at the center since 2012. According to the VCD, the readjustment counseling staff were either licensed in marriage and family therapy, social work, or mental health counseling.

The VCD shared with the OIG that the vet center was very connected with the community through the vet center's outreach program. The VCD reported placing an importance on attending a diverse mix of events throughout the year including events aimed at veteran and military organizations; community events; female veterans; senior citizen groups; Native Americans; and lesbian, gay, bisexual, transgender, queer, and questioning populations.

Findings

Suicide Prevention

The OIG determined that the VCD entered an outcome for all clients listed on the HRSF SharePoint site during the review period.

The OIG identified the following deficiency:

Mental health executive council participation: Vet center staff did not attend any mental health executive council meetings during fiscal year 2022. The VCD initially reported the meetings were no longer being held by the support VA medical facility but had difficulty finding confirmation. In follow-up communication, the VCD confirmed two meetings were held by the support VA medical facility during fiscal year 2022, neither of which were attended by vet center staff.

⁶¹Military Installations, *Tyndall AFB*, accessed February 15, 2023, <https://installations.militaryonesource.mil/in-depth-overview/tyndall-afb>. Tyndall Air Force Base is located 12 miles from Panama City, Florida and has an overall population of 30,572 including 2,902 active-duty service members. Military Installations, *Naval Support Activity Panama City*, accessed February 15, 2023, <https://installations.militaryonesource.mil/in-depth-overview/naval-support-activity-panama-city>. Naval Support Activity Panama City is a naval base located in Panama City, Florida and employs more than 4,000 military, Department of Defense civilians and federal contractors, and graduates nearly 1,300 students annually. Military Installations, *Fort Rucker*, accessed February 15, 2023, <https://installations.militaryonesource.mil/in-depth-overview/fort-rucker>. Fort Rucker is an army base located in Fort Rucker, Alabama, which is approximately 90 miles from Panama City, Florida. Fort Rucker has an overall population of 20,210 with 5,009 service members.

Consultation, Supervision, and Training

Consultation

The OIG determined all elements in the consultation review were compliant.

Supervision

The OIG determined all elements in the supervision review were compliant.

Training

The OIG determined that vet center staff completed S.A.V.E. training as required.

The OIG identified the following deficiencies:

- One out of four staff completed Skills Training for Evaluation and Management of Suicide for clinical staff.
- Three out of four staff completed military sexual trauma training for clinical staff.
- Two out of four staff completed lethal means safety education and counseling for clinical staff.
- No required staff completed BLS training.

The VCD reported a lack of oversight and a vet center position vacancy contributed to deficiencies in completion of the Skills Training for Evaluation and Management of Suicide and lethal means safety trainings. The VCD reported that arranging BLS training through the support VA medical facility was difficult due to having to complete an in-person module quarterly at the VA medical facility. The VCD arranged for vet center staff to complete BLS training through an outside company after the OIG's in-person inspection.

Outreach

The OIG determined the vet center had an outreach plan for fiscal year 2022 and that outreach activities were tailored to cultural orientations identified in the plan.

The OIG identified the following deficiency:

Outreach plan: The outreach plan was missing two required strategic components specifically, personal points of contact for non-VA service providers and strategic VA medical facility partners. The VCD reported not being aware of new requirements for the outreach plan, sending fiscal year 2022's plan to the district office for approval, and not receiving feedback from the district since the submission.

Environment of Care

The OIG determined that the fire and/or safety inspection, risk and vulnerability assessment, and servicing of on-site fire extinguishers and AED were completed annually. Staff completed monthly AED checks. The vet center had building evacuation plans posted in communal areas and had a critical event plan, including a desktop reference sheet outlining basic steps staff were to follow in an event of a mental health crisis.

The OIG identified the following deficiencies:

Fire extinguisher monthly inspections: Of the three months the OIG reviewed, monthly fire extinguisher checks were not completed for all fire extinguishers located within the facility. Two of four fire extinguishers did not have documentation of monthly checks. One fire extinguisher without documented monthly checks was located in a locked information technology room to which the VCD reported the vet center staff had access, but stayed out of unless a member of the VA medical facility requested entry. The other fire extinguisher was laying on a shelf in the front group room and did not have any inspection tags attached. The VCD reported being unaware of the extinguisher in the front group room and was unsure if the extinguisher belonged to the vet center. After the on-site inspection, the VCD reached out to the facility maintenance team to take that extinguisher from the vet center.

Emergency and crisis plan: The vet center's emergency and crisis plan did not include current guidance for phone and computer disruptions, weather and national disasters, site emergencies or a temporary location plan. The VCD reported being in the process of updating the plan with the assistance of a newly hired office manager.

Augusta Vet Center

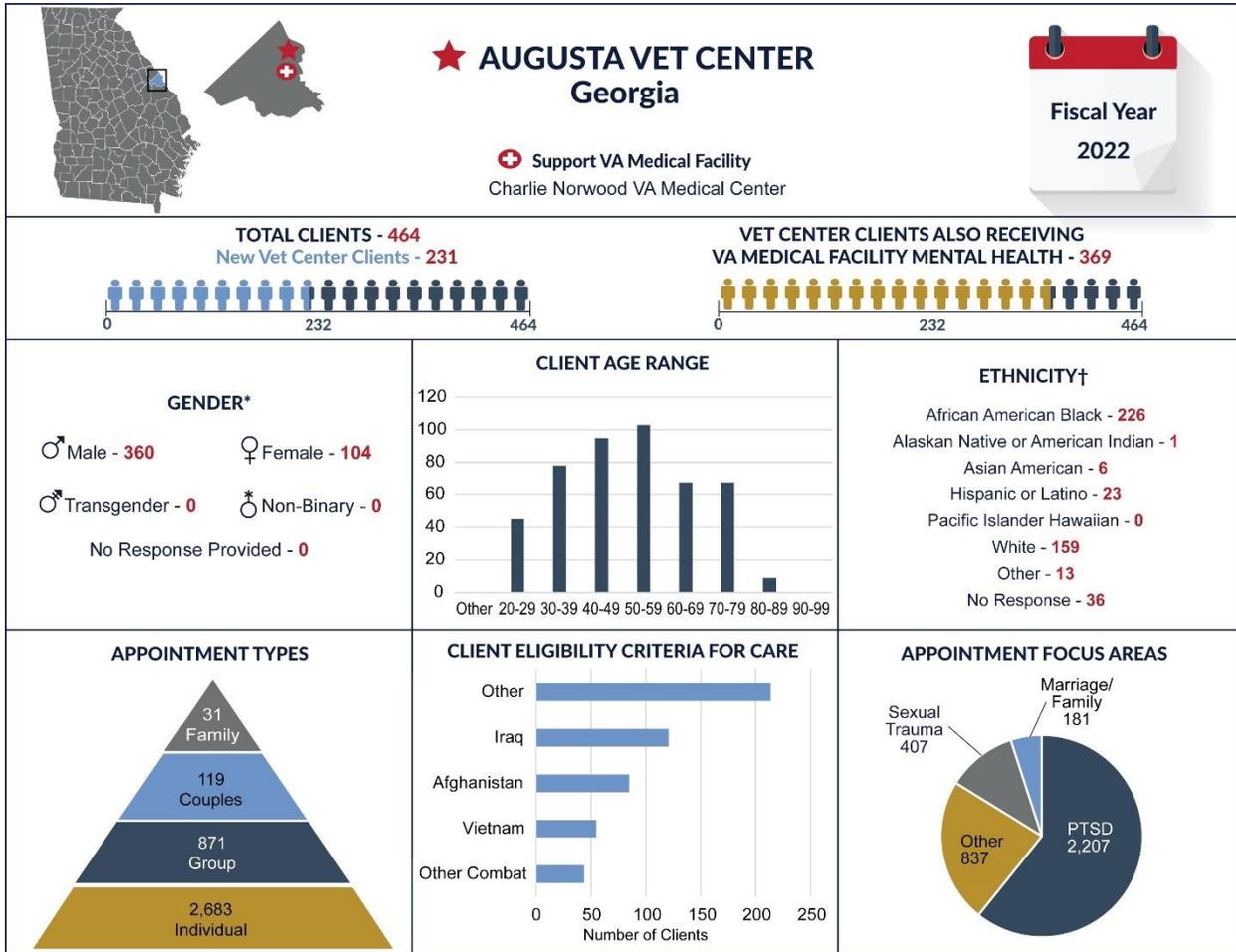


Figure 7. Client demographics across Augusta Vet Center during fiscal year 2022.

