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 1

Vet Center Inspection	24-00393-180	August 5, 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 that 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 1: Fort Wayne, Indiana; Detroit and Escanaba, Michigan; and Cincinnati, Ohio.[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 to 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[2] VHA Directive 1500(3), *Readjustment Counseling Service*, January 26, 2021, amended June 5, 2023, rescinded and replaced by VHA Directive 1500(4), *Readjustment Counseling Service*, January 26, 2021, amended November 21, 2023, rescinded and replaced by VHA Directive 1500(5), *Readjustment Counseling Service*, January 26, 2021, amended March 3, 2025.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 provider at the supporting 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]

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]

The OIG issued one recommendation to district leaders and applicable VCDs specific to suicide prevention activities.

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 a supporting VA medical facility.[7] Although external clinical consultation for clinically complex cases occurred at all four vet centers, three

[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 rescinded and 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 supporting VA medical facility mental health executive council meetings to assist with care coordination and collaboration for clients.

[5] On May 11, 2020, RCS implemented a HRSF SharePoint site containing names of RCS clients who also receive services at a VA medical facility and have a high risk for suicide flag; Chief Officer, Readjustment Counseling Services, "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 whether 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). Each vet center aligns with a VA medical facility to ensure access to clinical services and coordination of care for shared clients.

VCDs did not ensure completion of at least four hours of consultation per month.[8] All four VCDs completed monthly reviews of 10 percent of each counselor's client records.[9] Additionally, staff at two of four vet centers did not complete select required trainings related to basic life support.[10]

The OIG issued two recommendations to district leaders and applicable VCDs specific to consultation, supervision, and training.

Outreach

The OIG found all four vet centers had outreach plans with tailored outreach activities; however, all plans lacked one or more required strategic components.[11]

The OIG issued one recommendation to district leaders and applicable VCDs specific to outreach.

[8] VHA Directive 1500(4).

[9] VHA Directive 1500(4).

[10] VA Secretary, "Agency-Wide Required Suicide Prevention Training," memorandum to Under Secretaries, Assistant Secretaries and Other Key Officials, October 15, 2020; VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 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) 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; 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.

[11] 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 to be tailored to eligible individuals.

Environment of Care

The OIG found the three applicable vet centers had fire extinguishers inspected monthly, and all four vet centers had an automated external defibrillator (AED) inspected monthly and building evacuation plans posted in communal areas.[12]

The OIG found that of the four vet centers,

- one did not have an annual fire or safety inspection,
- three did not have an annual risk and vulnerability assessment completed by VA police or local law enforcement,
- one did not have annual servicing of all fire extinguishers,
- one did not have an annual servicing of the AED by VA medical center biomedical engineering, and
- two did not have a current emergency and crisis plan.[13]

The OIG identified inconsistencies between the RCS administrative site visit protocol and the Veterans Health Administration (VHA) requirements for the frequency of completion of risk and vulnerability assessments and AED servicing. RCS central office leaders reported working to align RCS and VHA requirements; however, RCS leaders continue to require annual risk and vulnerability assessments and annual AED servicing for vet centers until updates are made.

The OIG issued four recommendations to district leaders and applicable VCDs and two recommendations to the RCS Chief Officer specific to environment of care.

Conclusion

The OIG conducted a focused inspection in four review areas and made eight recommendations to the District Director and applicable VCDs and two recommendations 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

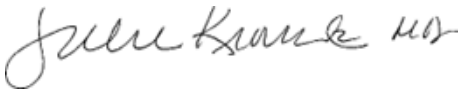
[12] RCS, *Administrative Site Visit (ASV) Protocol.* Vet centers are required to have a fire or safety inspection and a risk and vulnerability assessment annually. The risk and vulnerability assessment must be completed by VA police or local law enforcement. Vet centers must also have fire extinguishers and an AED available for staff, both requiring annual servicing and monthly inspections to ensure proper functioning. RCS require 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 the fire extinguisher annual servicing requirement at the Escanaba Vet Center due to having placed new fire extinguisher tags in January 2025, prior to the OIG on-site inspection.

