



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Vet Center Inspection of  
Continental District 4 Zone 1  
and Selected Vet Centers



## MISSION

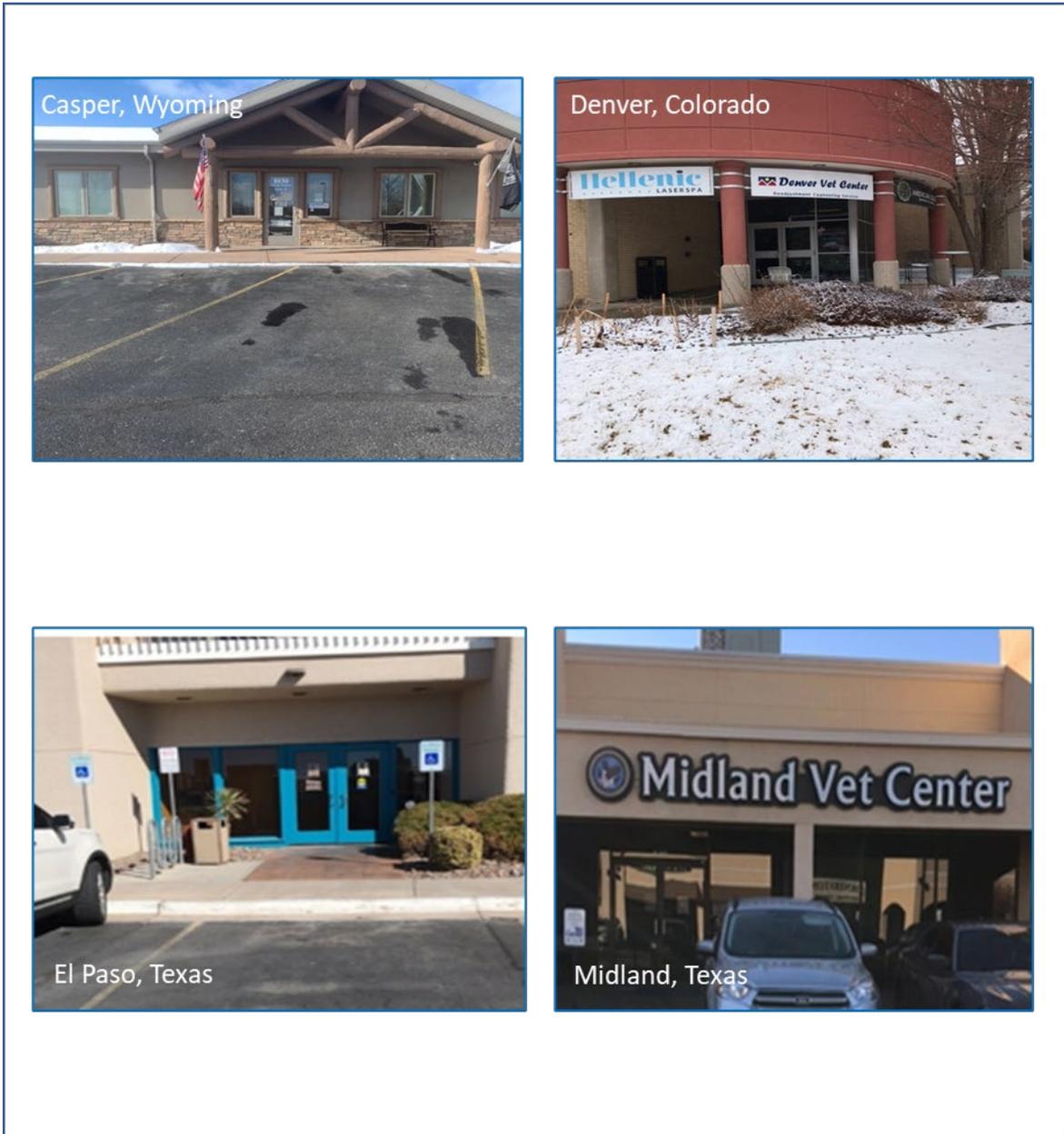
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**Figure 1.** Continental district 4 zone 1 vet centers inspected.

Source: VA Office of Inspector General inspection team virtual visit photographs.

## Abbreviations

OIG	Office of Inspector General
RCS	Readjustment Counseling Service
VCD	Vet Center Director
VCIP	Vet Center Inspection Program
VHA	Veterans Health Administration



## Report Overview

The VA Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) provides a focused evaluation of aspects of the quality of care delivered at vet centers. Vet centers are community-based clinics that provide a wide range of psychosocial services to clients, including eligible veterans, active duty service members, National Guard members, reservists, and their families, to support a successful transition from military to civilian life.<sup>1</sup> This inspection focused on Continental district 4 zone 1 and four selected vet centers: Casper, Wyoming; Denver, Colorado; and El Paso and Midland in Texas.<sup>2</sup>

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

To examine risks or potential risks to clients, the OIG inspection focused on six reviews that influence the quality of client care and service delivery at vet centers:<sup>3</sup>

- Leadership and organizational risks
- Quality reviews
- COVID-19 response
- Suicide prevention
- Consultation, supervision, and training
- Environment of care

The findings presented in this report are a snapshot of the selected zone and vet center's performance within the identified review areas at the time of the OIG inspection. Although it is

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<sup>1</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010, was in effect during part of the OIG's inspection period. It was rescinded and replaced by VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021. Unless otherwise specified, the requirements in the 2021 directive contain the same or similar language as the rescinded November 2010 document.

<sup>2</sup> Readjustment Counseling Service is divided into five districts. Each district consists of two to four zones. Each zone consists of multiple vet centers, ranging from 18–25 vet centers per zone.

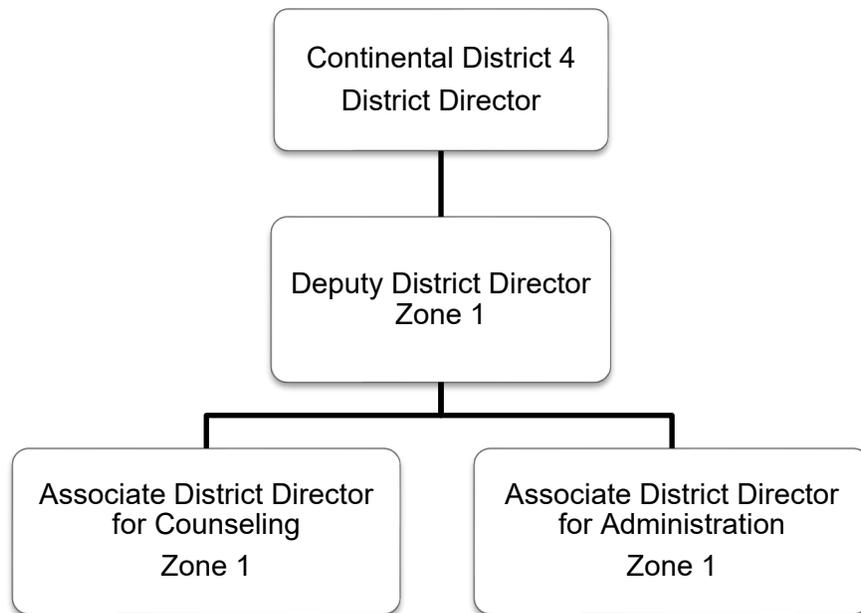
<sup>3</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021. Vet centers provide counseling interventions for psychological and psychosocial readjustment problems related to specific types of military deployment stressors. Readjustment counseling services are "designed by law to be provided without a medical diagnosis." Therefore, those receiving readjustment services are not considered patients. To be consistent with vet center policy and terminology, the OIG refers to veterans receiving such services as clients in this report.

difficult to quantify the risk of adverse impact to clients served at vet centers, the OIG recommendations should help vet centers identify areas of vulnerability or conditions that, if addressed, could improve safety and quality of care.

## Leadership and Organizational Risks

The leadership and organizational risks review is specific to district office and includes results from leadership questionnaires sent to all zone vet center directors.

The district 4 zone 1 leadership team consists of the District Director, Deputy District Director, Associate District Director for Counseling, and Associate District Director for Administration (see figure 2).<sup>4</sup>



**Figure 2.** Continental district 4 zone 1 leaders.  
Source: VA OIG analysis of district organizational chart.

At the time of the OIG inspection, the four district leaders had been working together as a group for more than 12 months.<sup>5</sup> Two of 23 vet center director (VCD) positions were vacant in the past 12 months. One VCD position vacant for four months had been filled, and the other vacancy of

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<sup>4</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021. Readjustment Counseling Service is an organizational element within VHA with direct-line authority for community-based vet centers and is responsible for the provision of readjustment counseling.

<sup>5</sup> For the purposes of this report, the term *district leaders* refer to the district 4 District Director, district 4 zone 1 Deputy District Director, Associate District Director for Counseling, and Associate District Director for Administration.

five months had an acting VCD. Both position vacancies were reported to be in areas with hiring challenges, and recruitment incentives had been used to fill them.

District leaders were knowledgeable about basic concepts of healthcare quality improvement and engaged in continuous improvement activities. Zone-wide VCD questionnaire responses showed that VCDs had an understanding of quality improvement concepts and perceived their role as important to quality oversight of care provided at vet centers.

