US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Inspection of Select Vet Centers in Midwest District 3 Zone 2

Vet Center Inspection	**24-00394-122**	**May 27, 2025**

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Report Overview

The purpose of the VA Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) is to provide a focused evaluation of the quality of care delivered at vet centers. Vet centers are community-based facilities that provide a wide range of psychosocial services to clients, including eligible veterans, to support a successful transition from military to civilian life.[1]

VCIP inspections are one element of the OIG's oversight to ensure the nation's veterans receive high-quality and timely mental health care and VA services. The inspections evaluate key clinical and administrative processes associated with promoting quality care and service delivery at vet centers.[2]

For this inspection, the OIG randomly selected four vet centers throughout Midwest District 3 zone 2: Evanston, Illinois; Gary Area, Indiana; and La Crosse and Milwaukee, Wisconsin.[3]

The inspection included 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 findings should help vet centers identify areas of vulnerability or conditions that, if addressed, could improve safety, accessibility, and quality of care.

[1] To be consistent with Readjustment Counseling Service (RCS) policy and terminology, the OIG refers to veterans receiving readjustment services as *clients* in this report.

[2] VHA Directive 1500(3), *Readjustment Counseling Service*, January 26, 2021, amended June 5, 2023, was in effect during part of the OIG's inspection period. It was replaced by VHA Directive 1500(4), *Readjustment Counseling Service*, January 26, 2021, amended November 21, 2023. This directive was replaced by VHA Directive 1500(5), *Readjustment Counseling Service*, January 26, 2021, amended March 3, 2025. Unless otherwise specified, the requirements in the directives contain the same or similar language. Vet centers provide counseling for readjustment concerns related to specific types of military deployment stressors. "Readjustment counseling services are designed by law to be provided without a medical diagnosis." Therefore, individuals receiving readjustment services are not considered patients.

[3] RCS is divided into five districts. Each district consists of two to four zones. Each zone consists of 18 to 26 vet centers.

Review Topics and Inspection Results

Suicide Prevention

The OIG found three of four vet center directors (VCDs) did not ensure the attendance of a licensed staff member at the support VA medical facility's mental health executive council meetings as required.[4] The OIG was unable to conduct the High Risk Suicide Flag (HRSF) SharePoint site review due to concerns with data accuracy as a result of duplication, inaccuracies, or missing data values.[5]

The OIG issued one recommendation specific to suicide prevention activities to three of the four vet centers. In April 2024, the OIG made a recommendation to the Readjustment Counseling Service (RCS) Chief Officer related to HRSF SharePoint site functionality. At the time of this inspection, the recommendation was open; therefore, the OIG did not issue a new recommendation. On May 22, 2025, the recommendation was closed.[6]

Consultation, Supervision, and Training

The OIG found all four vet centers had an assigned clinical liaison and independently licensed mental health external clinical consultant from the support VA medical facility. Although external clinical consultation for clinically complex cases occurred at all four vet centers, none of the four VCDs ensured completion of at least four hours of consultation per month.[7] One VCD

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[4] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015, required VA medical facilities to establish a mental health executive council that supports strategies, communication, and policies to improve mental health care and suicide prevention. Handbook 1160.01 was replaced with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service,* April 27, 2023, which maintains the mental health executive council requirement; however, the purpose was updated to focus on ensuring "the delivery of high-quality Veteran mental health care that is evidence-based and responsive to Veterans' preferences"; VHA Directive 1500(4). RCS requires a licensed vet center staff member to participate on all support VA medical facility mental health executive council meetings to assist with care coordination and collaboration for clients. Each vet center aligns with a VA medical facility to ensure access to clinical services and coordination of care for shared clients.

[5] On May 11, 2020, RCS implemented an HRSF SharePoint site containing names of RCS clients who also receive services at a VA medical facility and have a high risk for suicide flag; Chief Officer, Readjustment Counseling Service, "High Risk Suicide Flag Outreach," memorandum to all Vet Center staff, April 27, 2020. RCS staff confirmed as of June 2021, the SharePoint site was expanded to include Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) data. VA's REACH VET is a predictive analytics program developed to determine veterans who have a higher risk for suicide. In early 2023, the OIG identified problems with the HRSF SharePoint data that made it difficult to determine if follow-up of clients was being conducted as required. RCS leaders were notified of the data inaccuracies; The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[6] VA OIG, *Inspection of Southeast District 2 Vet Center Operations*, Report No. 22-03941-144, April 18, 2024. The OIG continued to monitor RCS's progress on the HRSF SharePoint site functionality recommendation until closure.

[7] VHA Directive 1500(4).

did not complete a monthly review of 10 percent of each counselor's client records.[8] Additionally, staff at three of four vet centers did not complete select required trainings related to suicide prevention and basic life support.[9]

The OIG issued three recommendations to applicable vet centers specific to consultation, supervision, and training.

Outreach

The OIG found all four vet centers had outreach plans. The OIG did not evaluate if outreach activities were tailored to eligible populations in the veterans service area in one of the four outreach plans because this component was not included in the plan. Three of four plans lacked one or more required strategic components.[10]

The OIG issued one recommendation to applicable vet centers specific to outreach.

Environment of Care

The OIG found the three inspected vet centers complied with the following requirements: fire or safety inspections, risk and vulnerability assessments completed annually by VA police or local law enforcement, fire extinguishers inspected monthly and serviced annually, an automated external defibrillator (AED) on-site and annual servicing by VA medical center biomedical

[8] VHA Directive 1500(4).

[9] 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; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer(CMO), "Lethal Means Safety (LMS) Education and Counseling," memorandum to Veterans Integrated Services Network (VISN) Directors (10N1-23), Medical Center Directors (00), VISN CMOs (10N1-23), VISN Chief Mental Health Officers (10N1-23), Readjustment Counseling Services (RCS) District Directors, RCS Deputy District Directors VISN CMOs (10N1-23), March 17, 2022; VHA Directive 1115.01(1), *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017, amended May 8, 2020; VHA Directive 1177, *Cardiopulmonary Resuscitation,* January 4, 2021.

[10] VHA Directive 1500(4). Required strategic components include: a strategic map of the vet center veteran service area identifying eligible population concentrations; background information of the local eligible communities; personal points of contact for non-VA medical facility community service providers; strategic VA medical facility partners including clinical and administrative liaisons, the external clinical consultant, the suicide prevention coordinator; and the facility contact for the prevention and management of disruptive behavior coordinator. RCS requires outreach activities must be tailored to the needs of eligible individuals.

engineering, a building evacuation plan posted in a communal area, and an emergency and crisis plan with required components.[11]

One of the three reviewed vet centers did not have monthly AED extinguisher inspections.[12]

The OIG issued one recommendation to the applicable vet center specific to environment of care.