[13] RCS*, ASV Protocol*. The Cincinnati VCD was noncompliant with annual fire extinguisher servicing. However, the VCD had servicing done during the OIG inspection; therefore, the OIG did not make a recommendation.

help improve operations and clinical care. The recommendations address systems' issues and site-specific findings that may compromise quality care.

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.



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Contents

Abbreviations

AED	automated external defibrillator
BLS	basic life support
HRSF	high risk suicide flag
OIG	Office of Inspector General
RCS	Readjustment Counseling Service
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 1 for review: Fort Wayne, Indiana; Detroit and Escanaba, Michigan; and Cincinnati, Ohio (see figure 1).[3]

[1] VHA Directive 1500(3), *Readjustment Counseling Service*, January 26, 2021, amended June 5, 2023, rescinded and replaced by VHA Directive 1500(4), *Readjustment Counseling Service*, January 26, 2021, amended November 21, 2023, rescinded and 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. According to VHA Directive 1500(4), "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.

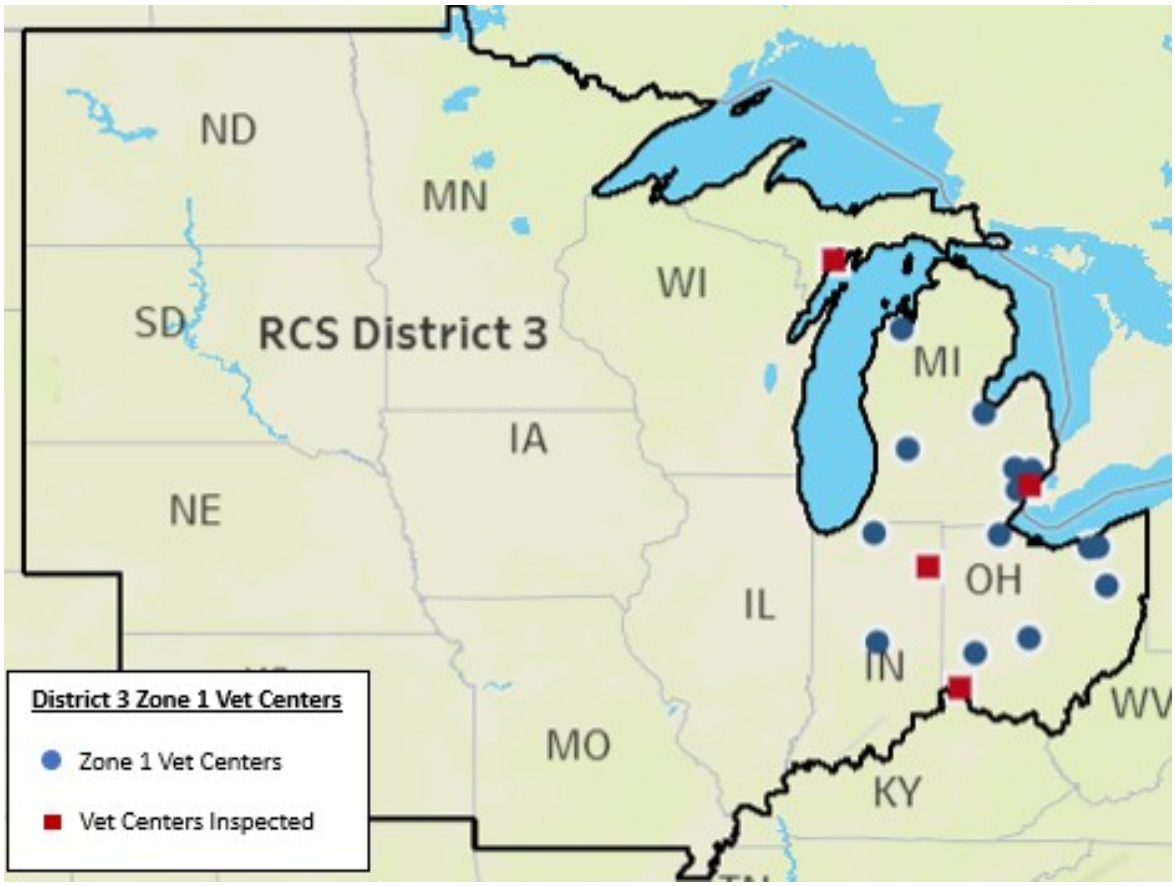

Figure 1. *Map of Midwest District 3 zone 1 vet centers, including sites visited by the OIG.*
Source: The OIG using RCS vet center data.

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 January 13, through February 5, 2025.[5] The OIG notified each selected vet center director (VCD) one day prior to the vet center site visit. During

[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, the term "district leaders" refers 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 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 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 supporting VA medical facility.[7] VHA and RCS staff members participate in the supporting 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 supporting 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 rescinded and 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 supporting 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.

Table 1. Suicide Prevention Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	**Fort Wayne Vet Center**	**Detroit Vet Center**	**Escanaba Vet Center**	**Cincinnati Vet Center**
A licensed vet center staff member participates in all supporting 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 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.

[9] On May 11, 2020, RCS implemented a HRSF SharePoint site containing names of RCS clients who also receive services at a VA medical facility and have a high risk for suicide flag; 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.

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

- *Mental health executive council participation*: The Detroit, Escanaba, and Cincinnati VCDs were aware of the requirement to attend the mental health executive council meetings, however, did not have processes in place to cover vet center staff absences.

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.[11]

The OIG made one recommendation related to suicide prevention.

Suicide Prevention Recommendation

Recommendation 1