The VA All Employee Survey is an annual, voluntary survey of VA workforce experiences.<sup>6</sup> District leaders shared in-depth information about actions taken during the previous 12 months to maintain or improve organizational health performance, employee satisfaction, and client experiences. The OIG identified district 4 zone 1's top fiscal year 2020 VA All Employee Survey priorities as growth, workload, communication, and innovation.<sup>7</sup>

The OIG reviewed fiscal year 2020 Vet Center Service Feedback survey results and found that district 4 zone 1 exceeded national scores in four of the six categories.

## Quality Reviews

The OIG conducted an analysis of vet center clinical and administrative quality reviews and critical incident quality reviews. Vet centers are required to have annual clinical and administrative quality reviews completed to ensure compliance with policy and procedures. At the time of the OIG's inspection, Readjustment Counseling Service (RCS) required critical incident quality reviews for client safety events (events not primarily related to the natural course of the client's illness or underlying condition) including clients with serious suicide or homicide attempts, death by suicide, or homicide.<sup>8</sup>

The OIG found the district 4 zone 1 Associate District Directors for Counseling and Administration compliant with requirements for completion of annual vet center quality site visit reviews. The OIG identified deficiencies with remediation plans including the lack of the deputy district director's approval, a date of approval, and documentation showing resolution of the issues. The OIG identified deficiencies with completion of critical incident quality reviews for

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<sup>6</sup> "VA All Employee Survey," VHA National Center for Organization Development, accessed September 10, 2019, <https://www.va.gov/ncod/vaworkforcesurveys.asp>.

<sup>7</sup> District leaders were asked to identify the top three 2020 VA All Employee Survey priorities. Two of the four priorities identified in the report were tied for third. Fiscal year 2020 is October 1, 2019, through September 30, 2020.

<sup>8</sup> VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010; VHA, *RCS Guidelines and Instructions for Vet Center Administration*, November 23, 2010. Both 2010 policies were rescinded and replaced by VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021. The 2021 directive uses the term mortality and morbidity reviews rather than critical incident quality reviews.

active clients with serious suicide attempts.<sup>9</sup> The OIG issued three recommendations for clinical and administrative quality reviews and one recommendation for critical incident quality reviews.

## **COVID-19 Response**

The COVID-19 response review results were obtained through a zone-wide questionnaire to staff and interviews with district leaders and VCDs from the four selected vet centers. The review is designed primarily to gather information from district leaders and staff within the zone and to draw general conclusions.

The OIG interviewed district leaders and VCDs of the four selected vet centers in the following areas: emergency planning, supplies and infrastructure, access and client care—telework and telehealth, and client screening including referral. District leaders were also interviewed about communication and field guidance. The OIG sent a COVID-19 voluntary questionnaire to 147 employees at the 23 zone 1 vet centers.

District leaders stated that the RCS Central Office provided timely guidance. While initially there were shortages of personal protective equipment for staff, adequate supplies were reported at the time of inspection. District leaders reported all zone staff were trained on VA Video Connect for the provision of client telehealth services and use of telework rapidly increased. District leaders and VCDs reported all vet center visitors had COVID-19 screenings, and visitors with positive screenings were referred to local healthcare pathways. Overall, employees' responses to the COVID-19 questionnaire indicated that district leaders and VCDs provided routine communication and guidance that helped with employee and client safety. Results for the COVID-19 response review generally do not rise to the level of findings.

## **Suicide Prevention**

The suicide prevention review included a zone-wide evaluation of electronic client records, and a focused review of the four selected vet centers. Results and recommendations related to identified deficiencies were made to the district office.

Vet centers are required to complete a psychosocial assessment including an intake and military history.<sup>10</sup> The OIG found overall noncompliance with completion of the intake sections of the psychosocial assessment and timely completion of lethality risk assessments. The OIG's review of electronic client record documentation identified deficiencies with clinician coordination and consultation with support VA medical facilities for high-risk clients, adherence to client

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<sup>9</sup> RCS policy does not define a serious suicide attempt; in the absence of an RCS definition of a serious suicide attempt, the OIG considered the client being transferred to the hospital an indicator of a serious suicide attempt that would have met the criteria for completion of a critical incident quality review.

<sup>10</sup> RCS-CLI-003, *Revised Clinical Site Visit (CSV) Protocol*, January 25, 2019; VHA, *RCS Guidelines and Instructions for Vet Center Client Records*, November 23, 2010; VHA Directive 1500(1), 2021.

confidentiality requirements and clinical staff consultation following lethality status changes. The OIG also found deficiencies with completion of crisis reports in all cases of suicide completions, attempts, gestures, and interventions; and homicide attempts, completions, and interventions.<sup>11</sup>

The OIG found the four selected vet centers complied with nontraditional hours and reviewing the high-risk suicide flag SharePoint site monthly and documenting dispositions for clients. The four selected vet centers each had an updated crisis plan. The OIG found deficiencies with vet center staffs' participation on VA medical facility mental health councils.<sup>12</sup> The OIG found vet centers' did not provide evidence of receiving or asking for the required Office of Mental Health and Suicide Prevention lists for clients with increased predictive risk for suicide and updated lists of clients designated as high risk for suicide.<sup>13</sup> The four selected vet centers did not have a standardized communication processes to collaborate with the support VA medical facility suicide prevention coordinators.

The OIG issued eight recommendations: seven specific to the suicide prevention zone-wide evaluation of electronic client records and one specific to the four selected vet centers' suicide prevention and intervention processes.<sup>14</sup>

## Consultation, Supervision, and Training

The consultation, supervision, and training review evaluated the four selected vet centers with results and recommendations specific only to those sites. The OIG found the four selected vet

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<sup>11</sup> VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021. A support VA medical facility is “aligned laterally with every Vet Center for providing supportive administration and clinical collaboration to better serve eligible individuals.”

<sup>12</sup> VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010; VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021. “To reinforce the partnership between the Vet Center and the support VA medical facility, to better serve eligible Veterans accessing services at both facilities, and to fully support critical incident response and suicide prevention, a licensed Vet Center staff member will be assigned to participate on all VA Medical Center Mental Health Councils.” VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. Mental Health Councils at “Each VA medical center must establish and maintain a Mental Health Executive Council that includes representation from core mental health professional disciplines and specialty VA mental health programs with administrative support from the medical center.” For the purposes of this report, the OIG uses the term VA medical facility instead of VA medical center.

<sup>13</sup> The Office of Mental Health and Suicide Prevention is the VA office responsible for sharing a monthly list of veterans who have an increased predictive risk for suicide with Readjustment Counseling Services, so vet centers can identify clients who are receiving counseling services and better coordinate care with VA medical facilities.

<sup>14</sup> The Deputy Under Secretary for Health for Operations and Management (10N)'s 2017 “Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services,” outlined responsibilities shared between RCS and the Office of Mental Health and Suicide Prevention. The OIG does not make recommendations for deficiencies identified in this report related to three suicide prevention-shared responsibilities as recommendations on the deficiencies were directed to the Under Secretary for Health, who has authority over both programs, in a recently issued OIG report—*Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021.

centers showed overall compliance with a clinical liaison appointed from a mental health or social work service, and overall compliance with having at least one licensed and credentialed VHA qualified mental health professional on staff.<sup>15</sup> The OIG found deficiencies with the four selected vet centers' external clinical consultation hours. The OIG identified the four vet centers were deficient with requirements for weekly staff supervision, monthly audit of records, and staff training.<sup>16</sup> The OIG issued five recommendations specific to the four selected vet centers' consultation, supervision, and training requirements.

## Environment of Care

The environment of care review evaluated the four selected vet centers with results and recommendations specific only to those sites. Generally, the four vet centers inspected followed environment of care requirements for the physical environment, general safety, and privacy. However, the four vet centers inspected did not have tactile (braille) exit signage.<sup>17</sup> Three vet centers did not secure clients records, and two vet centers did not have an updated emergency and crisis plan, as required, and the OIG issued three recommendations specific to the four selected vet centers' environment of care requirements.

## Conclusion

The OIG conducted a detailed inspection across six review areas and issued a total of 20 recommendations for improvement to the District Director. The number of recommendations should not be used as a gauge for the overall quality of care provided within the zone. The intent is for the district leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues, as well as other less critical findings that, if left unattended, may interfere with the delivery of quality care.

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<sup>15</sup> *RCS Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

<sup>16</sup> *RCS Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021; RCS-CLI-003, *Revised Clinical Site Visit Protocol*, January 25, 2019.

<sup>17</sup> Architectural Barriers Act of 1968 (codified as amended at 42 U.S.C. § 4151 et seq.).

## Comments

The RCS Chief Officer and District Director concurred with recommendations 1–3, 5–14, and 16–19, and concurred in principle with recommendations 4, 15, and 20. An action plan was provided (see responses within the body of the report for full text of RCS comments, and appendixes D and E for the Chief Officer and District Director memorandums). The OIG considers all recommendations open and will follow up on the planned and recently implemented actions to ensure they have been effective and sustained.