Additional Findings

The OIG found district leaders and Milwaukee VCDs did not implement adequate notification, oversight, and planning processes when closing and temporarily relocating the Milwaukee Vet Center after the identification of mold concerns in the building.[13]

The OIG issued two recommendations, one to the RCS Chief Officer and one to district leaders, specific to the Milwaukee Vet Center closure and temporary relocation.

Conclusion

The OIG conducted a focused inspection in four review areas and made seven recommendations to the District Director and applicable VCDs and one recommendation to the RCS Chief Officer. The number of recommendations should not be used as a gauge for the overall quality of care provided within the zone. These recommendations are intended to be used as a road map to help improve operations and clinical care. The recommendations address systems issues and site-specific findings that may compromise quality care.

[11] RCS, *Administrative Site Visit (ASV) Protocol*. 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 AED available for staff, both requiring annual servicing and monthly inspections to ensure proper functioning. RCS requires vet centers to have a current emergency and crisis plan that includes contingencies for the following: 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. The OIG was unable to evaluate environment of care requirements at the Milwaukee Vet Center due to the temporary relocation of the vet center to the Clement J. Zablocki VA Medical Center.

[12] RCS, *ASV Protocol.*

[13] For this inspection, the OIG review period was from October 1, 2023, through September 30, 2024, unless otherwise noted. During this time, the former Milwaukee VCD served in the position from October 1, 2023, through April 16, 2024. The current Milwaukee VCD assumed the role on June 17, 2024. According to a district staff member, two acting VCDs were appointed from April 18, through June 16, 2024.

VA Comments and OIG Response

The 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 all recommendations open and will follow up on the planned actions until they are completed.

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

Contents

Abbreviations

AED	automated external defibrillator
BLS	basic life support
HRSF	high risk suicide flag
OIG	Office of Inspector General
RCS	Readjustment Counseling Service
VCCC	Vet Center Call Center
VCD	Vet Center Director
VCIP	Vet Center Inspection Program
VHA	Veterans Health Administration

Introduction

The purpose of the VA Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) is to conduct 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.

RCS is an autonomous organizational element in the Veterans Health Administration (VHA) with authority for and oversight of vet centers and the provision 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.[2]

Scope and Methodology

The OIG randomly selected district 3 and the following four vet centers in zone 2 for review: Evanston, Illinois; Gary Area, Indiana; and La Crosse and Milwaukee, Wisconsin (see figure 1).[3]

[1] VHA Directive 1500(3), *Readjustment Counseling Service*, January 26, 2021, amended June 5, 2023, was in effect during part of the OIG's inspection period. It was replaced by VHA Directive 1500(4), *Readjustment Counseling Service*, January 26, 2021, amended November 21, 2023. This directive was replaced by VHA Directive 1500(5), *Readjustment Counseling Service*, January 26, 2021, amended March 3, 2025. Unless otherwise specified, the requirements in the directives contain the same or similar language. Vet centers provide counseling for readjustment concerns related to specific types of military deployment stressors. "Readjustment counseling services are designed by law to be provided without a medical diagnosis." Therefore, individuals receiving readjustment services are not considered patients. To be consistent with Readjustment Counseling Service (RCS) policy and terminology, the OIG refers to veterans receiving readjustment services as clients in this report.

[2] VHA Directive 1500(4). Vet center counselors provide readjustment counseling to assist clients with psychological and psychosocial readjustment.

[3] RCS is divided into five districts. Each district consists of two to four zones. Each zone consists of 18 to 26 vet centers.

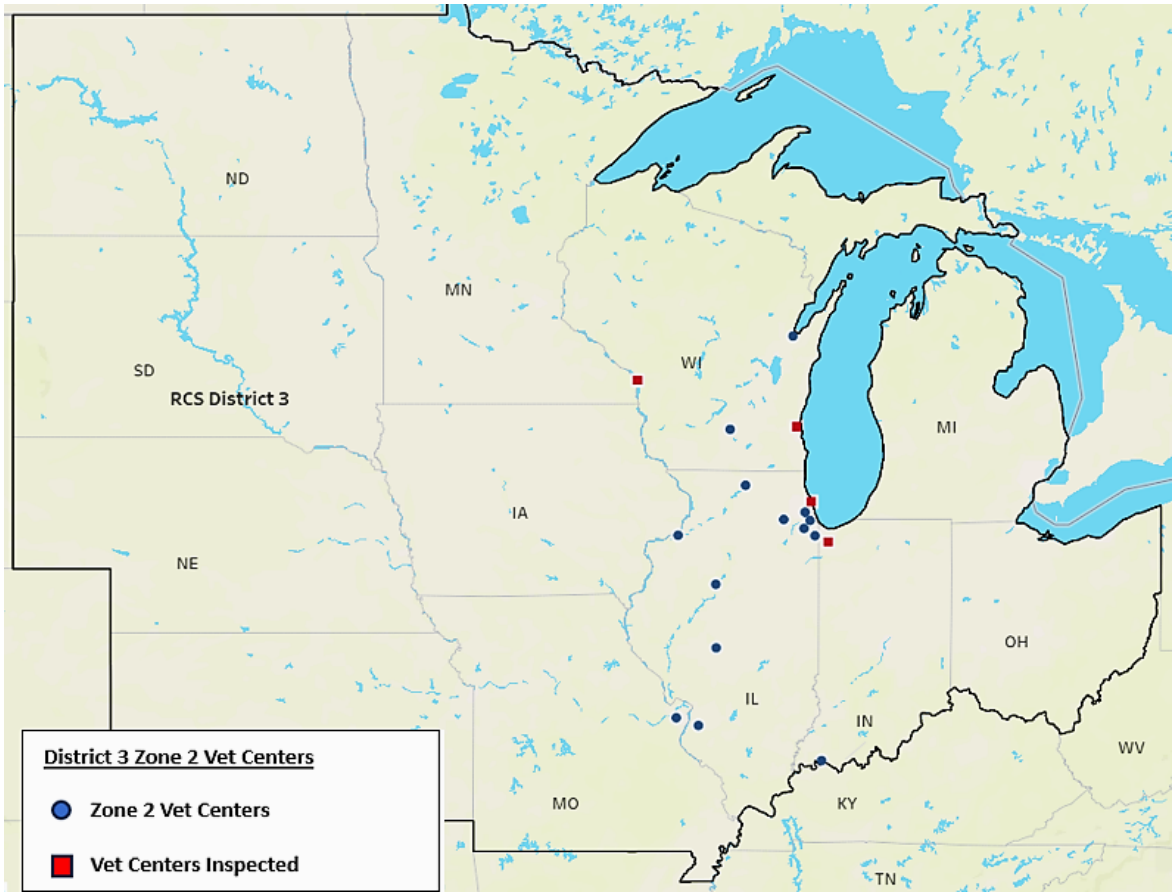

Figure 1. *Map of Midwest District 3 zone 2 vet centers, including sites visited by the OIG. Source: OIG using RCS vet center data.*

The OIG review included vet center operations from October 1, 2023, through September 30, 2024, in the following categories:[4]

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

The OIG announced the inspection to district leaders on October 21, 2024, and conducted subsequent on-site and virtual visits from October 22, 2024, through November 14, 2024.[5] The OIG notified each selected vet center director (VCD) one day prior to the vet center site visit.