District leaders and the Detroit, Escanaba, and Cincinnati Vet Center Directors collaborate with the supporting 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.[12] Mandatory training completion supports a competent and skilled staff to provide services to clients.[13]

Reviewed trainings included:

- Nonclinical staff
    - Initial or annual S.A.V.E. training[14]
- Clinical Staff

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

[12] VHA Directive 1500(4).

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

[14] VA Secretary, "Agency-Wide Required Suicide Prevention Training," memorandum to Under Secretaries, Assistant Secretaries and Other Key Officials, October 15, 2020; VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 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.

  - Initial or annual suicide risk management training[15]
  - One-time lethal means safety education and counseling[16]
  - One-time military sexual trauma training[17]
- All staff
  - Biannual basic life support (BLS) certification[18]

[15] 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(1).

[16] 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.

[17] 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."

[18] 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**	Fort Wayne Vet Center	Detroit Vet Center	Escanaba Vet Center	Cincinnati 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(1); 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 between October 1, 2023, and June 30, 2024.*

The OIG found all four vet centers had an assigned clinical liaison and independently licensed mental health external clinical consultant. Additionally, all four VCDs completed a monthly review of 10 percent of active client records for each counselor's caseload.

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

- *Completion of required four hours of monthly external clinical consultation:* The Fort Wayne VCD reported consultation meetings were either missed due to holidays without a plan to reschedule or due to VCD oversight while using two different tracking systems to document meetings. The Escanaba VCD was unaware that one of two external clinical consultants was not an independently licensed mental health

professional as required; therefore, hours completed by the unlicensed consultant did not meet the requirement. The Cincinnati VCD was aware of the requirement but did not reschedule meetings to account for holidays or when the external clinical consultant was not available.

- *Completion of select staff trainings:* The Detroit VCD was aware of the BLS training requirement and stated deficiencies were due to challenges in coordinating in-person training at the supporting VA medical facility. The Escanaba VCD was aware of the BLS training requirement for counselors but unaware the requirement also included veterans outreach program specialists and office managers.

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

Consultation, Supervision, and Training Recommendations

Recommendation 2

District leaders and the Fort Wayne, Escanaba, and Cincinnati 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 Detroit and Escanaba 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.[19]

[19] VHA Directive 1500(4).