Source: OIG created graphic utilizing RCS demographic data. Figures may not be exact replications of approximate percentages.

*Gender is self-reported by RCS clients according to an RCS leader.

†RCSNet functionality allows for the selection of one ethnicity category per client according to an RCS leader.

‡Age represents “age at date of last visit” according to an RCS leader.

The Augusta Vet Center serves clients throughout 20 counties within Georgia and South Carolina. The Augusta Vet Center is supported by the Charlie Norwood VA Medical Center. The vet center estimates approximately 65,000 eligible veterans are in the veteran service area, which includes the Fort Gordon Army Base.

According to the VCD, the Augusta Vet Center coordinates with the Columbia Vet Center for use of an MVC. In addition, the VCD also noted, the Augusta Vet Center uses the MVC for outreach activities, including approximately two events during this inspection period.

At the time of the inspection, the VCD reported that in addition to themselves, the vet center employed three readjustment counselors, and a veteran outreach program specialist. The VCD reported that readjustment counseling staff held licenses in either social work or marriage and family therapy. The VCD also reported that the office manager position had been vacant for two months.

The VCD reported using protected time for staff supervision, as well as client and staff self-care activities. The VCD described a great working relationship with the support VA medical facility and spoke of VA health trainers providing vet center staff and clients trainings for yoga, guitar, relaxation, self-care, and burn out awareness.

Findings

Suicide Prevention

The OIG determined all elements in the suicide prevention review were compliant.

Consultation, Supervision, and Training

Consultation

The OIG determined all elements in the consultation review were compliant.

Supervision

The OIG determined all elements in the supervision review were complaint.

Training

The OIG determined that vet center staff completed S.A.V.E. training as required.

The OIG identified the following deficiencies:

- Two out of four staff completed Skills Training for Evaluation and Management of Suicide for clinical staff.
- Three out of four staff completed lethal means safety education and counseling for clinical staff.
- Two out of four staff completed military sexual trauma training for clinical staff.
- Four out of five staff completed BLS training.

The VCD reported the required trainings were not assigned to staff for completion noting some items were left off staff learning profiles and the training was dropped from one staff member's training To-Do list. The VCD further reported the incomplete BLS training was a lapse in follow through by the VCD.

Outreach

The OIG determined the vet center had an outreach plan for fiscal year 2022 that included the following required strategic components: a strategic map of the vet center veteran service area identifying local eligible population concentrations, background information regarding the cultural orientations of the local eligible communities, and strategic coordination with MVC operations.

The OIG identified the following deficiencies:

Outreach plan: The outreach plan was missing two required strategic components: personal points of contact for non-VA service providers and for VA medical facility partners.

Tailored outreach activities: The outreach activities were not tailored to community demographics.

Environment of Care

The OIG determined completion of an annual fire and/or safety inspection, posting of building evacuation plans in communal areas, presence of a current emergency and crisis plan, and a critical event plan, including a desktop reference sheet outlining basic steps staff were to follow in an event of a mental health crisis.

The OIG identified the following deficiencies:

Risk and vulnerability assessment: An annual risk and vulnerability assessment was not completed by the VA police service or local law enforcement. The VCD reported being unaware of the requirement for an annual assessment and was told by the support VA medical facility that the assessment was needed every two years.

Fire extinguisher servicing: None of the fire extinguishers were serviced annually. The VCD reported being unaware of the requirement to have the fire extinguishers serviced annually.

Fire extinguisher inspection: Of the three months the OIG reviewed, monthly fire extinguisher inspections were not completed on any of the extinguishers. The VCD reported being unaware of the requirement to inspect fire extinguishers monthly.

AED inspection and servicing: The vet center did not have an AED and, therefore, monthly AED inspections and annual servicing were not completed. The VCD reported being unaware of requirements related to having, inspecting, and servicing an AED. The VCD reported the Associate District Director for Administration documented the absence of an AED during the last administrative site visit but did not identify this as a deficiency.