[4] The OIG review period was from October 1, 2023, through September 30, 2024, (fiscal year 2024) unless otherwise noted.

[5] 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.

During the site visits, the inspection team interviewed VCDs and key staff and reviewed RCS practices and policies.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

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

The OIG conducted 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.

Overall Findings

The OIG reviewed VHA and RCS requirements and below are the inspection findings for the four selected vet centers. For additional details related to specific site findings, select the vet center in the respective review table.

Suicide Prevention

Early identification of clients at high risk for suicide allows for the provision of enhanced services and may prevent ongoing suicidality.[6] In an effort to reduce client risk for suicide and enhance care, each vet center aligns with a support VA medical facility.[7] VHA and RCS staff members participate in the support VA medical facility's mental health executive council meetings to coordinate the care of shared clients.[8]

[6] VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide,* November 1, 2020.

[7] VHA Directive 1500(4). Each vet center aligns with a support VA medical facility to ensure access to clinical services and coordination of care for shared clients.

[8] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008, amended November 16, 2015, required VA medical facilities to establish a mental health executive council that supports strategies, communication, and policies to improve mental health care and suicide prevention. Handbook 1160.01 was replaced with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service,* April 27, 2023, which maintains the mental health executive council requirement; however, the purpose was updated to focus on ensuring "the delivery of high-quality Veteran mental health care that is evidence-based and responsive to Veterans' preferences"; VHA Directive 1500(4). RCS requires a licensed vet center staff member participate on all support VA medical facility mental health executive council meetings to assist with care coordination and collaboration for clients.

The High Risk Suicide Flag (HRSF) SharePoint site is part of an RCS national process intended to increase communication and coordination with VHA to ensure identification of clients at risk for suicide and provide resources that may reduce client risk.[9]

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

> The Readjustment Counseling Service Chief Officer ensures the HRSF SharePoint site functions as intended and includes accurate data.[10]

Despite continued communication with RCS, data concerns persisted because of duplication, inaccuracies, or missing data; therefore, the OIG was unable to evaluate the HRSF SharePoint site dispositions in this review. As of January 8, 2025, the OIG continued to find discrepancies in HRSF data.

Table 1. Suicide Prevention Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	**Evanston Vet Center**	**Gary Area Vet Center**	**La Crosse Vet Center**	**Milwaukee Vet Center**
A licensed vet center staff member participates in all support VA medical facility mental health executive council meetings.*	✗	✓	✗	✗
VCD ensures client contacts and outcomes are documented in the electronic record and the HRSF SharePoint site within five business days.	NA‡	NA‡	NA‡	NA‡

Sources: VHA Directive 1500(4); OIG analysis of vet center data.
**The OIG reviewed mental health executive council meeting documentation and interviewed staff to evaluate if required vet center staff participated in the meeting.*
‡The OIG did not review the HRSF SharePoint site due to concerns with data accuracy.

In the identified area, the VCDs reported the following explanations for noncompliance.

- *Mental health executive council participation*: The acting Evanston VCD reported being informed the previous VCD would continue to attend quarterly mental health council

[9] On May 11, 2020, RCS implemented an HRSF SharePoint site containing names of RCS clients who also receive services at a VA medical facility and have a high risk for suicide flag; Chief Officer, Readjustment Counseling Service, "High Risk Suicide Flag Outreach," memorandum to all Vet Center staff, April 27, 2020. RCS staff confirmed as of June 2021, the SharePoint site was expanded to include Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) data. VA's REACH VET is a predictive analytics program developed to determine veterans who have a higher risk for suicide; The underlined terms are hyperlinks to additional information. To return from the linked information, press and hold the "alt" and "left arrow" keys together.

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

meetings after being reassigned to another location.[11] The Evanston, La Crosse, and former Milwaukee VCDs reported being aware meetings were missed for varying reasons but did not arrange for someone else to attend.[12]

At the time of the inspection, the HRSF SharePoint site functionality recommendation directed to the RCS Chief Officer remained open; therefore, the OIG did not issue a new recommendation. On May 22, 2025, the recommendation was closed.[13]

The OIG made one recommendation related to suicide prevention.

Suicide Prevention Recommendation

Recommendation 1

District leaders and the Evanston, La Crosse, and Milwaukee Vet Center Directors collaborate with the support VA medical facility to determine reasons for noncompliance with staff participation on the mental health executive council, take action as indicated, and monitor compliance.

Consultation, Supervision, and Training

Consultation with an independently licensed mental health external clinical consultant increases client access to VA health care and supports vet center counselors with clinically complex or high-risk cases. Supervision provides opportunities for ongoing feedback regarding counselor documentation, case planning, and compliance with RCS guidance and procedures.[14] Mandatory training completion supports a competent and skilled staff to provide services to clients.[15]

Reviewed trainings included

- Nonclinical staff

[11] The Aurora VCD reported being appointed as the acting Evanston VCD in February 2023, and was serving in that capacity throughout the OIG inspection. For this report, the acting Evanston VCD will be referred to as the Evanston VCD.

[12] The general OIG inspection review period was from October 1, 2023, through September 30, 2024. During this time, the former Milwaukee VCD was in the position from October 1, 2023, through April 16, 2024. The current Milwaukee VCD assumed the role on June 17, 2024. According to a district staff member, the Milwaukee Vet Center had two acting VCDs from April 18, through June 16, 2024, who did not participate in inspection interviews. For this report, the former Milwaukee VCD will be referred to as such and the current Milwaukee VCD will be referred to as the Milwaukee VCD.

[13] VA OIG, *Inspection of Southeast District 2 Vet Center Operations*.

[14] VHA Directive 1500(4).