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## Background

Vet centers are community-based clinics that provide a wide range of psychosocial services to clients including eligible veterans, active duty service members, National Guard members, reservists, and their families, to support a successful transition from military to civilian life.<sup>1</sup> Services include individual, group, and family counseling for mental health conditions related to military sexual trauma, posttraumatic stress disorder, and other military-related concerns. Vet center staff assess and manage clients at risk for suicide, substance abuse, and other medical and mental health conditions.<sup>2</sup> Other services include bereavement support for families, referrals to the Veterans Benefits Administration, screening and assessment for employment, outreach including Post Deployment Health Reassessment, and help with linkage to the Veterans Health Administration (VHA) and community organizations.<sup>3</sup>

### Vet Center History

The Readjustment Counseling Service (RCS) is an organizational element within VHA with direct-line authority for community-based vet centers and is responsible for the provision of readjustment counseling.<sup>4</sup> Since opening vet centers in 1979, RCS was one of the first organizations to address the psychological and social effects combat has on veterans before the

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

<sup>2</sup> VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021; Policy Memorandum RCS-CLI-003, *Revised Clinical Site Visit (CSV) Protocol*, January 25, 2019.

<sup>3</sup> VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500 (1), January 26, 2021, amended May 3, 2021; U.S. Department of Veterans Affairs, "Vet Centers (Readjustment Counseling)" accessed March 24, 2021, <https://www.vetcenter.va.gov/Eligibility.asp>. Vet center staff use the Post Deployment Health Reassessment to screen and evaluate the health of service members returning from combat.

<sup>4</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010, was in effect during the OIG's inspection period. It was rescinded and replaced by VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. Unless otherwise specified, requirements in the 2021 directive use the same or similar language as the rescinded November 2010 guidelines. Vet center clinicians provide readjustment counseling to veterans to assist with combat related psychological and psychosocial readjustment.

American Psychiatric Association recognized posttraumatic stress disorder as an official diagnosis in 1980.<sup>5</sup>

While vet centers initially focused on Vietnam-era veterans, services are now offered to veterans of all combat theaters and active service members as well as their families.<sup>6</sup> From 1979 through 1985, an estimated 305,000 clients received services at vet centers; and in fiscal year 2019, RCS Central Office reported 307,737 clients were seen.<sup>7</sup> In an attempt to serve the growing veteran population, the number of vet centers expanded from 91 in 1979 to 300 as of June 2018.<sup>8</sup> Along with the increase in number of clients served, vet centers have undergone expansion to assist clients through a variety of services. Figure 3 shows a map of vet centers and vet center outstations.<sup>9</sup>

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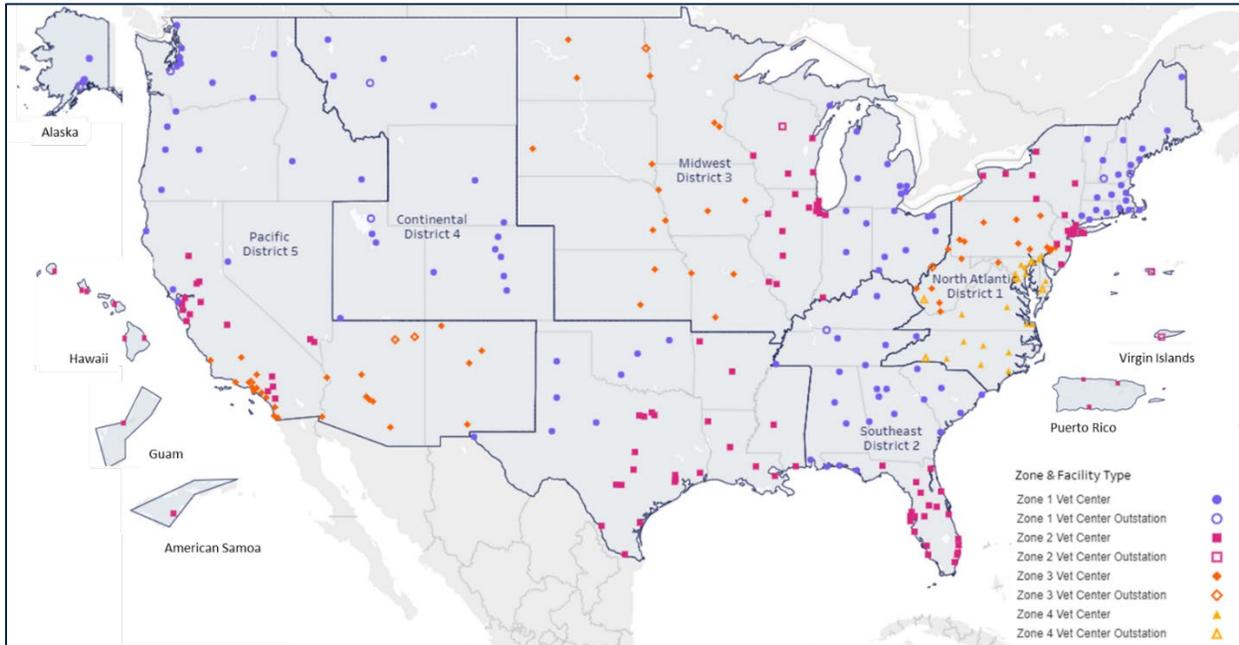
<sup>5</sup> Mayo Clinic website, “Post-traumatic stress disorder (PTSD),” accessed December 10, 2020, <https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967>. “Post-traumatic stress disorder (PTSD) is a mental health condition that’s triggered by a terrifying event – either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event.” VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

<sup>6</sup> VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), 2021. The 2021 directive clarified that “Family readjustment counseling is contingent upon there being a problem identified that is related to the eligible individuals’ readjustment and active involvement in the counseling with family members.”

<sup>7</sup> VHA Directive 1500 (1), 2021. RCS Central Office is the national office responsible for program policy and supervision of RCS district offices, providing direct line supervision for vet center administrative and clinical functions. Government Accountability Office. *Vietnam Veterans: A Profile of VA’s Readjustment Counseling Program*, Report No. GAO/HRD-87-63, August 1987, and 1996 *Readjustment Counseling Service: Vet Centers Address Multiple Client Problems, but Improvement Is Needed*, Report No. GAO/HEHS-96-113, July 1996. Fiscal year 2019 is October 1, 2018, through September 30, 2019.

<sup>8</sup> Arthur S. Blank Jr., “Apocalypse Terminable and Interminable: Operation Outreach for Vietnam Veterans.” *Hospital and Community Psychiatry*. Volume 33, Number 11, November 1982.

<sup>9</sup> VHA, *RCS Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. RCS outstations promote additional points of access for clients and are aligned under a host vet center. Vet center outstations are distant from established vet centers and while not having the same staffing requirements outstations have at least one full-time counselor.



**Figure 3.** Map of vet centers and vet center outstations. The placement of Alaska, American Samoa, Hawaii, Guam, Puerto Rico, and the Virgin Islands are not representative of their actual geographical locations.<sup>10</sup>  
 Source: VA OIG developed using VA Site Tracking (January 19, 2021) and RCS data (as of March 2, 2021).

Vet center services and eligibility started expanding in 1991 with a notable change in 2003 permitting RCS to provide bereavement counseling to surviving parents, spouses, children, and siblings of service members who die of any cause while on active duty.<sup>11</sup> Table 1 shows the expansion of vet center eligibility.

<sup>10</sup> VHA News Release, *VA Deploying 20 New Mobile Vet Centers*, January 4, 2012. Southeast District 2 includes Puerto Rico and the Virgin Islands. Pacific District 5 includes Alaska, Hawaii, Guam, and American Samoa. Not on the map are the locations of mobile vet centers used to provide counseling or outreach services to the community.

<sup>11</sup> VA, “Who We Are,” Vet Centers (Readjustment Counseling), accessed June 4, 2019, [https://www.vetcenter.va.gov/About\\_US.asp](https://www.vetcenter.va.gov/About_US.asp). Activated Reserve and National Guard members are eligible for services, as noted in table 1.