Table 3. Outreach Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	Fort Wayne Vet Center	Detroit Vet Center	Escanaba Vet Center	Cincinnati Vet Center
Presence of a written current outreach plan.	✓	✓	✓	✓
Inclusion of required outreach plan strategic components.*	✗	✗	✗	✗
Outreach activities tailored to eligible individuals.	✓	✓	✓	✓

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 identifying 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.*

The OIG found all 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 Fort Wayne, Detroit, Escanaba, and Cincinnati VCDs were unaware of all the required components for the outreach plan.

The OIG made one recommendation related to outreach.

Outreach Recommendation

Recommendation 4

District leaders and the Fort Wayne, Detroit, Escanaba, and Cincinnati 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.[20]

[20] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021, rescinded and replaced by 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 full months prior to district notification. The OIG evaluated the presence of an AED and a building evacuation plan during on-site inspections.

Table 4. Environment of Care Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	Fort Wayne Vet Center	Detroit Vet Center	Escanaba Vet Center	Cincinnati Vet Center
Fire or safety inspection completed annually.	✓	✓	✗	✓
Risk and vulnerability assessment completed annually by VA police or local law enforcement.	✗	✗	✗	✓
Fire extinguishers inspected monthly.	✓	✓	NA*	✓
Fire extinguishers serviced annually.‡	✓	✓	✓	✗
Automated external defibrillator (AED) located on-site.	✓	✓	✓	✓
AED inspected monthly.	✓	✓	✓	✓
AED serviced annually by VA medical center biomedical engineering.	✓	NA*	✓	✗
Building evacuation plan posted in communal area for staff and visitors to reference.	✓	✓	✓	✓
Emergency and crisis plan with required components.§	✓	✗	✗	✓

Sources: RCS, Administrative Site Visit (ASV) Protocol; OIG analysis of vet center results.
**In January 2025, prior to the OIG inspection, the Escanaba Vet Center had new fire extinguisher tags placed; therefore, the OIG was unable to evaluate compliance. On May 3, 2024, prior to the OIG on-site inspection, the Detroit Vet Center had a new AED issued; therefore, the OIG was unable to evaluate compliance.*
‡The Cincinnati VCD was noncompliant with annual fire extinguisher servicing. However, the VCD had servicing done during the OIG inspection; therefore, the OIG did not make a recommendation.
§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; weather or natural disaster emergency plan; site, facility, or building temporary relocation plan; management of disruptive behavior plan; violence in the workplace plan (including active shooter plan); and handling of suspicious mail and bomb threats.

The OIG found the three applicable vet centers had fire extinguishers inspected monthly, and all four vet centers had AEDs that were inspected monthly and building evacuation plans posted in communal areas.

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

- *Fire or safety inspection completed annually:* The Escanaba VCD was aware of the requirement but thought the requirement was met through the annual environment of care rounds.
- *Risk and vulnerability assessment completed annually:* In April 2024, the Fort Wayne VCD received documentation from the supporting VA medical facility stating the next risk and vulnerability assessment was not due to be completed until 2028. The Detroit VCD was aware of the requirement but miscalculated the due date. The Escanaba VCD thought the risk and vulnerability assessment was a one-time requirement.
- *Fire extinguishers serviced annually:* The Cincinnati VCD believed annual servicing of fire extinguishers was part of the fire inspection at the new vet center location and was not aware that servicing was due in December 2024. The VCD had servicing done during the OIG inspection; therefore, the OIG did not make a recommendation.
- *AED serviced annually:* The Cincinnati VCD was not aware of the RCS requirement for annual AED servicing.
- *Emergency and crisis plan with all components:* The Detroit and Escanaba VCDs recalled completing an annual review and updating the emergency and crisis plan but did not have documentation to support annual reviews or updates.

The OIG noted inconsistency between the RCS administrative site visit protocol requirement for an annual risk and vulnerability assessment and VA police guidance to the Fort Wayne VCD that an assessment was not due until 2028. RCS central office leaders reported working to align RCS and VHA requirements; however, RCS continues to require annual risk and vulnerability assessments for vet centers until updates are made.