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

- Initial or annual S.A.V.E. training[16]

- Clinical Staff
  - Initial or annual suicide risk management training[17]
  - One-time lethal means safety education and counseling[18]
  - One-time military sexual trauma training[19]

- All staff
  - Biannual basic life support (BLS) certification[20]

[16] 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 VHA's acronym for remembering steps involved in suicide prevention: **signs** of suicide, **ask** about suicide, **validate** feelings and **encourage** seeking help and **expedited** treatment. Vet center nonclinical staff include a veterans outreach program specialist and program support assistant or office manager.

[17] VA Secretary, "Agency-Wide Required Suicide Prevention Training," memorandum; Skills training for evaluation and management of suicide completion 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; VHA Directive 1071.

[18] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO), "Lethal Means Safety (LMS) Education and Counseling," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23), Medical Center Directors (00), VISN CMOs (10N1-23), VISN Chief Mental Health Officers (10N1-23), Readjustment Counseling Services (RCS) District Directors, RCS Deputy District Directors VISN CMOs (10N1-23), March 17, 2022. Lethal Means Safety 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.

[19] 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. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1115.01, *Military Sexual Trauma Mandatory Training Requirements*, July 15, 2024. The two directives contain the same or similar requirements for training. Military sexual trauma training completion is required within 90 days of entering the position for clinical providers or "a provider must have completed the assigned training program (or passed the test-out, if applicable) in TMS [Talent Management System], or have time remaining until the assignment due date."

[20] VHA Directive 1177, *Cardiopulmonary Resuscitation,* January 4, 2021. Any VA healthcare provider actively participating in direct patient care must maintain BLS training. The OIG was informed by an RCS leader that all RCS staff are required to complete BLS training biannually.

Table 2. Consultation, Supervision, and Training Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	Evanston Vet Center	Gary Area Vet Center	La Crosse Vet Center	Milwaukee Vet Center
Consultation: Assignment of a clinical liaison.	✓	✓	✓	✓
Consultation: Assignment of an independently licensed mental health external clinical consultant.	✓	✓	✓	✓
Consultation: Completion of four hours of monthly external clinical consultation for clinically complex cases.	✗	✗	✗	✗
Supervision: VCD monthly review of 10 percent of active client records for each counselor's caseload.	✓	✗	✓	✓
Training: Staff completion of select trainings in the required time frame.*	✓	✗	✗	✗

Sources: VHA Directive 1500(4); VHA Directive 1115.01(1); VHA Memorandum, "Lethal Means Safety (LMS) Education and Counseling"; VA Memorandum, "Agency-Wide Required Suicide Prevention Training"; VHA Directive 1071; OIG analysis of vet center results.

**The OIG reviewed training records or BLS card copies and had findings with recommendations if one or more training elements were not completed within the required time frame. The OIG evaluated BLS training for all staff and evaluated annual training requirements for staff who had been employed prior to July 1, 2024. The OIG evaluated timeliness for completion of initial trainings for staff hired from October 1, 2023, through June 30, 2024.*

The OIG found all four vet centers had an assigned clinical liaison and independently licensed mental health external clinical consultant.

In identified areas, the VCDs reported the following explanations for noncompliance.

- *Completion of required four hours of monthly external clinical consultation:* The Evanston VCD was aware of the requirement, but due to the competing priorities of managing two vet centers, did not develop a backup plan when consultation was canceled to ensure four hours were completed monthly. Although the Gary Area VCD had monthly external consultation, a document formatting change deleted meeting duration times; therefore, the OIG could not validate four hours of consultation. The La Crosse VCD was unaware that canceled external clinical consultation meetings needed to be rescheduled, and therefore did not meet the required four hours. The former Milwaukee VCD was aware of the requirement but did not track meeting hours.

- *Completion of monthly 10 percent record review*: The Gary Area VCD completed monthly record reviews for each staff member but did not complete 10 percent for one staff member for one month due to a miscalculation.
- *Completion of select staff trainings:* The Gary Area VCD only monitored trainings assigned to staff in the training application. Missing trainings were not assigned in the training application; therefore, the Gary Area VCD did not receive notifications and was unaware trainings were not completed. The La Crosse VCD also indicated missed trainings were not assigned to staff in the training application but was not aware of completion time frame requirements for one training. The Milwaukee VCD acknowledged responsibility for training oversight but was unaware of which trainings were mandatory, relying solely on notifications for past due trainings from the training application.

The OIG made three recommendations related to consultation, supervision, and training.

Consultation, Supervision, and Training Recommendations

Recommendation 2

District leaders and the Evanston, Gary Area, La Crosse, and Milwaukee Vet Center Directors determine reasons for noncompliance with completing four hours of external clinical consultation for clinically complex cases per month, ensure a process is implemented, and monitor compliance.

Recommendation 3

District leaders and the Gary Area Vet Center Director determine reasons for noncompliance with the Vet Center Director review of 10 percent of active client records monthly for each counselor's caseload, ensure completion, and monitor compliance.

Recommendation 4

District leaders and the Gary Area, La Crosse, and Milwaukee Vet Center Directors determine reasons for noncompliance with employees completing select trainings in the required time frame, ensure completion, and monitor compliance.

Outreach

An annual written outreach plan identifies events to engage eligible clients and their families and promote relationships with community partners and stakeholders.[21]

[21] VHA Directive 1500(4).

Table 3. Outreach Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	Evanston Vet Center	Gary Area Vet Center	La Crosse Vet Center	Milwaukee Vet Center
Presence of a written current outreach plan.	✓	✓	✓	✓
Inclusion of required outreach plan strategic components.*	✗	✗	✓	✗
Outreach activities tailored to eligible individuals.	✓	NA‡	✓	✓

Sources: VHA Directive 1500(4); OIG analysis of vet center results.
**The OIG reviewed outreach plan requirements, including a strategic map of the vet center service area that identifies eligible population concentrations, strategic coordination with mobile vet center operations, personal points of contact for non-VA service providers, and identification of all strategic VA medical facility partners.*
‡NA indicates the OIG did not evaluate if outreach activities were tailored to eligible individuals in the veterans service area because the component was not included in the plan.

The OIG found three of the four vet centers had an outreach plan with tailored outreach activities.

In identified areas, the VCDs reported the following explanations for noncompliance.

- *Inclusion of required strategic components:* The Evanston and Gary Area VCDs were unaware of all the required components for the outreach plan. The Milwaukee VCD was aware of the requirement but was not aware of what strategic partners meant.

The OIG made one recommendation related to outreach.

Outreach Recommendation

Recommendation 5

District leaders and the Evanston, Gary Area, and Milwaukee Vet Center Directors determine reasons for noncompliance with completion of an outreach plan with all required strategic components, ensure completion, and monitor compliance.