**Table 1. Vet Center Eligibility Expansion**

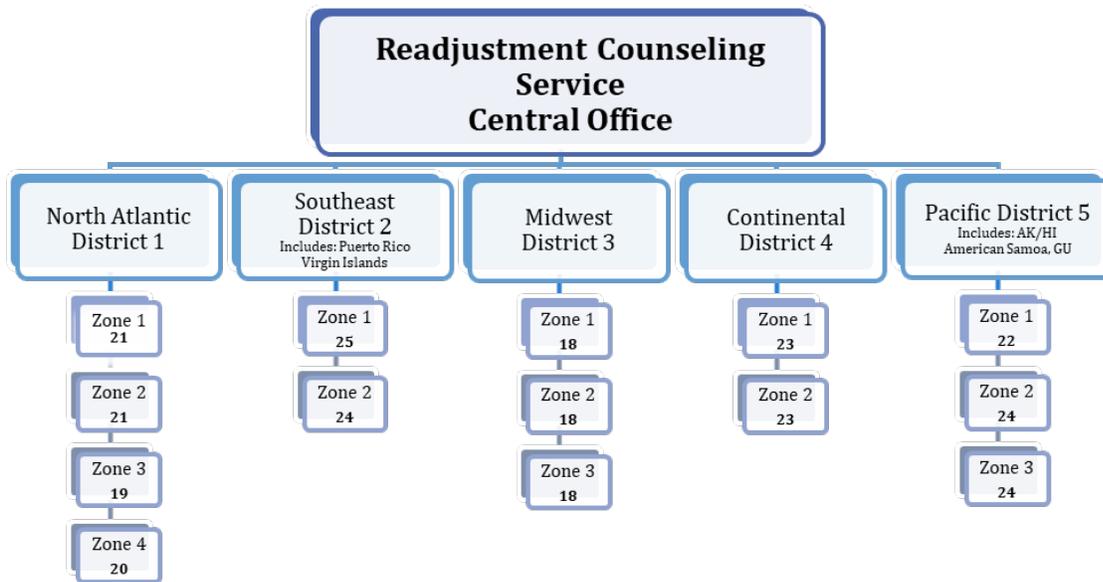
Year	Vet Center Eligibility Expansion
1991	Veterans who served post-Vietnam
1992	Veterans who experienced military sexual trauma
1996	Veterans who served in World War II and Korean Combat Veterans*
2002	Bereavement counseling to surviving family members of veterans receiving VA services at the time of death and family members of active duty service members killed while on active duty
2003	Veterans of Global War on Terrorism (GWOT) Veterans of Operation Enduring Freedom (OEF) Veterans of Operation Iraqi Freedom (OIF)
2011	Federally activated National Guard and Reserve forces who served on active duty in Operation Enduring Freedom or Operation Iraqi Freedom or both
2013	Family members of deployed service members for counseling Crew members of unmanned aerial vehicles in combat operations or areas of hostility Providers of direct emergent medical care or mortuary services while serving on active military duty
2014	Amended VA's authority to provide counseling and care and services to active duty service members reporting sexual assault or harassment without a Tricare referral
2020	Forces who served on active duty in response to a national emergency or major disaster National Guard in response to a disaster or civil disorder Any individual who participated in a drug-related military action as a member of the Coast Guard

Source: VA OIG analysis of vet center eligibility expansion information. *Vet Center Eligibility*, accessed June 4, 2019, <https://www.vetcenter.va.gov/Eligibility.asp>. Department of Veterans Affairs Health Care Programs Enhancement Act of 2001, Pub. L. No. 107-135 (2002). National Defense Authorization Act for Fiscal Year 2013, Pub. L. No. 112-239 (2013).

\*In 1996 armed hostile periods were expanded to include additional combat eras. *Federal Register*, Vol. 49, No. 49, Proposed Rules, March 13, 2012.

## RCS Organizational Structure

RCS is aligned under the VA Under Secretary for Health and has governance of 300 vet centers, 80 mobile vet centers, 18 outstations, and the Vet Center Call Center.<sup>12</sup> RCS establishes clinical and administrative policies for vet center operations.<sup>13</sup> The RCS Chief Officer reports directly to the VA Under Secretary for Health and is responsible for formulating program policy for vet centers, providing expertise to the field, and engaging in strategic planning. The RCS Operations Officer reports to the RCS Chief Officer and provides direction and oversight to the district directors who oversee the districts. RCS has five districts, each with two to four zones. Each zone has a range of 18 to 25 vet centers. Figure 4 shows the RCS organizational district and zone structure. Each vet center has a vet center director (VCD) who oversees all vet center operations.<sup>14</sup>



**Figure 4.** RCS organizational district and zone structure.

Source: VA OIG developed by analysis of RCS information.

Note: The number of vet centers in each zone is denoted below the respective zone. The OIG did not assess RCS data for accuracy or completeness.

<sup>12</sup> “Vet Centers (Readjustment Counseling),” VA, accessed July 8, 2019. <https://www.vetcenter.va.gov/>. The Vet Center Call Center, reached at 1-877-WAR-VETS or 1-877-927-8387, is a toll-free, 24-hour per day, 7 days per week, confidential call center for veterans and their families to receive support regarding their military experience or any other readjustment issue. VHA Directive 1500, September 8, 2010; VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), 2021.

<sup>13</sup> VHA Directive 1500, September 8, 2010; VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), 2021.

<sup>14</sup> VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

## Electronic Client Record

Vet center services are not required to be recorded in the client's VA electronic health record.<sup>15</sup> An RCS National Service Support leader noted that prior to fiscal year 2003, RCS used a paper record system to record client visits and data. In fiscal year 2003, a web-based software system called RCSnet was implemented to collect client information. On January 1, 2010, RCSnet became the sole record keeping system for client services. RCSnet's independence from VA medical facilities and Department of Defense's electronic health record systems allows vet centers to maintain secure and confidential records that will not be disclosed to VA medical facilities, VA clinics, or the Department of Defense unless a signed release of information.<sup>16</sup> The RCS National Service Support leader reported working with Cerner Corporation and VA's Office of Electronic Health Record Modernization for the development of an RCS-specific electronic client record system.<sup>17</sup>

## VA Medical Facilities

Guidelines, as outlined in this paragraph, were established by RCS for vet centers to maintain an active and reciprocal relationship with VA medical facilities to ensure clients receive quality care and needed services.<sup>18</sup> The support VA medical facility director in coordination with the VCD assigns a clinical and administrative liaison.<sup>19</sup> The VA medical facility clinical liaison coordinates services for complex and shared clients.<sup>20</sup> The VA medical facility administrative liaison provides support for procurement, engineering functions, commuter benefits, general post

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<sup>15</sup> VHA, *RCS Guidelines and Instructions for Vet Center Client Records*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

<sup>16</sup> VHA Handbook 1500.01, September 8, 2010. VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. 38 C.F.R. § 17.2000 – 816 (e). Vet centers will not disclose clients records unless a client authorizes release or there is a specific exemption.

<sup>17</sup> VHA Directive 1500, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. Per the RCS National Service Support leader, modernization of the RCSnet electronic client record system for vet centers was being considered but a determination had not been made. RCS Central Office is the national program office responsible for program policy and supervision of RCS district offices, providing direct line supervision for vet center administrative and clinical functions. Cerner Corporation, Cerner Government Services, "Federal Government," accessed June 29, 2021, <https://www.cerner.com/solutions/federal-government>. Cerner is a Corporation that promotes secure modern technology to improve healthcare operations, create solutions, and connect and engage healthcare communities.

<sup>18</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

<sup>19</sup> VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021. A support VA medical facility is "aligned laterally with every vet center for providing supportive administration and clinical collaboration to better serve eligible individuals."

<sup>20</sup> For the purposes of this report, the OIG uses the term VA medical facility instead of VA medical center and VHA medical facility.

funds, and fleet management for U.S. government vehicles.<sup>21</sup> RCS requires vet center staff to collaborate with VA medical facilities by participating on mental health councils and coordinating care with VA medical facility suicide prevention coordinators for shared clients.<sup>22</sup>

## Purpose and Scope

The purpose of the VA Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) is to conduct routine oversight of vet centers providing readjustment services to clients. The OIG inspection examined operations generally from November 1, 2019, through October 31, 2020. This report evaluates aspects of the quality of care delivered at vet centers and examines a broad range of key clinical and administrative processes associated with positive client outcomes. The OIG reports its findings to Congress and VHA, so informed decisions can be made on improving care.

The OIG findings are a snapshot of a zone and vet centers' performance within identified focus areas. Although it is difficult to quantify the risk of adverse impact to clients served at vet centers, the OIG recommendations in this report should help vet centers identify areas of vulnerability or conditions that, if addressed, could improve safety and quality of care ([see appendix A](#)).<sup>23</sup>

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

- Leadership and organizational risks
- Quality reviews
- COVID-19 response<sup>24</sup>

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<sup>21</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

<sup>22</sup> VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021.

<sup>23</sup> The underlined terms are hyperlinks to other sections of the report. To return from the point of origin, press and hold the “alt” and “left arrow” keys together.

<sup>24</sup> “A pneumonia of unknown cause detected in Wuhan, China, was first reported to the World Health Organization (WHO) Country Office in China on 31 December 2019. The virus was later named ‘SARS-CoV-2’ and the disease it causes named ‘coronavirus disease 2019’ (abbreviated ‘COVID-19’).” VHA – OEM, *COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan, Version 1.6*, March 23, 2020. World Health Organization, “WHO Director-General’s opening remarks at the media briefing on COVID-19 – 11 March 2020,” accessed on August 20, 2020, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>.

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

## Methodology

The OIG announced the inspection to district leaders on January 25, 2021, and conducted virtual site visits from January 25 through February 11, 2021.<sup>25</sup> The OIG interviewed district leaders and directors at the selected vet centers. Due to travel restrictions during the COVID-19 pandemic, the inspection was conducted virtually.<sup>26</sup>

The OIG reviewed RCS policies and practices, validated client RCSnet record findings, examined administrative and performance measure data, explored reasons for noncompliance, and virtually inspected select areas of care within vet centers.