Marietta Vet Center

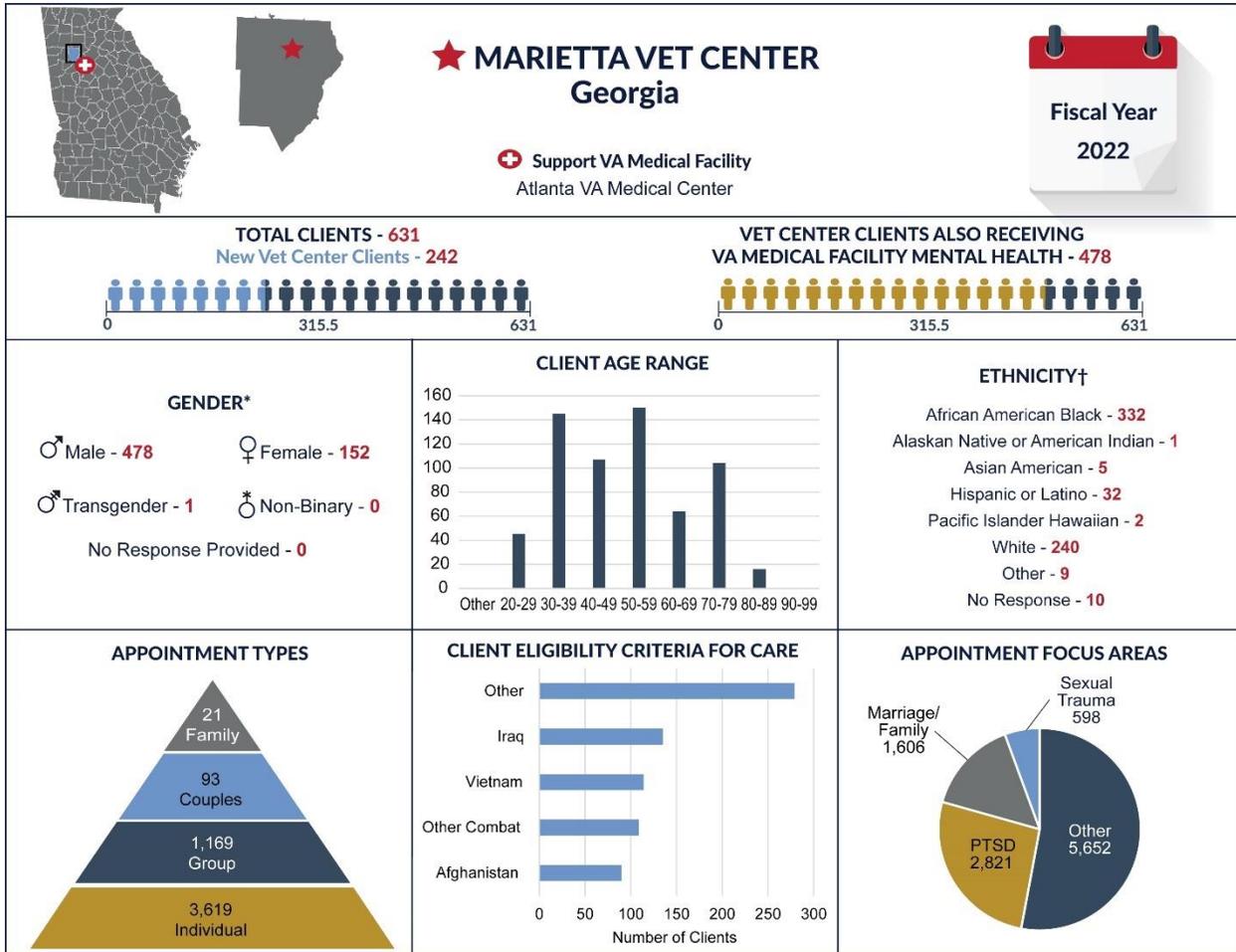


Figure 8. Client demographics across Marietta Vet Center during fiscal year 2022.

Source: OIG created graphic utilizing RCS demographic data. Figures may not be exact replications of approximate percentages.

*Gender is self-reported by RCS clients according to an RCS leader.

†RCSNet functionality allows for the selection of one ethnicity category per client according to an RCS leader.

‡Age represents “age at date of last visit” according to an RCS leader.

The Marietta Vet Center serves clients throughout 17 counties in Georgia and is near the Clay National Guard Center and Dobbins Air Reserve Base. The Joseph Maxwell Cleland Atlanta VA Medical Center provides supportive services to the vet center.

The VCD reported coordinating with the Lawrenceville Vet Center to use its MVC. According to the VCD, the vet center primarily used the MVC for outreach events; however, the MVC was used for counseling support at Dobbins Air Force base in response to a completed suicide. The vet center conducted 23 outreach events during the inspection period, 4 of which used the MVC.

At the time of the inspection, the VCD reported having four readjustment counselors and an office manager on staff. The VCD reported some readjustment counseling staff held licenses in social work or marriage and family therapy. The VCD reported the veterans outreach program specialist retired in the last quarter of fiscal year 2022 and also acknowledged being in the final stages of the hiring process to fill the position.

The VCD reported placing a high value on ensuring relationships with vet center stakeholders are nurtured and highlighted one opportunity for this was the quarterly community stakeholders meeting hosted by the vet center. The VCD reported sending a monthly newsletter to clients and stakeholders. The newsletter detailed vet center services and select community resources, such as employment opportunities, recreational classes, and affordable transportation resources. The newsletter included a section titled “Cornerstone of Our Community” that highlighted a specific community partner representative who served as a point of contact for clients interested in engaging with that resource.

The VCD reported the vet center building closed on August 8, 2022, due to a mold issue and remained closed at the time of inspection. While the building was closed, the VCD reported staff continued to meet clients’ needs through telehealth services, group sessions held outdoors, and individual sessions at the local community-based outpatient clinic. The VCD reported that the existing vet center lease terminates effective March 31, 2023, and that space has been secured through a community partner to meet with clients in person until a permanent location is established.⁶²

Findings

Suicide Prevention

The OIG determined the VCD entered an outcome for all clients listed on the HRSF SharePoint.

The OIG identified the following deficiency:

Mental health executive council participation: A licensed mental health staff member from the vet center attended 9 of 22 mental health executive council meetings held by the support VA medical facility. The VCD reported being aware meetings were held every two weeks but was unaware of the requirement for vet center staff to attend all meetings.

⁶² Throughout the time of the building closure, the VCD worked with district leaders and Joseph Maxwell Cleland Atlanta VA Medical Center safety/industrial hygiene to ensure the safety of the building prior to potentially reopening it. The VCD also worked with VA contracting to hold the lessor accountable for ensuring the safety of the building; however, district leaders decided to deactivate the building and VA contracting terminated the lease.

Consultation, Supervision, and Training

Consultation

The OIG determined a clinical liaison and an external clinical consultant licensed in mental health were assigned to the vet center from the support VA medical facility.

The OIG identified the following deficiency:

External clinical consultation hours: Counselors did not receive four hours of external clinical consultation for 2 of 12 months reviewed. The VCD reported a misunderstanding of the requirement and believing the requirement was for the external clinical consultant to remain available to staff for four hours a month, but that staff were not required to use the time.

Supervision

The OIG determined the vet center was compliant with all elements in the supervision review.

Training

The OIG identified the following deficiencies:

- No required staff completed the S.A.V.E. training for nonclinical staff.
- Two out of five staff completed Skills Training for Evaluation and Management of Suicide for clinical staff.
- Three out of five staff completed lethal means safety education and counseling for clinical staff.
- Two out of five staff completed military sexual trauma training for clinical staff.
- Four out of six staff completed BLS training.

The VCD reported belief that all required trainings were assigned to staff by human resources or the district office and did not verify that required training was assigned. This resulted in mandatory training not being completed by staff. The VCD reported malfunctioning training equipment prevented BLS training completion for one staff member.

Outreach

The OIG determined the vet center had a fiscal year 2022 outreach plan that was tailored to cultural orientations identified in the plan.

The OIG identified the following deficiency:

Outreach plan: The outreach plan did not include the following required strategic components: points of contact for the clinical and administrative liaisons, the external clinical consultant, and

the support VA medical facility's prevention and management of disruptive behavior program. The VCD reported the absence of points of contact in the plan was an oversight.

Environment of Care

Since the vet center was closed for mold, the OIG was unable to complete a physical inspection. As a result, the OIG did not assess compliance with environment of care inspection elements.