The Cincinnati VCD told the OIG that according to VA biomedical engineering, the specific AED model requires servicing every other year, according to manufactures guidelines, and therefore was not due for servicing until September 2025. However, RCS administrative site visit protocol necessitates annual AED servicing and does not allow for variations in requirements related to the AED model.[21]

[21] RCS, *ASV Protocol*.

The OIG made four recommendations to district leaders and VCDs and two recommendations to the RCS Chief Officer related to environment of care.

Environment of Care Recommendations

Recommendation 5

District leaders and Escanaba Vet Center Director determine reasons for noncompliance with annual fire or safety inspections, ensure completion, and monitor compliance.

Recommendation 6

District leaders and the Fort Wayne, Detroit, and Escanaba Vet Center Directors determine reasons for noncompliance with having an annual risk and vulnerability assessment completed by VA police or local law enforcement, ensure completion, and monitor compliance.

Recommendation 7

District leaders and the Cincinnati Vet Center Director determine reasons for noncompliance with annual automated external defibrillator servicing by VA medical center biomedical engineering, ensure completion, and monitor compliance.

Recommendation 8

District leaders and the Detroit and Escanaba Vet Center Directors determine reasons for noncompliance with having a current emergency and crisis plan that includes required components, ensure completion, and monitor compliance.

Recommendation 9

The Readjustment Counseling Service Chief Officer reviews the administrative site visit protocol and Veterans Health Administration requirements related to inconsistencies in frequency for risk and vulnerability assessments and updates the administrative site visit protocol as indicated.

Recommendation 10

The Readjustment Counseling Service Chief Officer reviews the administrative site visit protocol and Veterans Health Administration requirements related to automated external defibrillator annual servicing and updates the administrative site visit protocol as indicated.

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.

Fort Wayne Vet Center

The VCD reported the Fort Wayne Vet Center serves clients throughout 19 counties within northeast Indiana and northwest Ohio and is supported by the VA Northern Indiana Healthcare System. The VCD reported 65,968 eligible veterans reside in the veteran service area, which includes the 1st-293rd Army National Guard Armory, 122nd Air National Guard Base, Grissom Air Force Base, and PFC William L. Gillespie US Army Reserve Center. The VCD highlighted implementing art classes which were enjoyed by clients.

Table A.1. Fiscal Year 2024 Vet Center Profile

Profile	Fort Wayne Vet Center
Budget	$825,274.78
Total Unique Clients	205
New Clients	66
Active Duty Clients	11
Bereavement Clients	4
Family Clients	41
Total Authorized Full-time Positions	6
Total Filled Positions	6
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

Consultation, Supervision, and Training

External clinical consultation hours: Four hours of external clinical consultation were not provided for 6 of the 12 months reviewed.

Outreach

Outreach plan: The outreach plan was missing three required strategic components: a strategic map identifying local eligible population concentrations, personal points of contact for non-VA service providers, and strategic VA medical facility partners.[22]

[22] 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.

Environment of Care

Risk and vulnerability assessment: VA police or local law enforcement had not completed an annual risk and vulnerability assessment since May 2023 as VA police informed the VCD that the inspection was not due until 2028.

Detroit Vet Center

The VCD reported the Detroit Vet Center serves clients throughout Wayne County, Michigan, and is supported by the John D. Dingell VA Medical Center. The VCD reported 66,179 eligible veterans reside in the veteran service area and highlighted assisting a veteran in navigating the VA disability claim process and receiving a discharge upgrade.

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	Detroit Vet Center
Budget	$627,253.66
Total Unique Clients	167
New Clients	43
Active Duty Clients	6
Bereavement Clients	1
Family Clients	4
Total Authorized Full-time Positions	5
Total Filled Positions	4
Total Vacancies	1

Source: RCS data.