A new VHA directive was issued in January 2021 (amended May 3, 2021) after the OIG's inspection period of VCIP operations (November 1, 2019–October 31, 2020) discussed in this report.<sup>27</sup> The new directive rescinded and replaced multiple VHA guidelines and policies addressing RCS operations that were in effect during the inspection period. The OIG compared the rescinded guidelines and policies with the newly issued directive to identify modifications. Unless otherwise specified, requirements in the new directive use the same or similar language as the rescinded RCS-related guidelines and policies under discussion in this report. The OIG findings in this report are based on the RCS-related guidelines and policies that were in effect during the inspection period. Recommendations are consistent with the 2021 directive addressing RCS operations.

The OIG emailed two questionnaires: the first questionnaire focused on quality improvement activities and was sent to all VCDs within the zone, and the second focused on the COVID-19 response and was sent to all staff within the zone.

## District and Zone Selection

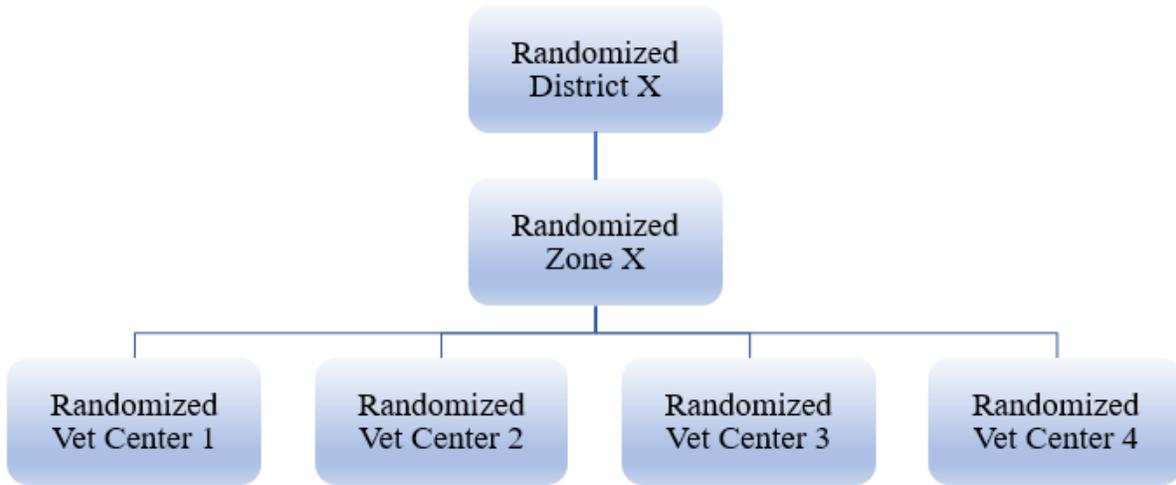
Site selection was completed through randomization, beginning sequentially with the district, zone, and vet centers respectively (see figure 5).

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<sup>25</sup> For the purpose of this report, *district leaders* refers to the district 4 district director, district 4 zone 1 deputy district director, associate district director for counseling, and associate district director for administration.

<sup>26</sup> "Travel During COVID-19," Centers for Disease Control and Prevention, accessed on March 24, 2021, <https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-during-covid19.html>.

<sup>27</sup> VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

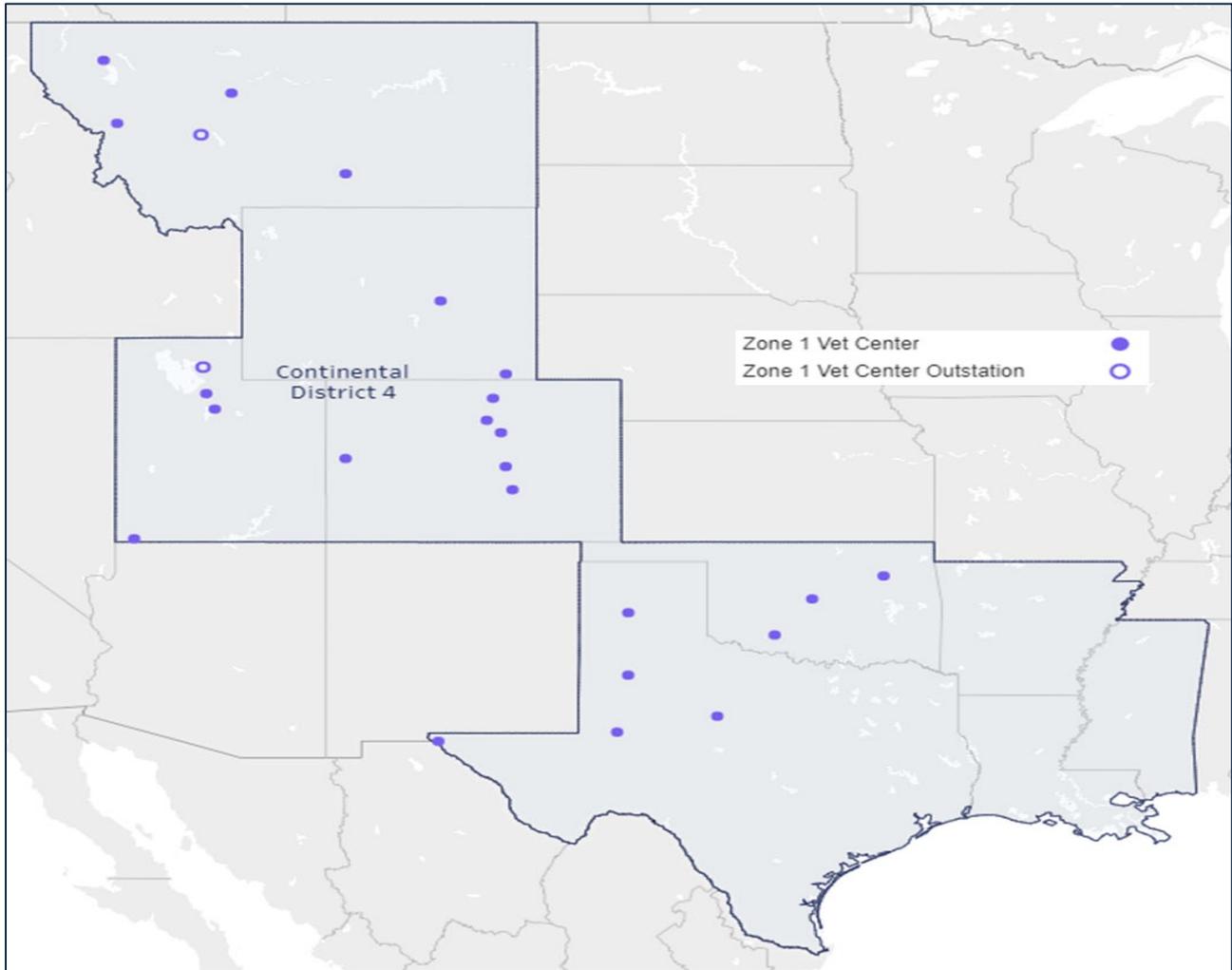


**Figure 5.** Randomization and selection of inspection sites  
*Source: VA OIG.*

For this inspection, district 4 zone 1 was randomly selected. Within zone 1, the Casper, Wyoming; Denver, Colorado; El Paso and Midland, Texas, Vet Centers were randomly selected. Geographical locations of the district’s zone 1 vet centers are noted in figure 6. For demographic profiles of district 4 zone 1 and the four selected vet centers see [appendix B](#) and [appendix C](#). The OIG provided one-day notice to each vet center prior to formal evaluation.<sup>28</sup>

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<sup>28</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. Vet centers are composed of small multidisciplinary teams. The OIG team provided one-day notice for coordination of client care as needed.



**Figure 6.** Map of district 4 zone 1 vet centers including outstations.

Source: VA OIG developed using Veteran Affairs Site Tracking.

The leadership and organizational risks review is specific to the district and zone office and included interviews with district leaders and reviews of

- leadership stability,
- quality improvement activities,
- VA All Employee Survey results,
- Vet Center Service Feedback survey results, and
- response results gathered through a zone-wide questionnaire sent to all VCDs.

The assessment of quality reviews included evaluating the vet center clinical and administrative oversight reviews for the zone and critical incident quality reviews.

The COVID-19 response review results were obtained through a zone-wide questionnaire to staff and interviews with district leaders and VCDs from the four selected vet centers. The COVID-19 review was designed primarily to gather information from district leaders and staff within the zone and to draw general conclusions. Results from the COVID-19 questionnaire response review generally do not rise to the level of findings.

The suicide prevention review included a zone-wide evaluation of RCSnet electronic client records with results and recommendations specific to the district office, and a focused review of the four selected vet centers with results and recommendations to the district office and the four vet center sites.<sup>29</sup>

The consultation, supervision, and training review and environment of care review evaluated the four selected vet centers with results and recommendations specific only to those sites.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, (codified as amended 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leadership if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

## Results and Recommendations

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

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<sup>29</sup> For vet center clients shared with support VA medical facilities, the OIG also reviewed VHA electronic health records. The Deputy Under Secretary for Health for Operations and Management (10N)'s 2017 "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services," outlined responsibilities shared between RCS and the Office of Mental Health and Suicide Prevention. The OIG does not make recommendations for deficiencies identified in this report related to three suicide prevention-shared responsibilities as recommendations on the deficiencies were directed to the Under Secretary for Health, who has authority over both programs, in a recently issued OIG report—*Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021.