Savannah Vet Center

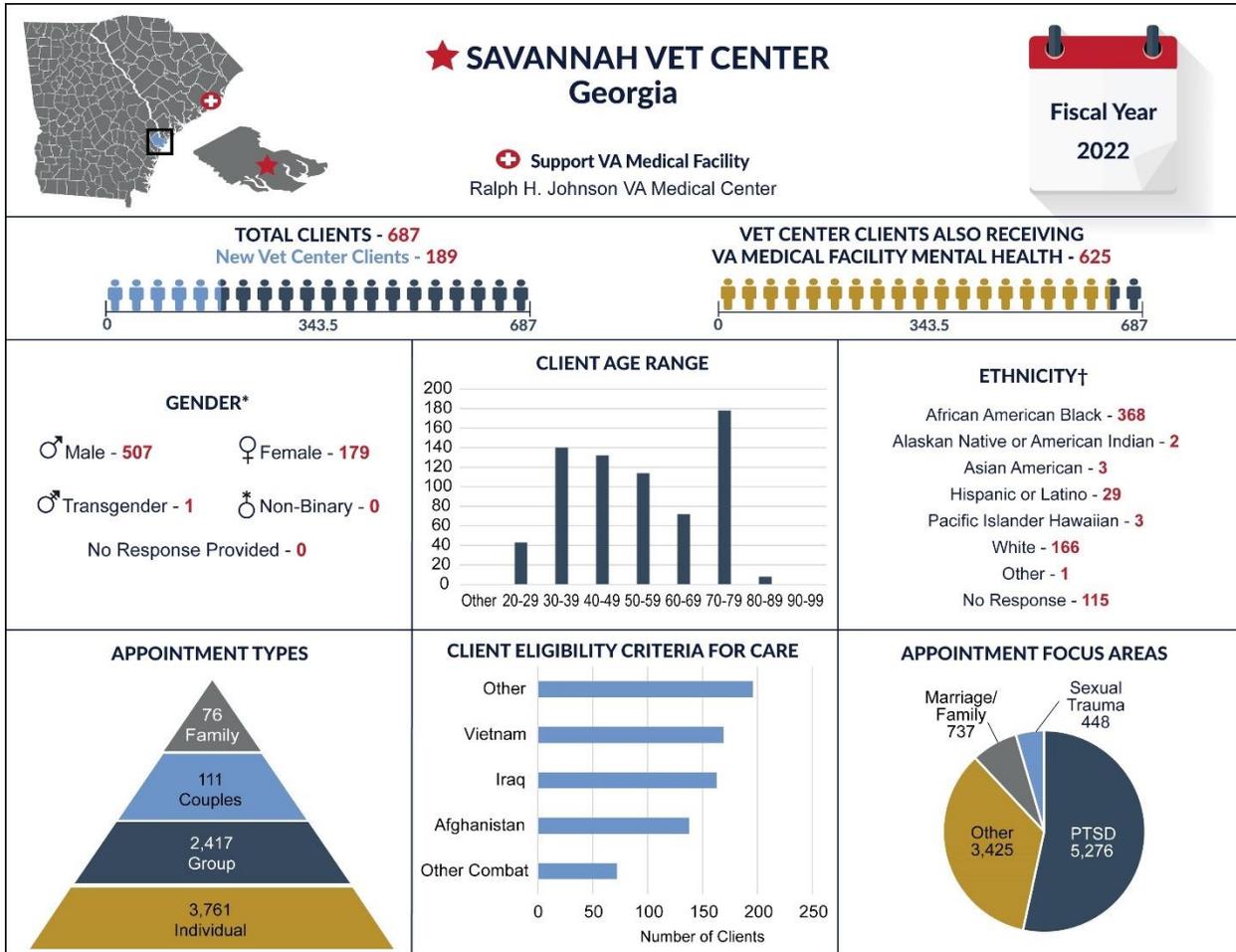


Figure 9. Client demographics across Savannah Vet Center during fiscal year 2022.

Source: OIG created graphic utilizing RCS demographic data. Figures may not be exact replications of approximate percentages.

*Gender is self-reported by RCS clients according to an RCS leader.

†RCSNet functionality allows for the selection of one ethnicity category per client according to an RCS leader.

‡Age represents “age at date of last visit” according to an RCS leader.

The Savannah Vet Center serves clients throughout six counties in eastern Georgia and is supported by the Ralph H. Johnson VA Medical Center. The vet center is located near Hunter Army Airfield Base and Fort Stewart Army Base, which “is the largest Army installation east of

the Mississippi River.”⁶³ Service area counties include Chatham, Bulloch, Effingham, Liberty, Bryan, and McIntosh and have a veteran population of 46,029.

The VCD reported having an MVC assigned to the vet center in July 2022 and planning to drive the MVC in the Savannah Veterans Day parade and to provide outreach to smaller, underserved areas. The VCD also highlighted that staff participated in 12 outreach events in fiscal year 2022.

At the time of the inspection, the VCD reported having four readjustment counselors and a veterans outreach program specialist. The VCD also reported that two positions, an office manager and a readjustment counselor, were vacant and actively being recruited. The VCD reported the readjustment counseling staff held licenses in social work or counseling and highlighted that all vet center clinical staff were trained to provide Eye Movement Desensitization and Reprocessing therapy to veterans requesting this treatment.⁶⁴

The VCD reported the vet center building was closed on October 3, 2022, due to a mold issue and was reopened on December 12, 2022, following mold remediation. During the building closure, the VCD reported staff were allowed to work remotely or, for seeing clients in person, utilize identified alternate worksites, such as a community-based outpatient clinic or the MVC.

Findings

Suicide Prevention

The OIG determined the VCD entered an outcome for all clients listed on the HRSF SharePoint.

The OIG identified the following deficiency:

Mental health executive council participation: Savannah vet center staff did not attend either of the two support VA medical facilities’ mental health executive council meetings held. Four meetings were scheduled, two were canceled and the VCD arranged for coverage from another VCD for one of the two meetings held. The VCD reported having an informal arrangement with fellow VCDs to provide coverage when a meeting is missed. The OIG could not confirm vet center representation at one of the two meetings held.

⁶³ Military.com, *Fort Stewart Army Base*, accessed February 28, 2023, <https://www.military.com/base-guide/fort-stewart>; Military.com, *Hunter Army Airfield Base Guide*, accessed February 28, 2023, <https://www.military.com/base-guide/hunter-army-airfield>.

⁶⁴ “Eye Movement Desensitization and Reprocessing (EMDR) Therapy,” American Psychological Association, accessed March 1, 2023, <https://www.apa.org/ptsd-guideline/treatments/eye-movement-reprocessing/>. EMDR is a psychotherapy used to treat PTSD. The structured eight-phase approach encourages an individual to process memories, thoughts, and feelings related to trauma by using eye movements.

Consultation, Supervision, and Training

Consultation

The OIG determined all elements in the consultation review were compliant.

Supervision

The OIG determined all elements in the supervision review were compliant.

Training

The OIG determined vet center staff completed S.A.V.E. and Skills Training for Evaluation and Management of Suicide trainings as required.

The OIG identified the following deficiencies:

- Four out of five staff completed lethal means safety education and counseling for clinical staff.
- One out of five staff completed military sexual trauma training for clinical staff.
- Two out of six staff completed BLS training.

The VCD reported the lethal means and military sexual trauma trainings were appropriately assigned to counselors; however, the VCD overlooked email reminders that notified the VCD of incomplete trainings. Additionally, the VCD stated the BLS training was not completed by four staff due to scheduling challenges during the COVID-19 pandemic.

Outreach

The OIG determined the vet center had an outreach plan for fiscal year 2022.

The OIG identified the following deficiencies:

Outreach plan: The outreach plan was missing four required strategic components. Specifically, the outreach plan did not contain background information regarding the cultural orientations of the local eligible communities, personal points of contact for non-VA service providers, strategic VA medical facility partners, and strategic coordination with MVC operations.

Tailored outreach activities: Cultural orientations were not identified in the outreach plan, and therefore outreach activities were not tailored to cultural orientations of the local eligible communities. The VCD reported, when starting in 2020, the veteran outreach program specialist position was vacant. This resulted in the outreach plan not being completed or updated.

Environment of Care

The OIG determined all elements in the environment of care review were compliant.