Environment of Care

Safety in the physical environment is essential for promoting effective therapeutic work and requires adherence to general safety and emergency preparedness standards.[22]

Table 4. Environment of Care Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	Evanston Vet Center	Gary Area Vet Center	La Crosse Vet Center	Milwaukee Vet Center
Fire or safety inspection completed annually.	✓	✓	✓	NA‡
Risk and vulnerability assessment completed annually by VA police or local law enforcement.	✓	✓	✓	NA‡
Fire extinguishers inspected monthly.	✓	✓	✓	NA‡
Fire extinguishers serviced annually.	✓	✓	✓	NA‡
Automated external defibrillator (AED) located on-site.	✓	✓	✓	NA‡
AED inspected monthly.	✓	✓	✗	NA‡

[22] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021; VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023. Unless otherwise specified, the requirements in the June 2021 directive contain the same or similar language as the amended September 2023 document. The OIG evaluated compliance of monthly inspections for fire extinguishers and AEDs by reviewing inspection documentation for the three months prior to district notification. The OIG evaluated the presence of an AED and a building evacuation plan during on-site inspections.

✓ Compliant ✗ Noncompliant **RCS Requirement**	Evanston Vet Center	Gary Area Vet Center	La Crosse Vet Center	Milwaukee Vet Center
AED serviced annually by VA medical center biomedical engineering.	✓	✓	✓	NA‡
Building evacuation plan posted in communal area for staff and visitors to reference.	✓	✓	✓	NA‡
Emergency and crisis plan with required components.*	✓	✓	✓	NA‡

Sources: RCS, Administrative Site Visit Protocol; OIG analysis of vet center results.
**The OIG evaluated if the plan had been reviewed or updated within two years of the inspection date. The emergency and crisis plan includes contingencies for phone and computer disruptions; a weather or natural disaster emergency plan; a site, facility, or building temporary relocation and emergency plan; a management of disruptive behavior plan; a violence in the workplace plan (including an active shooter plan); and handling of suspicious mail and bomb threats.*
‡The Milwaukee Vet Center is temporarily located in the domiciliary building at the Clement J. Zablocki VA Medical Center after mold was identified and the lease at the previous location was terminated. The domiciliary is a residential rehabilitation and treatment program for veterans and does not follow RCS requirements. Therefore, the OIG did not review environment of care elements for the Milwaukee Vet Center.

The OIG found the three inspected vet centers had an annual fire or safety inspection, annual risk and vulnerability assessment completed by VA police or local law enforcement, annual servicing and monthly inspections of fire extinguishers, AEDs on-site with annual servicing by VA medical center biomedical engineering staff, building evacuation plans posted in communal areas for staff and visitor reference, and emergency and crisis plans with required components.

In the identified area, the VCD reported the following explanation for noncompliance.

- *AED inspected monthly:* The La Crosse VCD stated the program support assistant is responsible for checking the AED monthly. However, the VCD and program support assistant were both unaware that the AED's functionality should be tested and instead, were only checking to ensure the tamper-proof seal on the AED storage box was intact.

The OIG made one recommendation related to environment of care.

Environment of Care Recommendation

Recommendation 6

District leaders and the La Crosse Vet Center Director determine reasons for noncompliance with monthly automated external defibrillator inspections, ensure completion, and monitor compliance.

Additional Findings for the Milwaukee Vet Center

The OIG found district leaders and the VCDs did not implement adequate notification, oversight, and planning processes when closing and relocating the Milwaukee Vet Center after mold was identified in the vet center walls.

RCS requires vet centers to be located within the community to allow for ease of access to readjustment counseling services and space for informal social interaction among eligible individuals. RCS also requires vet centers to be located in "leased space outside of and apart from VA medical facilities, in easily accessible locations."[23]

The OIG found the following at the Milwaukee Vet Center:

1. The former VCD routed phone lines to the Vet Center Call Center (VCCC) with no direct line to vet center staff.
2. The former VCD did not ensure a formal process was used to notify all clients of the vet center relocation.
3. District leaders were unaware of the disruption to vet center phone services.
4. The OIG found different vet center addresses on various websites such as RCS, VHA, Bing, and Google one year after the vet center closure.
5. The VCCC provided an inaccurate vet center location.
6. The domiciliary had a secured access and lacked signage.
7. Leaders and a vet center staff member were aware of client complaints regarding the domiciliary site.
8. RCS lacked written guidance and oversight of vet center closures or relocations.

The OIG interviewed district leaders, the former and new Milwaukee VCD, and a vet center staff member to determine actions taken to ensure continuity of client care and identification of a new location (see figure 2 for a timeline of events as reported by district leaders and VCDs and documents provided).

[23] VHA Directive 1500(4).