## Leadership and Organizational Risks

Leadership and organizational risks can affect a healthcare system's ability to provide safe and sustainable care.<sup>30</sup> Stable and effective leadership is critical to improving care and sustaining meaningful change within a healthcare system, and effective healthcare leadership is essential for achieving quality of care.<sup>31</sup>

The OIG assessed leadership and organizational risks for district 4 zone 1 by evaluating the following:

- District leadership position stability
- Quality improvement activities
- Employee satisfaction (VA All Employee Survey results)
- Vet Center Service Feedback Survey results
- Leadership and organizational risk questionnaire results<sup>32</sup>

### District Leadership Position Stability

RCS district directors oversee the deputy district directors who are responsible for an assigned zone (one deputy per zone). Deputy district directors supervise zone associate district directors. The associate district director for counseling is responsible for providing guidance on all clinical operations, including clinical quality reviews and critical incident reporting. The associate district director for administration is responsible for providing guidance on administrative operations and administrative quality reviews. VCDs report to deputy district directors and are responsible for the overall vet center operations including staff supervision, administrative and fiscal operations, outreach events, community relations, hiring staff, and clinical programs.<sup>33</sup> Figure 7 shows the leadership organizational structure for district 4 zone 1.

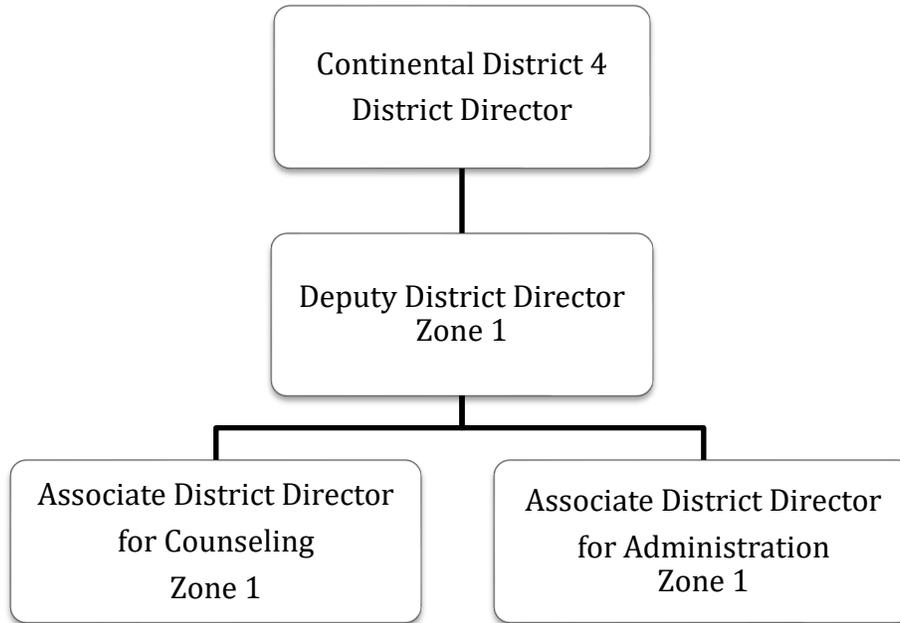
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<sup>30</sup> Botwinick L, Bisognano M, Haraden, C. *Leadership Guide to Patient Safety*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2006.

<sup>31</sup> Sfantou, D, Laliotis, A, Patelarou, A, Sifaki-Pistolla, D, Matalliotakis, M, Patelarou, E, *Importance of Leadership Style towards Quality of Care Measures in Healthcare Settings: A Systematic Review*; Healthcare (Basel). 2017 Dec; 5(4): 73. Published online October 14, 2017.

<sup>32</sup> The leadership and organizational risk questionnaire is a tool the OIG used to ask zone-wide VCDs about quality improvement to evaluate knowledge and practices.

<sup>33</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.



**Figure 7.** District leaders

Source: VA OIG analysis of district organizational chart.

At the time of the OIG inspection, all four district leaders had been working together for more than 12 months. The longest tenure in a district leader position was eight years and 11 months and shortest was one year and seven months.<sup>34</sup> The District Director reported that two of 23 VCD positions were vacant in the past 12 months. At the time of the inspection, one VCD position vacant for four months had been filled, and the other vacancy of five months had an acting VCD. The District Director stated both position vacancies were in areas with hiring challenges and recruitment incentives had been used.

## Quality Improvement Activities

To assess district leaders' knowledge about healthcare quality improvement concepts and practices, the OIG interviewed district leaders. The information provided in this report section is based on those interviews.

Overall, district leaders were knowledgeable about the basic concepts of quality improvement and generally spent five or more hours a week engaged in quality improvement activities for vet centers. District leaders shared in detail actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and client experiences. District leaders reported that RCS Central Office provided adequate resources for district quality planning needs. The Deputy District Director gave an example of RCS Central Office dedicated

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<sup>34</sup> The Deputy District Director was in the leadership position eight years and 11 months and the Associate District Director for Counseling for one year and seven months.

staff that facilitated the district's VA All Employee Survey results review, analysis, and strategic planning.

## Employee Satisfaction

In 2001, the VA All Employee Survey was developed to meet VA needs for assessment of workforce satisfaction and organizational climate. According to the VHA National Center for Organization Development, the VA All Employee Survey is an annual, voluntary survey of VA workforce experiences.<sup>35</sup> Responses are confidential and data anonymous. Since 2001, the instrument has been updated in response to operational inquiries by VA leadership on VA culture and organizational health relationships.<sup>36</sup> Although the OIG recognizes that employee satisfaction survey data are subjective, the information can be a starting point for discussions, be indicative of areas for further inquiry, and be considered along with other information for leaders' evaluation.

The OIG identified the top fiscal year 2020 VA All Employee Survey priorities as growth, workload, communication, and innovation.<sup>37</sup> The OIG asked district leaders how the VA All Employee Survey results were prioritized and what changes were made within the zone based on the survey findings. District leaders reported implementing actions including but not limited to the following:

- Monthly District Director email to all staff with updates
- Zone-wide staff distribution of district conference call minutes
- Recorded "NAP [Not a Podcast] Chats" (audio training featuring guest speakers)<sup>38</sup>
- Unified district clinical meetings with counseling staff from both zones

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<sup>35</sup> "VA All Employee Survey," VHA National Center for Organization Development, accessed September 10, 2019, <https://www.va.gov/ncod/vaworkforcesurveys.asp>.

<sup>36</sup> "Healthy organizations are places where employees want to work and customers want to receive services." Smith, J. L. and McCarren, H., VHA National Center for Organization Development, *Organizational Health*, "Developing servant leaders contributes to VHA's improved organizational health," Volume 19, Summer 2013. Osatuke, K., Draime, J., Moore, S.C., Ramsel, D., Meyer, A., Barnes, S., Belton, S., Dyrenforth, S.R. (2012). Organization development in the Department of Veterans Affairs. In T. Miller (Ed.), *The Praeger handbook of Veterans Health: History, challenges, issues and developments, Volume IV: Future directions in Veterans healthcare* (pp. 21-76). Santa Barbara, CA: Praeger.

<sup>37</sup> District leaders were asked to identify the top three 2020 VA All Employee Survey priorities. Two of the four priorities identified in the report were tied for third.

<sup>38</sup> District leaders reported they started a podcast-like communication tool for the district to increase communication; NAP, an acronym stands for Not a Podcast, and was used to create NAP chats.

- VA Virtual Whole Health staff training<sup>39</sup>
- VA Video Connect staff training<sup>40</sup>

One district leader told the OIG the District Director was a champion of the annual VA All Employee Survey results.

## Vet Center Service Feedback Survey

A Vet Center Service Feedback survey is required by RCS for a client once a case is closed or a client has not been seen in the last one hundred days and other select criteria are met.<sup>41</sup> The Vet Center Service Feedback survey includes feedback from clients and family members. RCS uses the following criteria for sending a Vet Center Service Feedback survey:

- The client agreed to participate in questionnaire.
- The client is not receiving services from a VA contracted provider.
- There is no indication the client is deceased.

Results from the survey provide district leaders and VCDs with feedback to evaluate the effectiveness of readjustment counseling.<sup>42</sup> The RCS national database system maintains all client survey feedback and compiles district and national data into summary reports.<sup>43</sup>

Although the scores were generally favorable, the only exceptions were with the “feel better” and overall quality of services categories as both were below the national average.<sup>44</sup> Overall, fiscal year 2020 Vet Center Service Feedback survey scores for district 4 zone 1 exceeded national scores. Clients, service members and family members reported overall average

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<sup>39</sup> VA Whole Health training consists of eight areas of self-care and designed to make connections between one’s health and well-being, VA Whole Health – Whole Health Basics, accessed August 24, 2021, <https://www.va.gov/WHOLEHEALTH/veteran-resources/whole-health-basics.asp>.

<sup>40</sup> VA Video Connect allows Veterans and caregivers to meet with VA health care providers through live video or mobile devices with an internet connection. VA Mobile, *VA Video Connect*, accessed April 6, 2021, <https://mobile.va.gov/app/va-video-connect>.

<sup>41</sup> VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021. RCS-NSS-001, *Readjustment Counseling Service (RCS) Customer Feedback Procedures*, February 1, 2019.