Charleston Vet Center

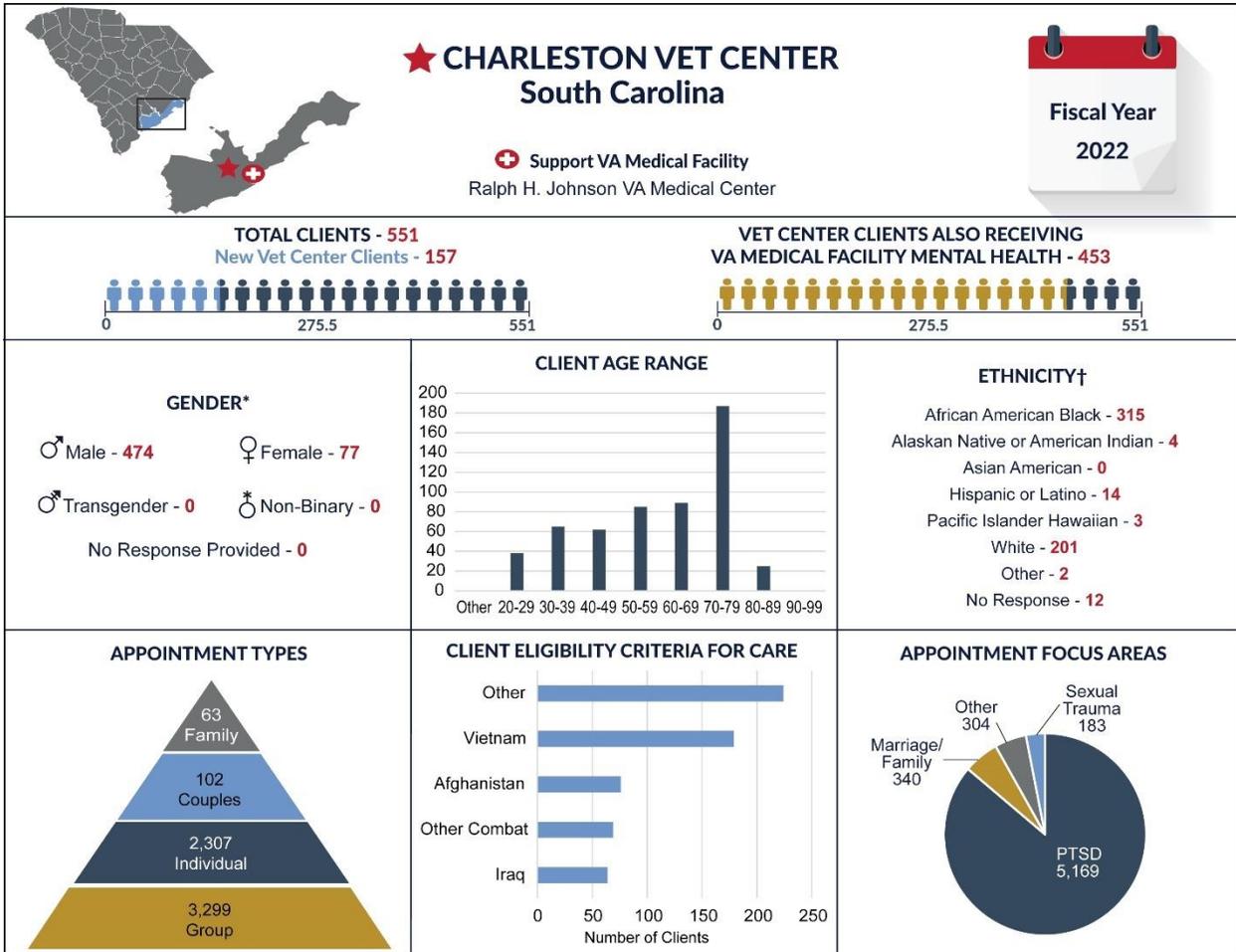


Figure 10. Client demographics across Charleston Vet Center during fiscal year 2022.

Source: OIG created graphic utilizing RCS demographic data. Figures may not be exact replications of approximate percentages.

*Gender is self-reported by RCS clients according to an RCS leader.

†RCSNet functionality allows for the selection of one ethnicity category per client according to an RCS leader.

‡Age represents “age at date of last visit” according to an RCS leader.

The VCD estimates approximately 85,000 veterans living within the veteran service area spanning seven counties in South Carolina. The vet center is supported by the Ralph H. Johnson VA Medical Center, which is also located in Charleston, South Carolina.

The VCD discussed that the Charleston Vet Center coordinates with the Columbia and Savannah vet centers for use of an MVC. The VCD reported not using the MVC for direct counseling services and using the MVC for one of 134 outreach events during fiscal year 2022.

The VCD reported, at the time of the inspection, the vet center employed a VCD in addition to four readjustment counselors, a veteran outreach program specialist and an office manager. The readjustment counseling staff held licenses in marriage and family therapy, social work, or mental health counseling.

The VCD highlighted having a collaborative relationship with the support VA medical facility. The VCD cited participation in quarterly meetings with the facility's associate director as well as attendance at quarterly suicide prevention reduction meetings as opportunities taken to collaborate and share information to improve client care. The VCD also highlighted conducting drive-through outreach events in the vet center's parking lot during the pandemic, which were well received by clients.

Findings

Suicide Prevention

The OIG determined that a licensed mental health staff member participated on the support VA medical facility's mental health executive council. Additionally, the OIG confirmed the VCD entered an outcome for all clients listed on the HRSF SharePoint site.

Consultation, Supervision, and Training

Consultation

The OIG determined a clinical liaison and an external clinical consultant licensed in mental health were assigned to the vet center.

The OIG identified the following deficiency:

External clinical consultation hours: Counselors did not receive four hours of external clinical consultation for 3 of 12 months reviewed. The VCD stated no plan was in place to ensure consultation occurred when meetings were canceled due to holidays or when the consultant was unavailable.

Supervision

The OIG determined all elements in the supervision review were compliant.

Training

The OIG determined that all required staff completed the S.A.V.E. and lethal means safety trainings.

The OIG identified the following deficiencies:

- Four out of five staff completed Skills Training for Evaluation and Management of Suicide for clinical staff.

- Three out of five staff completed military sexual trauma training for clinical staff.
- Six out of seven staff completed BLS training.

The VCD reported delinquent training for BLS was in the process of being scheduled. Other trainings were not completed because training was not assigned by district staff, which resulted in the VCD and clinical staff being unaware of the need to complete required training.

Outreach

The OIG identified the following deficiency:

Outreach Plan: The outreach plan was not developed for fiscal year 2022 and, therefore, the OIG did not evaluate required elements. The VCD reported the outreach plan was not updated due to the COVID-19 pandemic.⁶⁵

Environment of Care

The OIG determined completion of a fire and/or safety inspection, a risk and vulnerability assessment, fire extinguisher inspections and AED servicing annually. Building evacuation plans were posted in communal areas.

The OIG identified the following deficiencies:

Fire extinguisher inspection: Of the three months OIG reviewed, monthly fire extinguisher inspections were not completed on one extinguisher for two months. The VCD stated the missed inspection was an oversight by the staff member responsible for completing the inspection.

AED inspection: Of the three months the OIG reviewed, monthly AED inspections were not completed for any month. The VCD reported being unaware of the requirement to inspect the AED monthly.

Emergency and crisis plan: The emergency and crisis plan did not identify an alternate location. The VCD reported being aware of the requirement for an alternate location but was unaware that the location was not documented in the emergency and crisis plan.

Desktop reference sheet: Staff were unable to provide a desktop reference sheet to the OIG during the on-site inspection. The VCD provided a copy of the desktop reference sheet to the OIG when alerted and reported that staff were previously provided with desktop references, which were misplaced.

⁶⁵ “A pneumonia of unknown cause detected in Wuhan, China was first reported to the World Health Organization (WHO) Country Office in China on 31 December 2019. The virus was later named ‘SARS-CoV-2’ and the disease it causes named ‘coronavirus disease 2019’ (abbreviated ‘COVID-19’).” *Veterans Health Administration – Office of Emergency Management, COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan, Version 1.6*, March 23, 2020.