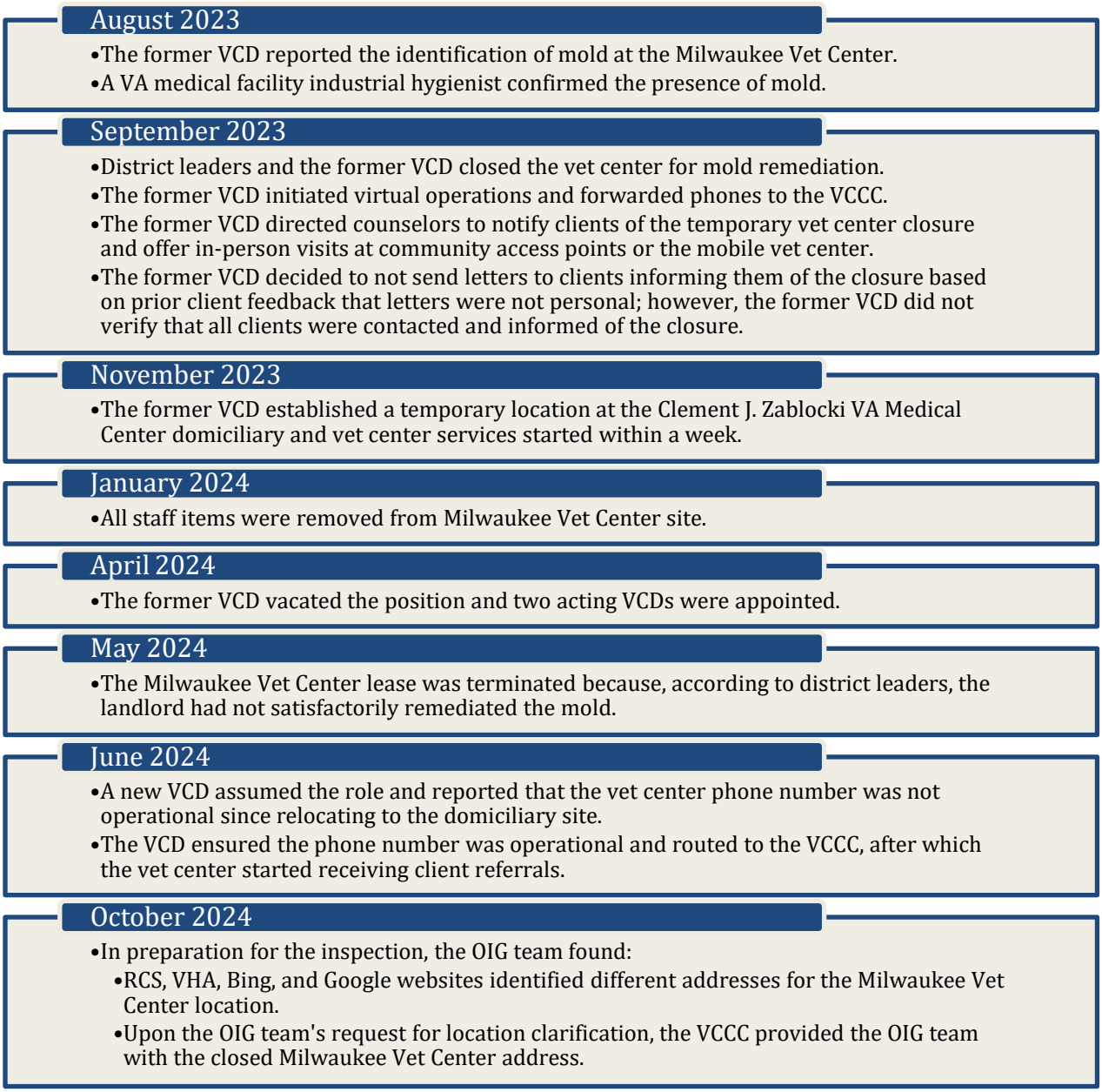

Figure 2. *Milwaukee Vet Center closure and relocation to domiciliary site timeline.*

During the October 2024 site visit to the domiciliary, the OIG did not find vet center signage on the building. The building door was locked, and a stationed security guard unlocked the door after alerting the OIG team to push a button on the wall for the door to be unlocked. Once inside, the security guard requested the inspection team sign in and contacted a vet center staff member to come to the lobby and escort the team into the building. Contrary to the RCS requirement for vet centers to provide easily accessible space outside of VA medical facilities, vet center staff confirmed that clients go through this same security process to enter the building.[24] Vet center staff reported that some clients preferred to not receive services at the temporary location because of feelings of distress related to coming to a VA medical facility, the presence of a security guard, and having previously received services at the domiciliary.

During OIG interviews, district leaders described a lack of awareness of address and phone issues and failure to oversee the process because of a reliance on the former VCD to ensure clients' care was not disrupted. District leaders reported not having visited the temporary relocation site prior to occupancy due to turnover in the district office but noted having been in contact with VCDs. The District Director was unaware of RCS written guidance related to the closure or relocation of a vet center. An RCS leader confirmed there was no written guidance related to vet center closures, but did provide the OIG a Relocation Process Summary document and reference to RCS policy for oversight responsibilities. The OIG reviewed the Relocation Process Summary document and RCS policy for oversight responsibilities and did not find the documents included process steps for the relocation, including temporary relocation, of a vet center to a new location or identify oversight responsibilities for RCS leaders during the closure and relocation process.[25]

As of December 2, 2024, district leaders had not identified a new site for the Milwaukee Vet Center. District leaders estimated that due to renovations, occupancy of a new site would not occur for a year to 18 months after the location was secured.

The closure of a vet center site without implementation of processes for notification, planning, and oversight could create barriers for clients to access counseling that may contribute to deterioration of clients' health and missed opportunities for intervention including suicide prevention.

The OIG made two recommendations related to the additional findings.

[24] VHA Directive 1500(4).

[25] VHA Directive 1500(4).

Recommendation 7

District leaders determine reasons why the closing of the Milwaukee Vet Center resulted in multiple communication failures, and ensure all clients are notified of the new location, the Vet Center Call Center has accurate information, and websites include correct location and phone number information.

Recommendation 8

The Readjustment Counseling Service Chief Officer considers developing written guidance for vet center closure and temporary relocation processes including oversight responsibilities.

Appendix A

This section presents an overview of each selected vet center along with inspection results. For an overview of all results see Overall Findings.

Evanston Vet Center

The VCD reported the Evanston Vet Center serves clients throughout three counties within Illinois and is supported by the Lovell Federal Health Care Center, which is the first combined US Department of Veterans Affairs and the Department of Defense facility. The VCD reported 120,145 eligible veterans reside in the veteran service area, which includes the Naval Station Great Lakes, Sheridan Army Reserve Complex, Marine Air Control Group, and United States Military Entrance Processing Command. The VCD highlighted the recent vet center remodel to make the space more welcoming and the expansion of outreach to first responders in the community.

Table A.1. Fiscal Year 2024 Vet Center Profile

Profile	Evanston Vet Center
Budget	$1,181,624.22
Total Unique Clients	260
New Clients	47
Active Duty Clients	4
Bereavement Clients	1
Family Clients	16
Total Authorized Full-time Positions	8
Total Filled Positions	7
Total Vacancies	1

Source: RCS data.

For compliant element findings, please see findings related to Suicide Prevention; Consultation, Supervision, and Training; Outreach; and Environment of Care.

Identified Deficiencies

Suicide Prevention

Mental health executive council participation: The vet center did not provide documentation of representation for any mental health council meeting held in fiscal year 2024.

Consultation, Supervision, and Training

External clinical consultation hours: Four hours of external clinical consultation were not provided for 7 of the 12 months reviewed.

Outreach

Outreach plan: The outreach plan was missing one required strategic component: identification of VA medical facility partners.[26]

[26] Strategic VA medical facility partners did not include clinical and administrative liaisons, an external clinical consultant, a suicide prevention coordinator, or the facility contact for prevention and management of disruptive behavior.

Gary Area Vet Center

The VCD reported the Gary Area Vet Center serves clients throughout 11 counties within Northwest Indiana and is supported by the Jesse Brown VA Medical Center. The VCD reported 62,951 eligible veterans reside in the veteran service area, which has no local military bases or installations. The VCD highlighted the use of integrative groups, such as trauma-sensitive yoga, guitar, chess, and golf that focus on the whole person and promote the veterans' well-being.

For compliant element findings, please see findings related to Suicide Prevention; Consultation, Supervision, and Training; Outreach; and Environment of Care.