<sup>42</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. The Vet Center Service Feedback survey was formerly known as the Vet Center Client Satisfaction survey. The 2021 directive did not update the survey title and the requirements for administration remained the same.

<sup>43</sup> RCS has a National Service Support section of its program office that maintains its database tracking system.

<sup>44</sup> The OIG considered the vet center service feedback questionnaire results favorable because scores averaged 4 or more and exceeded RCS national averages in four of the six categories. For the feel better question, zone 1 score was 4.27 versus RCS national score of 4.39. For overall quality of services, zone 1 score was 4.45 versus RCS national score of 4.48.

satisfaction with appointment availability, staff courtesy, and vet center services. Table 2 details the results of the Vet Center Service Feedback survey.

**Table 2. Vet Center Service Feedback Survey Results  
(October 1, 2019–September 30, 2020)**

Questions	Zone 1 Average Score*	RCS National Average Score*
I was treated in a welcoming and courteous manner by the Vet Center staff.	4.86	4.67
My appointments have been scheduled at a time that was convenient.	4.66	4.59
I would likely recommend the vet center to another Veteran, servicemember, or family member.	4.66	4.55
The Vet Center services were located conveniently in my community.	4.47	4.39
I feel better as a result of the services provided by the Vet Center staff.	4.27	4.39
How satisfied were you with the overall quality of services at the Vet Center?	4.45	4.48

*Source: VA OIG developed based on RCS District 4 Zone 1 data for clients, service members and family members (received January 25, 2021) The OIG did not assess RCS data for accuracy or completeness.*

*\* Scoring 1=very dissatisfied, 2=dissatisfied, 3=neither satisfied nor dissatisfied, 4=satisfied, 5=very satisfied*

District leaders felt the positive survey results were in part due to vet center counselors’ flexibility in scheduling and vet center accessibility. The District Director reported vet centers work hard to get clients in quickly and access is typically good. District leaders stated vet centers tap into community access points to promote client access by using outstations, mobile vet centers, VA community-based outpatient clinics and fee for service providers. The Deputy District Director stated that vet centers intentionally create a welcoming environment that contributes to client satisfaction and cited the following examples:

- Ease of vet center parking
- Nicely furnished waiting areas
- Full coffee pots in waiting areas
- Staff answering phones instead of using voice mail
- Staff calling clients personally to remind them of appointments

## Leadership and Organizational Risk Questionnaire

The OIG sent a leadership and organizational risk questionnaire to all district 4 zone 1 VCDs consisting of six questions and an optional feedback question to evaluate the perspectives of VCDs about select quality improvement activities and organizational health. Of the 23 questionnaires distributed, 23 were returned. The questionnaire had open-ended questions (with one exception) with no categories or options provided for selection. The OIG reviewed responses for themes, best practices and concerns.<sup>45</sup>

Overall, district leadership was identified as a resource and support structure for vet center quality improvement activities. VCDs had an understanding of quality improvement concepts and perceived their role as important to quality oversight. A majority reported spending less than five hours per week engaged in quality related functions. VCDs cited different ways they sought to promote psychological safety in the workplace that included individual supervision, staff (team) meetings, staff engagement, transparency, and an open-door policy. VCDs used the fiscal year 2020 VA All Employee Survey results for establishing vet center goals and strategic planning. VCDs responses indicated leaders supported quality planning through communication, engagement, and resources. However, one respondent described an initial delay in availability of resources; however, they were resolved. A review of responses showed no safety concerns.

## Leadership and Organizational Conclusion

The OIG concluded that the five areas assessed for leadership and organizational risk were compliant. District 4 zone 1's leadership team was cohesive and stable, and recruitment efforts had been taken to recruit for the VCD position vacancies. District leaders and VCDs were knowledgeable about quality improvement concepts and engaged in continuous improvement activities. District leaders took an interest in VA All Employee Survey results and viewed results as opportunities for improvement. Vet Center Service Feedback survey results for the zone exceeded national averages in four of the six categories. The OIG questionnaire results showed VCDs indicated their role was important to quality improvement oversight, and they engaged weekly in quality activities that district leadership supported.

## Quality Reviews

VHA leaders have articulated the goal to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care.<sup>46</sup> In its efforts to ensure quality of care, client safety,

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<sup>45</sup> The OIG reviewed and categorized VCD responses for general themes using a manual counting method for frequency of responses. Some responses were analyzed but not included in this review due to infrequency, lack of clarity, or redundancy.

<sup>46</sup> VA, Veterans Health Administration's *Blueprint for Excellence – Fact Sheet*, September 2014.

and oversight, RCS policy outlines the use of various tools to monitor its wide range of psychosocial and psychological services to clients.<sup>47</sup>

The OIG evaluated quality oversight for district 4 zone 1 in the following areas:

- Clinical and administrative quality reviews
- Critical incident quality reviews

## **Clinical and Administrative Quality Reviews**

RCS requires an annual quality review of all vet centers to ensure compliance with policies and procedures for the administration and provision of readjustment counseling.<sup>48</sup> Annual quality reviews are composed of separate clinical and administrative site visit reviews. Clinical and administrative quality reviews are similar processes that follow the same time frames and policy, but are completed independently, produce separate reports, and are documented differently.<sup>49</sup>

Clinical quality reviews include but are not limited to:

- Vet center team composition
- Access to vet center services
- Readjustment counseling
- Active client caseloads
- Clinical productivity
- Customer feedback<sup>50</sup>

Administrative quality reviews include but are not limited to:

- Vet center key staff
- Vet center physical site
- Administrative operations
- Privacy and information security management

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<sup>47</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

<sup>48</sup> VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

<sup>49</sup> RCS-CLI-004, *Implementation of Automated Vet Center Clinical Site Visit (CSV) Operations*, November 4, 2019; VHA Directive 1500(1), 2021.

<sup>50</sup> RCS-CLI-003, *Revised Clinical Site Visit (CSV) Protocol*, January 25, 2019.

- Quality management
- Fiscal management<sup>51</sup>

RCS policy requires district directors ensure annual vet center clinical and administrative quality reviews are conducted.<sup>52</sup> Deputy district directors are responsible for approving annual clinical and administrative quality reviews and remediation plans.<sup>53</sup> Associate district directors for counseling and administration conduct the annual quality review that results in a written report. Deficiencies identified in the annual quality review are also included in the report.<sup>54</sup>

Within 30 days of receiving the annual quality review report, the VCD, with the help of the associate district director for counseling or administration, develops a remediation plan with target dates for deficiencies to be corrected.<sup>55</sup> Within 60 days from the date the deputy district director approves the remediation plan, the VCD is responsible for resolving all deficiencies.<sup>56</sup> The associate district director for counseling or administration is required to conduct a follow-up review within 30 days of the target date for completion of the remediation plan to validate the resolution of all deficiencies.<sup>57</sup> Figure 8 depicts the annual vet center quality review process.

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<sup>51</sup> RCS, *District 1 Vet Center Administrative Quality Review Template*, sections I. to VI., revised October 24, 2016.

<sup>52</sup> RCS-CLI-001, *Vet Center Clinical and Administrative Site Visits*, November 2, 2018; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

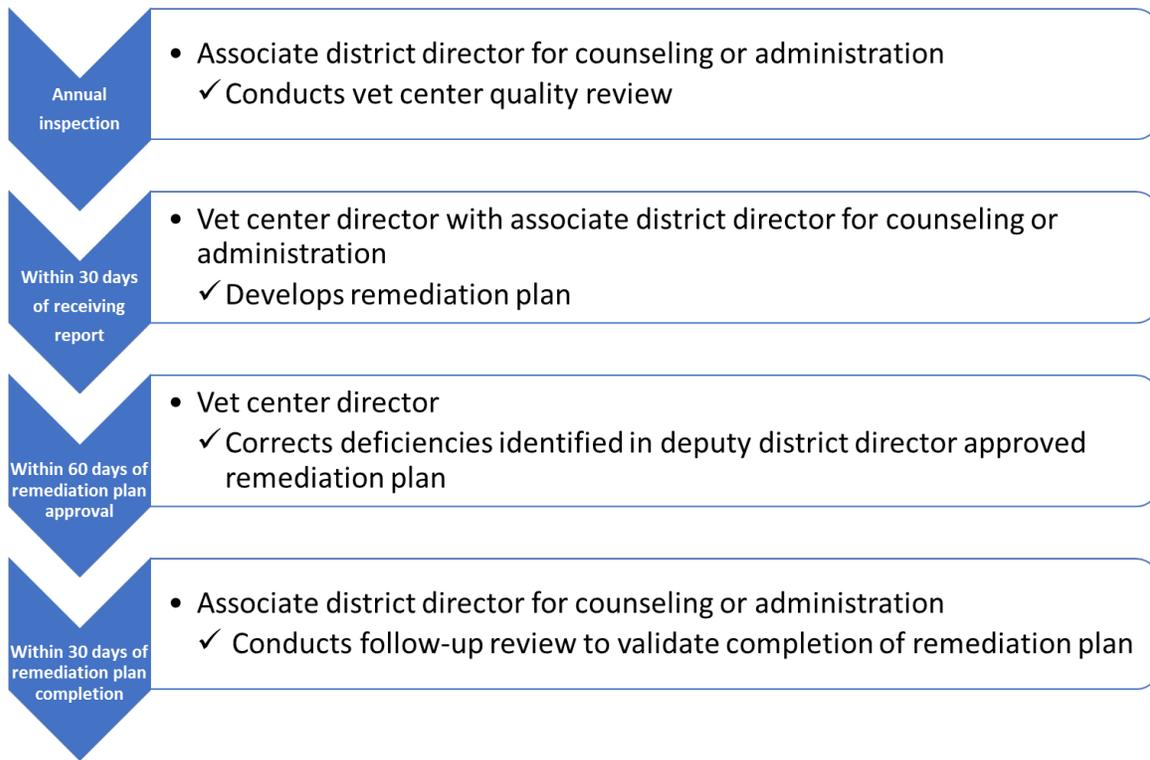
<sup>53</sup> RCS-CLI-001, November 2, 2018; RCS-CLI-003, January 25, 2019; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

<sup>54</sup> RCS-CLI-001, November 2, 2018; RCS-CLI-003, January 25, 2019.