Johnson City Vet Center

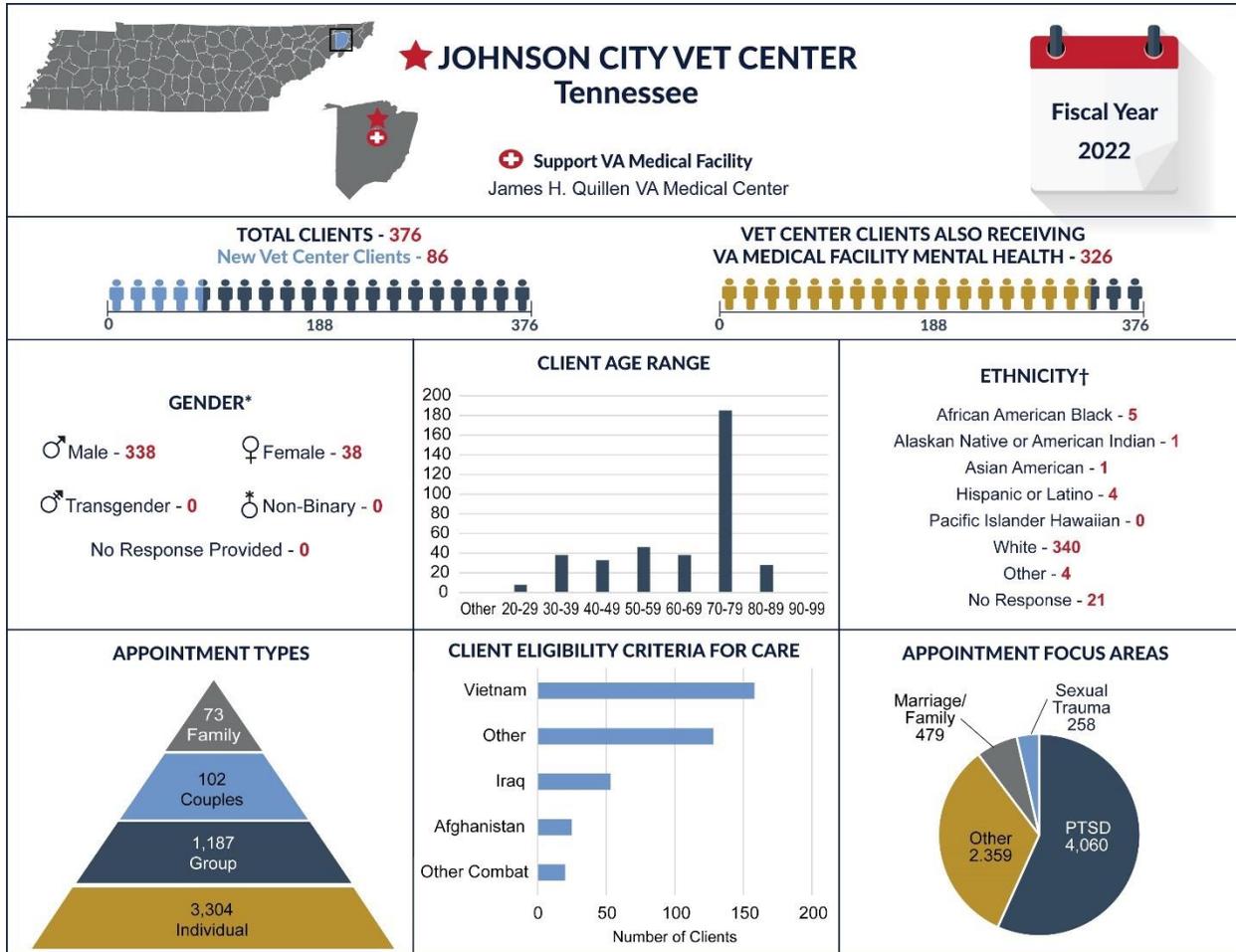


Figure 11. Client demographics across Johnson City Vet Center during fiscal year 2022.

Source: OIG created graphic utilizing RCS demographic data. Figures may not be exact replications of approximate percentages.

*Gender is self-reported by RCS clients according to an RCS leader.

†RCSNet functionality allows for the selection of one ethnicity category per client according to an RCS leader.

‡Age represents “age at date of last visit” according to an RCS leader.

The vet center staff estimates approximately 20,000 veterans living within the veteran service area, which spans twelve counties and three states: Tennessee, Virginia, and Kentucky. The Johnson City Vet Center is supported by the James H. Quillen VA Medical Center, which is located in Mountain Home, Tennessee.

The VCD reported the Knoxville MVC would be utilized if there was a need for an MVC. An MVC was used five times for outreach events during the last fiscal year. Johnson City staff participated in 218 outreach events during fiscal year 2022.

At the time of the on-site inspection, the VCD reported the vet center having three readjustment counselors, a veterans outreach program specialist, and an office manager. The VCD reported starting in the position about a year prior to the inspection and working to refine vet center processes. The VCD reported the clinical staff having licenses in marriage and family therapy, social work, or mental health counseling.

The VCD spoke of historic flooding that impacted five counties across eastern Kentucky in 2022. Within 36 hours, vet center team members from multiple vet centers, along with two MVC's, deployed to the area to provide support to the impacted communities. Johnson City Vet Center staff participated in the coordinated effort by performing needs assessments, identifying resources, and issuing direct support referrals.

Findings

Suicide Prevention

The OIG determined all elements in the suicide prevention review were compliant.

Consultation, Supervision, and Training

Consultation

The OIG determined all elements in the consultation review were compliant.

Supervision

The OIG determined all elements in the supervision review were compliant.

Training

The OIG determined that nonclinical staff completed S.A.V.E. training and clinical staff completed the lethal means and military sexual trauma trainings.

The OIG identified the following deficiencies:

- Three out of four staff completed Skills Training for Evaluation and Management of Suicide for clinical staff.
- One out of six staff completed BLS training.

The VCD reported the Skills Training for Evaluation and Management of Suicide and BLS trainings were not completed because the trainings were not assigned resulting in staff members being unaware of the required training. Additionally, the VCD attributed the BLS noncompliance to the training no longer being offered in person at the vet center and having to identify how staff could participate.

Outreach

The OIG determined that the vet center had an outreach plan for fiscal year 2022.

The OIG identified the following deficiencies:

Outreach plan: The outreach plan was missing four required strategic components. Specifically, the outreach plan did not include a strategic map of the veterans service area identifying local eligible population concentrations, background information regarding the cultural orientations of the local eligible communities, personal points of contact for non-VA service providers, and the required strategic VA medical facility partners.

Tailored outreach activities: Since the plan did not identify cultural orientations, outreach activities were not tailored to the cultural background information identified in the plan. The VCD shared that the vet center normally attended events that staff had attended the year prior. The VCD reported intending to search for underserved populations and increase outreach to those groups.

Environment of Care

The OIG determined completion of a fire and/or safety inspection, a risk and vulnerability assessment, fire extinguisher and AED servicing annually, in addition to monthly AED checks. The vet center also had evidence of the building evacuation plan posted in communal areas, and a critical event plan, including a desktop reference sheet outlining basic steps staff were to follow in an event of a mental health crisis.

The OIG identified the following deficiency:

Fire extinguisher inspections: Of the three months the OIG reviewed, monthly fire extinguisher checks were not completed for any fire extinguishers located within the facility. Vet center staff reported not completing monthly checks due to an oversight by the person assigned to that task and the VCD.

Results and Recommendations Summary

The following section is an overview of results for the six reviewed vet centers and resulting recommendations. Recommendations target deficiencies that, if improved, would positively influence the quality of client care. These recommendations are intended to be used as a road map to help improve operations and clinical care.

Suicide Prevention Results

For details on the review topic requirements and methodology see [Suicide Prevention](#).