Table A.2. Fiscal Year 2024 Vet Center Profile

Profile	Gary Area Vet Center
Budget	$944,205.93
Total Unique Clients	154
New Clients	24
Active Duty Clients	2
Bereavement Clients	4
Family Clients	9
Total Authorized Full-time Positions	6
Total Filled Positions	6
Total Vacancies	0

Source: RCS data.

Identified Deficiencies

Consultation, Supervision, and Training

External clinical consultation hours: The OIG could not verify four hours of external clinical consultation for any of the 12 months reviewed.

Completion of monthly 10 percent record review: The VCD did not complete record reviews of at least 10 percent of active counseling records for one staff member during one of the last three months of the review period.

Staff training:

- One of two nonclinical staff members did not complete the initial S.A.V.E. training.
- Two of six staff members did not complete required BLS training.

Outreach

Outreach plan: The outreach plan was missing three required strategic components: a strategic map identifying eligible population concentrations, personal points of contact for non-VA service providers, and strategic VA medical facility partners.[27]

[27] Strategic VA medical facility partners did not include clinical and administrative liaisons, an external clinical consultant, or the facility contact for prevention and management of disruptive behavior.

La Crosse Vet Center

The VCD reported the La Crosse Vet Center serves clients throughout 32 counties within Wisconsin and is supported by the Tomah VA Medical Center. The VCD reported 79,303 eligible veterans reside in the veteran service area, which includes the United States Army Fort McCoy Total Force Training Center and Volk Field Air National Guard Base. The VCD highlighted the relocation of the vet center to a new site in December 2023 and the initiation of in-person services at the Wausau Outstation in July 2024.[28]

Table A.3. Fiscal Year 2024 Vet Center Profile

Profile	La Crosse Vet Center
Budget	$911,572.79
Total Unique Clients	425
New Clients	110
Active Duty Clients	9
Bereavement Clients	0
Family Clients	62
Total Authorized Full-time Positions	9
Total Filled Positions	8
Total Vacancies	1

Source: RCS data.

For compliant element findings, please see findings related to Suicide Prevention; Consultation, Supervision, and Training; Outreach; and Environment of Care.

Identified Deficiencies

Suicide Prevention

Mental health executive council participation: Of the six meetings held in fiscal year 2024, the vet center had representation at four.

Consultation, Supervision, and Training

External clinical consultation hours: Four hours of external clinical consultation were not provided for 5 of the 12 months reviewed.

Staff training:

- One of two nonclinical staff did not complete S.A.V.E training.
- Two of the eight staff members did not complete BLS training.

Environment of Care

AED inspection: Of the three months the OIG reviewed, no AED inspections were completed.

[28] VHA Directive 1500(4). 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.

Milwaukee Vet Center

The VCD reported the Milwaukee Vet Center serves clients throughout nine counties across Wisconsin and is supported by the Clement J. Zablocki VA Medical Center. The VCD reported 110,799 eligible veterans reside in the veteran service area, which includes the 128 Air Refueling Wing and the US Army Milwaukee Recruiting Battalion. The VCD highlighted a collaboration among the Milwaukee Vet Center staff to streamline the referral process to ensure clients are scheduled for an initial assessment as quickly as possible.

Table A.4. Fiscal Year 2024 Vet Center Profile

Profile	Milwaukee Vet Center
Budget	$937,974.18
Total Unique Clients	268
New Clients	55
Active Duty Clients	8
Bereavement Clients	1
Family Clients	24
Total Authorized Full-time Positions	8
Total Filled Positions	8
Total Vacancies	0

Source: RCS data.

For compliant element findings, please see findings related to Suicide Prevention; Consultation, Supervision, and Training; Outreach; and Environment of Care.

Identified Deficiencies

Suicide Prevention

Mental health executive council participation: Of the 12 meetings held during fiscal year 2024, the vet center had representation at 9.

Consultation, Supervision, and Training

External clinical consultation hours: Four hours of external clinical consultation were not provided for any of the 12 months reviewed.

Staff training:

- One of five clinical staff did not complete suicide risk management training.
- Six of the eight staff members did not complete BLS training.

Outreach

Outreach plan: The outreach plan was missing one required strategic component: identification of VA medical facility partners.[29]

Environment of Care

The OIG did not review environment of care elements for the Milwaukee Vet Center due to its temporary relocation to the domiciliary building at the Clement J. Zablocki VA Medical Center.

Additional Findings

During the Milwaukee Vet Center inspection, the OIG found district leaders and the VCDs did not implement adequate notification, oversight, and planning processes when closing and relocating after mold was identified in the vet center walls.

[29] Strategic VA medical facility partners did not include clinical and administrative liaisons, an external clinical consultant, a suicide prevention coordinator, or the facility contact for prevention and management of disruptive behavior.

Appendix B: RCS Chief Readjustment Counseling Service Officer Memorandum

Department of Veterans Affairs Memorandum

Date: April 22, 2025

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

Subj: Inspection of Select Vet Centers in Midwest District 3 Zone 2

To: Director, Office of Healthcare Inspections, Vet Center Inspection Program (VC00)
Director, GAO/OIG Accountability Liaison (VHA 10OIC 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 Midwest District 3 Zone 2*. I have reviewed the recommendations and submitted action plans to address all findings in the report.

(*Original signed by:*)

Michael Fisher
Chief Officer, Readjustment Counseling Service

[OIG comment: The OIG received the above memorandum from VHA on April 22, 2025.]

Appendix C: RCS Midwest District Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 17, 2025

From: Joseph Dudley, Director, Midwest District 3 (RCS3)

Subj: Inspection of Select Vet Centers in Midwest District 3 Zone 2

To: Chief Officer, Readjustment Counseling Service, (VHA 10 RCS Action)
Director, GAO/OIG Accountability Liaison Office (VHA 10OIC GOAL Action)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Vet Centers Inspection Program-District 3 Zone 2.

2. I reviewed the draft report and request closure of recommendations 1, 3, 6 and 7. District leaders and Vet Center Directors took action to resolve concerns identified during the District 3 Zone 2 inspection. Specific actions taken are in the attachments including evidence of compliance over at least a ninety-day period. District leaders also will make it a point of emphasis to confirm and validate ongoing compliance during annual clinical and administrative site visits. District leaders and Vet Center Directors also took immediate action on all other recommendations and expect to have evidence showing sustained compliance for each remaining recommendation in the next few months.

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

[OIG comment: The OIG received the above memorandum from VHA on April 22, 2025.]