Identified Deficiencies

Suicide Prevention

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

Consultation, Supervision, and Training

Staff training: Three of four staff did not complete BLS training.

Outreach

Outreach plan: The outreach plan was missing two required strategic components: personal points of contact for non-VA service providers and strategic VA medical facility partners.[23]

Environment of Care

Risk and vulnerability assessment: VA police or local law enforcement had not completed an annual risk and vulnerability assessment since September 2023.

[23] 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.

Emergency and crisis plan: The emergency and crisis plan included all required components; however, the plan was not current.

Escanaba Vet Center

The VCD reported the Escanaba Vet Center serves clients throughout 15 counties within Michigan and is supported by the Iron Mountain VA Medical Center. The VCD reported 30,387 veterans reside in the veteran service area, which includes five Army Reserve National Guard units. The VCD highlighted that the vet center offers non-traditional groups related to bowling and golf.

Table A.3. Fiscal Year 2024 Vet Center Profile

Profile	Escanaba Vet Center
Budget	$988,298.42
Total Unique Clients	266
New Clients	90
Active Duty Clients	3
Bereavement Clients	1
Family Clients	38
Total Authorized Full-time Positions	9
Total Filled Positions	7
Total Vacancies	2

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 four meetings held in fiscal year 2024, the vet center had representation at two.

Consultation, Supervision, and Training

External clinical consultation hours: Four hours of external clinical consultation were not provided for 11 of the 12 months reviewed.

Staff training: Three of the seven staff members did not complete BLS training.

Outreach

Outreach plan: The outreach plan was missing two required strategic components: personal points of contact for non-VA service providers and identification of strategic VA medical facility partners.[24]

[24] 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.

Environment of Care

Fire or safety inspection: An annual fire or safety inspection was not completed.

Risk and vulnerability assessment: VA police or local law enforcement had not completed an annual risk and vulnerability assessment since April 2023.

Emergency and crisis plan: The emergency and crisis plan included all required components; however, the plan was not current.

Cincinnati Vet Center

The VCD reported the Cincinnati Vet Center serves clients throughout the tri-state region, spanning Ohio, Kentucky, and Indiana, and is supported by the Cincinnati VA Medical Center. The VCD reported approximately 107,831 eligible veterans reside in the veteran service area, which includes the US Air Force - Center for Sustainment of Trauma and Readiness Skills and the Ohio National Guard 216th Engineer Battalion. The VCD highlighted receiving congressional recognition for being awarded the Vet Center Excellence in Customer Experience Award for fiscal year 2024.

Table A.4. Fiscal Year 2024 Vet Center Profile

Profile	Cincinnati Vet Center
Budget	$1,047,443.99
Total Unique Clients	334
New Clients	70
Active Duty Clients	13
Bereavement Clients	2
Family Clients	36
Total Authorized Full-time Positions	7
Total Filled Positions	6
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 nine meetings held in fiscal year 2024, the vet center had representation at six.

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 three required strategic components: a strategic map identifying local eligible population concentrations, personal points of contact for non-VA service providers, and strategic VA medical facility partners.[25]

[25] 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.

Environment of Care

Fire extinguisher servicing: None of the four fire extinguishers were serviced annually.

AED inspection: The AED was not serviced annually.

Appendix B: RCS Chief Readjustment Counseling Service Officer Memorandum

Department of Veterans Affairs Memorandum

Date: *June 26, 2025*

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

Subj: Inspection of Select Vet Centers in Midwest District 3 Zone 1

To: Director, Office of Healthcare Inspections, Vet Center Inspection Program (VC00)
Director, GAO/OIG Accountability Liaison (VHA 10OIC GOAL)

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 1. I have reviewed the recommendations and submitted action plans to address all findings in the report.

2. Should you require any additional information, please contact Readjustment Counseling Service.

(*Original signed by:*)

Michael Fisher

[OIG comment: The OIG received the above memorandum from VHA on June 26, 2025.]