Requirement	Impact	Noncompliant Vet Center(s)
1. A licensed vet center staff attends all support VA medical facility mental health executive council meetings	Lack of vet center participation on the support VA mental health executive council may decrease collaboration between the vet center and support VA facility, which could result in a lack of services offered to clients.	Marietta Bay County Savannah

Suicide Prevention Recommendation

Recommendation 1

District leaders and the Marietta, Bay County, and Savannah Vet Center Directors collaborate with the support VA medical facility clinical liaisons to determine the reasons for noncompliance, take action as indicated, and monitor to ensure compliance with staff participation on the mental health executive council.

Consultation, Supervision, and Training Results

For details on review topic requirements and methodology see [Consultation, Supervision, and Training](#).

Requirement	Impact	Noncompliant Vet Center(s)
2. External clinical consultant provides at least four hours of consultation monthly	Vet center may lack enough support for readjustment of clients with clinically complex cases.	Marietta Charleston

Requirement	Impact	Noncompliant Vet Center(s)
3. Staff members complete required trainings in the allotted timeframe	Lack of completion of required training may result in inappropriate staff response and interventions when providing services to clients.	Augusta Johnson City Marietta Charleston Bay County Savannah

Consultation, Supervision, and Training Recommendations

Recommendation 2

District leaders and the Marietta and Charleston Vet Center Directors determine reasons for noncompliance, ensure a process is implemented for completing and tracking four hours of external clinical consultation per month, and monitor compliance.

Recommendation 3

District leaders and the Augusta, Johnson City, Marietta, Charleston, Bay County and Savannah Vet Center Directors determine reasons for noncompliance, develop processes to ensure all staff complete mandatory trainings, and monitor compliance.

Outreach Results

For details on review topic requirements and methodology see [Outreach](#).

Requirement	Impact	Noncompliant Vet Center(s)
4. Vet center has a written outreach plan	The absence of an outreach plan may lead to a lack of focus on engagement of eligible clients, decreased visibility and utilization of vet centers, and a less robust referral network.	Charleston
5. Outreach plan includes required strategic components	The absence of strategic outreach plan components may lead to missed opportunities to target outreach services accurately and establish personal relationships with relevant providers.	Augusta Johnson City Marietta Bay County Savannah
6. Outreach activities are tailored to cultural orientations	Failure to tailor outreach activities may lead to decreased outcomes and quality of care and contribute to sustained health disparities,	Augusta Johnson City Savannah

Requirement	Impact	Noncompliant Vet Center(s)
identified in the outreach plan	specifically related to race and ethnicity.	

Outreach Recommendations

Recommendation 4

District leaders and the Charleston Vet Center Director determine reasons for noncompliance and ensure outreach plans are completed.

Recommendation 5

District leaders and the Augusta, Johnson City, Marietta, Bay County, and Savannah Vet Center Directors determine reasons for noncompliance and ensure outreach plans include all required strategic components.

Recommendation 6

District leaders and the Augusta, Johnson City, and Savannah Vet Center Directors determine reasons for noncompliance, ensure outreach activities are tailored to the cultural demographics of the vet center’s veteran service area, and monitor compliance.

Environment of Care Results

For details on review topic requirements and methodology see [Environment of Care](#).

Requirement	Impact	Noncompliant Vet Center(s)
7. Risk and vulnerability assessment updated annually	Lack of current risk and vulnerability assessment may cause staff to be uninformed and/or unprepared for emergencies.	Augusta
8. Fire extinguishers serviced annually	Failure to complete annual servicing of fire extinguishers could impact reliability and effectiveness in an emergency.	Augusta
9. Fire extinguishers inspected monthly	Failure to complete monthly inspections of portable fire extinguishers could impact reliability and effectiveness in an emergency.	Augusta Johnson City Charleston Bay County

Requirement	Impact	Noncompliant Vet Center(s)
10. AED located on-site	Lack of AED on-site could prevent the ability to provide life saving measures in the event of a medical emergency.	Augusta
11. AED inspected monthly	Failure to complete monthly inspections of AED could impact reliability and effectiveness in an emergency.	Charleston
12. Current emergency and crisis plan that includes required components	Lack of current and comprehensive emergency and crisis plan may cause staff to be unsafe and unprepared in the event of an emergency.	Charleston Bay County
13. Desktop reference sheet outlining steps for ancillary staff to follow in the event of a suicidal or homicidal client	Failure to have desktop reference available for each staff member may leave the staff less equipped to manage a client in crisis.	Charleston

Environment of Care Recommendations

Recommendation 7

District leaders and the Augusta Vet Center Director determine reasons for noncompliance, ensure the risk and vulnerability assessment is completed by VA police or local law enforcement, and monitor compliance.

Recommendation 8

District leaders and the Augusta Vet Center Director determine reasons for noncompliance, ensure fire extinguishers are serviced annually, and monitor compliance.

Recommendation 9

District leaders and the Augusta, Johnson City, Charleston and Bay County Vet Center Directors determine reasons for noncompliance, ensure fire extinguishers are inspected monthly, and monitor compliance.

Recommendation 10

The District Director and zone leaders, in conjunction with the Augusta Vet Center Director, determine reasons for noncompliance and ensure vet center obtains an automated external defibrillator.

Recommendation 11

District leaders and the Charleston Vet Center Director determine reasons for noncompliance, ensure automated external defibrillators are inspected monthly, and monitors compliance.

Recommendation 12

District leaders and the Charleston and Bay County Vet Center Directors determine reasons for noncompliance, ensure completion of a current and comprehensive emergency and crisis plan, and monitor compliance.

Recommendation 13

District leaders and the Charleston Vet Center Director determine reasons for noncompliance and ensures ancillary staff have a desktop reference sheet to address mental health crisis situations.

Appendix A: District 2 Zone 1 Profiles

Table A.1. FY22 Vet Center Profiles

Profile	Augusta Vet Center	Johnson City Vet Center	Marietta Vet Center	Charleston Vet Center	Bay County Vet Center	Savannah Vet Center
Budget	\$525,234.31	\$714,981.66	\$546,857.96	\$699,317.98	\$547,453.87	\$539,313.51
Total Unique Clients	462	376	635	551	381	712
New Clients	230	86	241	157	165	188
Active-Duty Clients	34	27	28	22	37	59
Bereavement Clients	19	60	51	21	37	25
Family Clients	33	52	45	63	71	36
Total Number of Positions						
Authorized Full-time Positions	6	7	7	7	6	8
Filled Positions	5	6	6	7	6	6
Vacancies	1	1	1	0	0	2

Source: RCS District 2 demographic and position data.

Appendix B: RCS Chief Readjustment Counseling Officer Memorandum

Department of Veterans Affairs Memorandum

Date: February 9, 2024

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

Subj: Inspection of Select Vet Centers in Southeast District 2 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, *Inspection of Select Vet Centers in Southeast District 2 Zone 1*. I have reviewed the recommendations and submit action plans to address all findings in the report.