District Director Response

Recommendation 1

District leaders and the Evanston, La Crosse, and Milwaukee Vet Center Directors collaborate with the support VA medical facility to determine reasons for noncompliance with staff participation on the mental health executive council, take action as indicated, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Request Closure

Director Comments

Vet Center Directors (VCD) were not consistently participating in the VA medical facility Mental Health Executive Council (MHEC). District 3 Zone 2 leadership provided education to VCDs and reminders to complete this requirement. The VCDs are tracking compliance locally, and the district will confirm ongoing compliance during the annual clinical site visit. These Vet Centers coordinated with their support VA medical centers, and all now have consistent participation in the local MHEC.

OIG Comments

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

Recommendation 2

District leaders and the Evanston, Gary Area, La Crosse, and Milwaukee Vet Center Directors determine reasons for noncompliance with completing four hours of external clinical consultation for clinically complex cases per month, ensure a process is implemented, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: May 31, 2025

Director Comments

The VCDs were not consistently completing and monitoring compliance for the four hours of monthly external consultation at these Vet Centers. District 3 Zone 2 leadership provided education to VCDs and ongoing reminders to meet this requirement. The VCDs are tracking

compliance locally, and the district team will confirm ongoing compliance during the annual clinical site visit. These Vet Centers are now consistently completing four hours of external clinical consultation and working on processes to confirm ongoing compliance.

Recommendation 3

District leaders and the Gary Area Vet Center Director determine reasons for noncompliance with Vet Center Director review of 10 percent of active client records monthly for each counselor's caseload, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Request Closure

Director Comments

The Gary Area VCD was not consistently auditing the correct number of client records. The VCD has developed and implemented a plan to review 10 percent of all counselors' active caseloads per month. The VCD tracks locally, and the district will confirm ongoing compliance during the annual clinical site visit. The Gary Area Vet Center Director is now consistently completing a monthly review of 10 percent of active client records for each counselor's caseload.

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 Gary Area, La Crosse, and Milwaukee Vet Center Directors determine reasons for noncompliance with employees completing select trainings in the required time frame, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: May 31, 2025

Director Comments

In fiscal year 2024, these Vet Centers did not meet full compliance for mandatory staff training. District leadership provided instructions to VCDs to ensure completion of mandatory training. Vet Center staff training is documented in the Talent Management System (TMS) and tracked locally by VCDs. Ongoing compliance will be confirmed by the district team during the annual administrative site visit.

Recommendation 5

District leaders and the Evanston, Gary Area, and Milwaukee Vet Center Directors determine reasons for noncompliance with completion of an outreach plan with all required strategic components, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: May 31, 2025

Director Comments

The fiscal year 2024 outreach plans at these locations did not include all required strategic components. District 3 Zone 2 leadership will provide instruction for creating an outreach plan that includes all strategic components listed in VHA Directive 1500(4) Appendix B. The VCDs will track compliance locally, and the district team will confirm ongoing compliance during the annual clinical site visit.

Recommendation 6

District leaders and the La Crosse Vet Center Director determine reasons for noncompliance with monthly automated external defibrillator inspections, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Request Closure

Director Comments

The La Crosse Vet Center was not in compliance with the monthly inspection and monitoring of the automated external defibrillator (AED). The VCD created a process and tracking mechanism, which is being used to ensure compliance locally, and the district will confirm ongoing compliance during the annual administrative site visit. The La Crosse Vet Center is now consistently completing monthly inspections of the AED.

OIG Comments

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

Recommendation 7

District leaders determine reasons why the closing of the Milwaukee Vet Center resulted in multiple communication failures, and ensure all clients are notified of the new location, the Vet Center Call Center has accurate information, and websites include correct location and phone number information.

_X _Concur

____Nonconcur

Target date for completion: Request Closure

Director Comments

District leaders acknowledge that there were missed opportunities in communication to include accurate Vet Center Call Center information, correct website location, and updated phone number in relocating Milwaukee Vet Center services. During the transition, VCDs successfully provided opportunities for Veterans to be seen in person via a coverage plan which included the use of community access points, Mobile Vet Center, and the VA Medical Center Domiciliary. The Vet Center Call Center has been updated to include accurate information, and the website has been updated to reflect the correct location and phone number. All current clients have completed in-person services at their current locations. The websites for the Milwaukee Vet Center, VA location finder, and internet search engines all provide current location and phone number information.

OIG Comments

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

Recommendation 8

The Readjustment Counseling Service Chief Officer considers developing written guidance for vet center closure and temporary relocation processes including oversight responsibilities.

_X _Concur

____Nonconcur

Target date for completion: December 31, 2025

Chief Officer Comments

On November 13, 2024, GAO published the report GAO-25-106781, *VA Vet Centers: Opportunities Exist to Improve Asset Management and Identification of Future Counseling Locations*, with a recommendation that RCS should develop a strategic asset management plan that outlines RCS' asset management approach, as well as how that approach ties to RCS'

mission and objectives. RCS is actively working on developing a strategic asset management plan that will include written guidance for Vet Center closure and temporary relocation processes, including oversight responsibilities.

Glossary

To go back, press "alt" and "left arrow" keys.

automated external defibrillator. Is "a sophisticated, yet easy-to-use, medical device that can analyze the heart's rhythm and, if necessary, deliver an electrical shock, or defibrillation, to help the heart to re-establish an effective rhythm."[30]

clinical liaison. Is a mental health professionals assigned by the support VA medical facility who assists the VCD in coordinating care and suicide prevention activities and making referrals for shared VA medical facility clients.[31]

independently licensed mental health external clinical consultant. Is assigned by the VA support medical facility to provide vet center counseling staff with a minimum of four hours per month of consultation for clinically complex cases. "In situations where the VA medical facility is unable to provide an external consultant due to local staffing logistics, the Vet Center will be authorized to seek such services from the private sector."[32]

High Risk Suicide Flag (HRSF) SharePoint site. Lists names of RCS clients identified by VA medical facilities as high risk. VCDs are required to review the HRSF SharePoint site monthly to identify clients who 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.

outreach plan. A written strategic document developed for eligible individuals within that vet center's service area. The outreach plan identifies specific outreach locations and events that will allow vet center staff to directly provide eligible individuals and families with information about vet center services. Additionally, the outreach plan identifies local service providers, within the VA and non-VA to establish referral networks for vet center clients. Outreach plans are updated annually.[33]

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.[34]

[30] "What is AED?," American Red Cross, accessed August 8, 2022, https://www.redcross.org/take-a-class/aed/using-an-aed/what-is-aed.

[31] VHA Directive 1500(4).

[32] VHA Directive 1500(4).

[33] VHA Directive 1500(4).

[34] VHA Directive 1500(4).

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