Appendix C: RCS Midwest District 3 Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 26, 2025

From: District 3 Director, Midwest Region (RCS3)

Subj: Inspection of Select Vet Centers in Midwest District 3 Zone 1

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

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 1.

2. I reviewed the draft report and am working with the Midwest District 3 leadership team and Vet Center Directors (VCD) to implement a plan of correction and sustainment for all recommendations. District leaders and VCDs took action to begin resolving concerns identified during the inspection and will continue to monitor until there is sufficient evidence to demonstrate compliance with all findings. I am requesting closure of recommendation 3 as the staff at Escanaba and Detroit Vet Centers are now compliant with Basic Life Support training. I am also requesting closure of recommendation 4 as the Fort Wayne, Detroit, Escanaba, and Cincinnati Vet Centers are now compliant with updated outreach plans to include missing components found during the inspection process.

3. Please express my thanks to the team for their professionalism and assistance in our continuing efforts to improve the care we provide to our Veterans.

(*Original signed by*:)

Gregory Schenck
For
Joseph Dudley

[OIG comment: The OIG received the above memorandum from VHA on June 26, 2025.]

District Director Response

Recommendation 1

District leaders and the Detroit, Escanaba, and Cincinnati Vet Center Directors collaborate with the supporting 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: September 2025

Director Comments

Vet Center Directors (VCD) were not consistently participating in the VA medical facility Mental Health Executive Council (MHEC). District 3 Zone 1 leadership reviewed VCDs the requirements outlined in VHA Directive 1500(5) with VCDs. The VCDs are tracking compliance locally, and the district leaders will monitor until there is sufficient evidence to demonstrate compliance. District leadership will verify sustained compliance during the annual clinical site visit.

Recommendation 2

District leaders and the Fort Wayne, Escanaba, and Cincinnati 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: December 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 1 leadership reviewed with VCDs the requirements as outlined by the VHA Directive 1500(5). The VCDs are tracking compliance locally, and district leadership will monitor until there is sufficient evidence to demonstrate compliance. District leadership will verify sustained compliance during the annual clinical site visit.

Recommendation 3

District leaders and the Detroit and Escanaba 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: Request Closure.

Director Comments

In Fiscal Year 2024, these Vet Centers did not achieve full compliance with mandatory staff training. Specifically, some staff members at the Detroit and Escanaba Vet Centers were non-compliant with Basic Life Support (BLS) training. This non-compliance stemmed from various complications, including issues related to how, when, and who is responsible for assigning training to individuals. District leadership worked to clarify which trainings are assigned at the national, district, and local levels by the VCD and has instructed VCDs to ensure completion of mandatory training. Vet Center staff training is recorded in the Talent Management System (TMS) and tracked locally by VCDs. The staff at Detroit and Escanaba Vet Centers have completed the required BLS training and are now compliant. District leadership will verify sustained compliance during the annual administrative site visit.

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 Fort Wayne, Detroit, Escanaba, and Cincinnati 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: Request Closure.

Director Comments

During Fiscal Year 2024, the outreach plans at these Vet Centers did not include all required strategic components. Reasons for non-compliance included a district transition to a new outreach template during Fiscal Year 2024, a lack of understanding about the need for a specific

level of detail (e.g., naming a strategic partner instead of providing a title only), and a lack of clarity on how certain strategic components were relevant to their plan. District 3 Zone 1 leadership provided guidance on creating an outreach plan that incorporates all strategic components listed in VHA Directive 1500(5). VCDs and Veterans Outreach Program Specialists (VOPS) made specific revisions to include items identified within the inspection report. VCDs will track compliance locally on an ongoing basis, and district leadership will verify compliance during the annual clinical site visit.

OIG Comments

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

Recommendation 5

District leaders and the Escanaba Vet Center Director determine reasons for noncompliance with annual fire or safety inspections, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: September 2025

Director Comments

The Escanaba Vet Center was not in compliance with annual fire and safety inspections. To address this, the VCD will collaborate with its support facilities to ensure the completion of these inspections. The VCD will establish a process and tracking mechanism to maintain compliance. District leadership will verify compliance during the annual administrative site visit.