(Original signed by:)

Michael Fisher
Chief Officer, Readjustment Counseling Service

Appendix C: RCS Southeast District 2 Director Memorandum

Department of Veterans Affairs Memorandum

Date: February 2, 2024

From: Joseph Dudley, Southeast District 2 (RCS2)

Subj: Vet Center Inspection of Select Vet Centers in Southeast District 2 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 2 Zone 1.
2. I reviewed the draft report and request closure of all recommendations. District leaders and Vet Center Directors took immediate action to resolve all concerns presented during the District 2 Zone 1 inspection. Specific actions taken are in the attachments including evidence of compliance over at least a ninety-day period. District leaders also made it a point of emphasis to confirm and validate compliance during annual clinical and administrative site visits.
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 Dudley
District Director

District Director Response

Recommendation 1

District leaders and the Marietta, Bay County, and Savannah Vet Center Directors collaborate with the support VA medical facility clinical liaison to determine the reasons for noncompliance, take action as indicated, and monitor to ensure compliance with staff participation on the mental health executive council.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

Vet Center Directors (VCD) were not consistently documenting participation in the Mental Health Executive Council (MHEC) meetings. District 2 Zone 1 management provided instruction to VCDs and developed a comprehensive checklist of quality assurance requirements including regular participation in MHEC meetings. This checklist is sent automatically each month as a reminder to attend MHEC meetings. The requirement to attend the MHEC meeting is also reviewed during bi-monthly VCD meetings conducted by District 2 Zone 1 management. The VCDs track compliance locally and the district confirms compliance during the annual clinical site visit. These Vet Centers coordinated with their support VA medical centers and are all now regularly attending the MHEC.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 2

District leaders and the Marietta and Charleston Vet Center Directors determine reasons for noncompliance, ensure a process is implemented for completing and tracking four hours of external clinical consultation per month, and monitor compliance.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The VCDs were not consistently completing and monitoring compliance for the four hours of monthly external consultation at these two Vet Centers. District 2 Zone 1 management provided instruction to VCDs and developed a comprehensive checklist of quality assurance requirements including completing and tracking four hours of external clinical consultation. This checklist is sent automatically each month as a reminder to complete external consultation as required. This requirement is also reviewed during bi-monthly VCD meetings conducted by District 2 Zone 1 management. The VCDs track compliance locally and the district confirms compliance during the annual clinical site visit. these Vet Centers have been consistently completing four hours of external clinical consultation since October 2023.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 3

District leaders and the Augusta, Johnson City, Marietta, Charleston, Bay County, and Savannah Vet Center Directors determine reasons for noncompliance, develop processes to ensure all staff complete mandatory trainings, and monitor compliance.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

In Fiscal Year (FY) 2022, these Vet Centers did not meet full compliance for mandatory staff trainings. District management provided instruction to VCDs to ensure completion of mandatory trainings. Vet Center staff training is documented in the Talent Management System (TMS) and tracked locally by Vet Center Directors. Compliance is confirmed by the district during the annual administrative site visit. All staff are compliant with mandatory training.

OIG Comments

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

Recommendation 4

District leaders and the Charleston Vet Center Director determine reasons for noncompliance and ensure outreach plans are completed.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The Charleston Vet Center did not complete a FY 2022 outreach plan. The FY 2023 outreach plan was created by the Vet Center and verified by the district during the annual clinical site visit. District management also confirmed the Vet Center has an outreach plan for FY 2024 and will continue to monitor compliance moving forward.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 5

District leaders and the Augusta, Johnson City, Marietta, Bay County, and Savannah Vet Center Directors determine reasons for noncompliance and ensure outreach plans include all required strategic components.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The FY 2022 outreach plans at these locations did not include all required strategic components. District 2 Zone 1 management provided instruction for creating an outreach plan that includes all strategic components listed in VHA Directive 1500(4) Appendix B. The VCDs track compliance locally and the district confirms compliance during the annual clinical site visit. These Vet Centers all have a current outreach plan that includes all required strategic components.

OIG Comments

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

Recommendation 6

District leaders and the Augusta, Johnson City, and Savannah Vet Center Directors determine reasons for noncompliance, ensure outreach activities are tailored to the cultural demographics of the vet center's veteran service area, and monitor compliance.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The FY 2022 outreach plans at these locations did not include activities tailored to the cultural demographics of the Vet Center's Veteran service area. District 2 Zone 1 management provided instruction for creating an outreach plan that includes outreach activities are tailored to the cultural demographics of the local area. The VCDs track compliance locally and the district confirms compliance during the annual clinical site visit. These Vet Centers all have a current outreach plan that includes activities tailored to the local cultural demographics.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 7

District leaders and the Augusta Vet Center Director determine reasons for noncompliance, ensure the risk and vulnerability assessment is completed by VA police or local law enforcement, and monitor compliance.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The Augusta Vet Center did not have a risk and vulnerability assessment in FY 2022. The new VCD received guidance and instruction from district management and the risk and vulnerability assessment was completed on December 12, 2023. The VCD will track compliance locally and the district will confirm compliance during the annual administrative site visit.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 8

District leaders and the Augusta Vet Center Director determine reasons for noncompliance, ensure fire extinguishers are serviced annually and monitor compliance.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The fire extinguishers in the Augusta Vet Center did not receive the required annual service in FY 2022. The new VCD received guidance and instruction from district management and the fire extinguishers were serviced in FY 2023 (May 2023). The VCD tracks compliance locally and the district confirmed compliance during the annual administrative site visit.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 9

District leaders and the Augusta, Johnson City, Charleston, and Bay County Vet Center Directors determine reasons for noncompliance, ensure fire extinguishers are inspected monthly, and monitor compliance.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The VCDs were not consistently inspecting fire extinguishers monthly. District 2 Zone 1 management provided instruction to VCDs and developed a monitoring log for monthly fire extinguisher inspections. An automatic reminder is sent each month to complete fire extinguisher inspections. The VCD or designated staff member completes the monthly fire extinguisher inspection and tracks to ensure compliance. The district verifies monthly monitoring during the

annual administrative site visit. These Vet Centers are now consistently completing monthly inspection of fire extinguishers.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 10

The District Director and zone leaders, in conjunction with the Augusta Vet Center Director, determine reasons for noncompliance and ensure vet center obtains an automated external defibrillator.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The Augusta Vet Center did not have an automated external defibrillator (AED) during the Vet Center Inspection Program visit in October 2022. The Vet Center received an AED on November 17, 2022. The VCD confirmed installation of the AED and the district confirmed the AED is in the Vet Center during the annual administrative site visit.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 11

District leaders and the Charleston Vet Center Director determine reasons for noncompliance, ensure automated external defibrillators are inspected monthly, and monitors compliance.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The Charleston Vet Center was not in compliance with monthly inspection and monitoring of the AED. District 2 Zone 1 management provided instruction to the VCD and developed a monitoring log for monthly AED inspections. An automatic reminder is sent each month to

complete AED inspections. The VCD or designated staff member completes the monthly AED inspection and tracks to ensure compliance. The district verifies monthly monitoring during the annual administrative site visit. the Charleston Vet Center has consistently completed monthly inspection of the AED.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 12

District leaders and the Charleston and Bay County Vet Center Directors determine reasons for noncompliance, ensure completion of a current and comprehensive emergency and crisis plan, and monitor compliance.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The VCD at Charleston and Bay County Vet Centers did not maintain a current and comprehensive emergency and crisis plan. These Vet Centers updated their emergency and crisis plan for FY 2023 and again for FY 2024. The VCDs track compliance locally and the district confirmed compliance during the annual clinical and administrative site visits.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 13

District leaders and the Charleston Vet Center Director determine reasons for noncompliance, and ensures ancillary staff have a desktop reference sheet to address mental health crisis situations.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The Charleston Vet Center was not in compliance with ensuring all ancillary staff had a crisis desktop reference sheet at their worksite. In October 2022, the VCD corrected this and made sure that all staff have the desktop reference sheet. The VCD monitors ongoing compliance locally and the district confirmed compliance during the annual clinical and administrative site visits.

OIG Comments

The OIG considers this recommendation closed.

OIG Contact and Staff Acknowledgments

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