Recommendation 6

District leaders and the Fort Wayne, Detroit, and Escanaba Vet Center Directors determine reasons for noncompliance with having an annual risk and vulnerability assessment completed by VA police or local law enforcement, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

Per VHA Directive 1500(5), Vet Center annual site visits, both counseling and administrative, are required for all Vet Centers. The directive makes explicit the requirement that all site visits

are conducted according to a detailed site visit protocol. The Fort Wayne, Detroit, and Escanaba Vet Centers were not in compliance with the annual risk and vulnerability assessment required by the site visit protocol. District leadership is working with the VCDs on options to have these assessments completed for their Vet Centers. District leadership will verify sustained compliance during the annual site visit.

Recommendation 7

District leaders and the Cincinnati Vet Center Director determine reasons for noncompliance with annual automated external defibrillator servicing by VA medical center biomedical engineering, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

Per VHA Directive 1500(5), Vet Center annual site visits, both counseling and administrative, are required for all Vet Centers. The directive makes explicit the requirement that all site visits are conducted according to a detailed site visit protocol. The Cincinnati Vet Center was not in compliance with the requirement established by the site visit protocol to have an automated external defibrillator (AED) serviced annually by the VAMC Biomedical Engineering Service. District leadership is working with the VCD to ensure AED servicing by the VA medical center's biomedical engineering. District leadership will verify sustained compliance during the annual site visit.

Recommendation 8

District leaders and the Detroit and Escanaba Vet Center Directors determine reasons for noncompliance with having a current emergency and crisis plan that includes required components, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

The Detroit and Escanaba Vet Centers were not in compliance with having a current emergency and crisis plan that includes all the required components. District leadership provided VCDs guidance on the required components that needed to be included in the emergency and crisis plan

as outlined in the site visit protocol. District leadership is working with VCDs to ensure that their plans are updated with the required components. District leadership will verify sustained compliance during the annual site visit.

Recommendation 9

The Readjustment Counseling Service Chief Officer reviews the administrative site visit protocol and Veterans Health Administration requirements related to inconsistencies in frequency for risk and vulnerability assessments and updates the administrative site visit protocol as indicated.

_X _Concur

____Nonconcur

Target date for completion: December 2025

Chief Officer Comments

The Chief Readjustment Counseling Officer will ensure that the administrative site visit protocol and guidance are updated to align with the Veterans Health Administration requirements for the frequency of risk and vulnerability assessments.

Recommendation 10

The Readjustment Counseling Service Chief Officer reviews the administrative site visit protocol and Veterans Health Administration requirements related to automated external defibrillator annual servicing and updates the administrative site visit protocol as indicated.

_X _Concur

____Nonconcur

Target date for completion: December 2025

Chief Officer Comments

The Chief Readjustment Counseling Officer will ensure that the administrative site visit protocol and guidance are updated to align with the Veterans Health Administration (VHA) requirements for the servicing of automated external defibrillators. In April 2025, RCS became aware of the disparity between the administrative site visit protocol and the VHA requirements for servicing AEDs. RCS has met with the VHA Office of Healthcare Technology Management (HTM) to discuss the policy on alternative equipment maintenance (AEM) for high-risk medical equipment and will update the site visit protocol to reflect the maintenance procedures and frequency defined in the VHA HTM-derived standard that is specific to each make and model.

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."[26]

clinical liaison. Mental health professionals assigned by the supporting VA medical facility who assist the VCD in coordinating care and suicide prevention activities and making referrals for shared VA medical facility clients.[27]

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 the need for client contact, and complete follow-up, as appropriate.

independently licensed mental health external clinical consultant. Assigned by the supporting VA 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."[28]

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.[29]

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

[27] VHA Directive 1500(4).

[28] VHA Directive 1500(4).

[29] VHA Directive 1500(4).

OIG Contact and Staff Acknowledgments

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