<sup>55</sup> RCS-CLI-001, November 2, 2018.

<sup>56</sup> RCS-CLI-001, November 2, 2018.

<sup>57</sup> RCS-CLI-001, November 2, 2018.



**Figure 8.** Vet center administrative and clinical quality review process.

Source: VA OIG graphic developed using RCS-CLI-001, November 2, 2018 and VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. VHA Directive 1500(1) does not include a step for the deputy district director's approval of the remediation plan, the requirement remains per RCS-CLI-001 (has not been rescinded).

To evaluate the clinical and administrative quality review process for all district 4 zone 1 vet centers, the OIG interviewed district leaders and reviewed

- clinical and administrative site visit reports, and
- clinical and administrative remediation plans.

### Clinical Quality Reviews Findings

Overall, the OIG found the district 4 zone 1 compliant with requirements for the completion of annual vet center clinical quality reviews. The OIG determined that each of the 23 vet centers had completed an annual clinical quality review report, for a total of 23 reports. On average, the 23 reports were approved within 18 days of the annual site visit.<sup>58</sup> Of the 23 completed reports, 10 reports had deficiencies with remediation plans. The 10 reports contained a total of 25

<sup>58</sup> RCS-CLI-003, January 25, 2019.

identified deficiencies across the 10 vet centers, and all deficiencies had documentation of resolution.

Clinical quality reviews and remediation plans are documented in RCSnet to improve monitoring of site visits and to allow for trending of deficiencies for quality improvement activities.<sup>59</sup> RCS requires deputy district director approval of remediation plans to establish the 60-day time frame for deficiency resolution.<sup>60</sup>

The OIG found that remediation plans in RCSnet did not have a location or process step to record a leader’s signature or date. A district leader explained that while RCSnet does not have signature locations for the deputy district director to approve clinical remediation plans in RCSnet, they are involved with the Associate District Director for Counseling throughout the remediation plan process. The OIG was able to see documentation of completed remediation in RCSnet; however, dates of resolution were not documented. Therefore, the OIG was unable to identify if vet center clinical deficiencies were resolved within the required time frames.

**Table 3. Annual Vet Center Clinical Quality Reviews  
(November 1, 2019–October 31, 2020)**

Requirement	Completed Reports	Expected Reports
Annual Clinical Quality Review	23	23
Remediation Plan	10	10

*Source: VA OIG requested the last signed clinical and administrative site visit reviews and remediation plans, if applicable for each vet center in the zone completed on or prior to October 31, 2020; analysis based on district 4 zone 1 documents completed between November 1, 2019 through October 31, 2020.*

The OIG identified the following findings:

- Remediation plans did not include documentation of the Deputy District Director’s approval or date of approval.
- Documentation limitations resulting in an inability to determine dates of resolution for site visit deficiencies.

### *Administrative Quality Reviews Findings*

Overall, the OIG found the zone compliant with requirements for the completion annual vet center administrative quality reviews. Each of the 23 vet centers had completed an annual administrative quality review report, for a total of 23 reports. The OIG determined that the 23 reports were approved on average 26 days from the annual site visit and six reports were not signed within the required 30 days.

<sup>59</sup> RCS-CLI-004, *Implementation of Automated Vet Center Clinical Site Visit (CSV) Operations*, November 4, 2019.

<sup>60</sup> RCS-CLI-001, November 2, 2018.

Of the 23 completed administrative quality review reports, eight reports identified deficiencies at the respective vet centers. Each of the eight had remediation plans. Zone documentation showed 18 deficiencies across the eight vet centers. Of the 18 identified deficiencies, five had documentation of resolution. The OIG evaluated timeliness of deficiency resolution and determined that two of the five deficiencies with documentation of resolution did not have evidence that corrections occurred within the required time frame. Overall, the OIG found the vet centers noncompliant with resolution of administrative site visit deficiencies.

**Table 4. Annual Vet Center Administrative Quality Reviews  
(November 1, 2019–October 31, 2020)**

Requirement	Expected Reports	Completed Reports
Annual Administrative Quality Review	23	23
Remediation Plan	8	8

*Source: VA OIG requested the last signed clinical and administrative site visit reviews and remediation plans, if applicable for each vet center in the zone completed on or prior to October 31, 2020; analysis based on district 4 zone 1 documents completed between November 1, 2019 through October 31, 2020.*

The OIG identified the following findings:

- Remediation plans did not include documentation dates for the Deputy District Director’s approval.
- Seven of eight remediation plans did not have documentation of timely resolution for all deficiencies.
- Two of five deficiencies with documentation of resolution did not have evidence that corrections occurred within the required time frame.

### *Clinical and Administrative Quality Reviews Recommendations*

#### **Recommendation 1**

The District Director determines the reasons clinical and administrative quality review remediation plans do not include the Deputy District Director’s approval and date of approval as required and ensures compliance.

District Director response: Concur

RCS requires that every Vet Center receive an administrative and clinical oversight visit within a given Fiscal Year (FY). After reviewing the identified finding, the District Director developed a Remediation Plan tracker that will be signed by the Deputy District Director (DDD) once remediation plans are reviewed and approved.

Status: Ongoing

Target date for completion: May 31, 2022

## **Recommendation 2**

The District Director evaluates the clinical and administrative quality review process for resolution of quality review deficiencies and initiates action steps as necessary.

District Director response: Concur

After reviewing the identified finding, the District Director developed a Remediation Plan for identified deficiencies that will be monitored by the Associate District Director (ADD) and the DDD for resolution within timelines specified in RCS policy. The ADD's will monitor monthly progress and compliance.

Status: Ongoing

Target date for completion: May 31, 2022

## **Recommendation 3**

The District Director evaluates the clinical and administrative quality review report process for determining timeliness in resolving quality review site visit deficiencies and initiates action steps as necessary.

District Director response: Concur

After reviewing the identified finding, the District Director developed a Remediation Plan for identified deficiencies will be monitored by the ADD and the DDD for resolution and close out within the timelines specified in RCS policy. The ADD's and DDD will monitor monthly progress and completion.

Status: Ongoing

Target date for completion: May 31, 2022

## **Critical Incident Quality Reviews**

VHA's National Patient Safety Improvement Handbook states that careful investigation and analysis of client safety events (events not primarily related to the natural course of a client's

illness or underlying condition), as well as evaluation of corrective action, are essential to reduce risk and prevent adverse events.<sup>61</sup> RCS requires the VCD or assigned counselor to complete a crisis report within 24 hours of a serious suicide or homicide attempt or when a client dies by suicide or homicide, with notification to the district and the national RCS Central Office within 48 hours.<sup>62</sup>

At the time of the OIG's inspection, RCS also required critical incident quality reviews (also known as mortality and morbidity reviews) for client safety events including serious suicide or homicide attempts, death by suicide, or homicide, when the client is only seen at the vet center.<sup>63</sup> For vet center clients who are also seen at a VA medical facilities, the mortality and morbidity review should be completed by the VA medical facility.<sup>64</sup> Critical incident quality reviews follow RCS psychological autopsy protocol to evaluate actions taken and make recommendations to improve the effectiveness of vet center suicide prevention activities.<sup>65</sup>

To examine the quality oversight process, the OIG requested critical incident quality reviews, interviewed district leaders, and reviewed crisis reports completed for clinical critical events that occurred during the review period.

### *Critical Incident Quality Reviews Findings and Recommendations*

The OIG reviewed 52 crisis reports and identified five clients who died by suicide and found that the district completed critical incident quality reviews as required. A review of documentation showed no crisis reports for homicide related events. The team found that critical incident quality reviews were not completed for seven active clients with serious suicide attempts.<sup>66</sup>

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<sup>61</sup> VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

<sup>62</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

<sup>63</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. The term critical incident quality review is not used in the 2021 directive; the directive refers to all such reviews as mortality and morbidity reviews.

<sup>64</sup> VHA Handbook 1500.01, September 8, 2010.

<sup>65</sup> Isometsä, ET, Psychological autopsy studies – a review, *Eur Psychiatry*, November 2001 16(7): 379-85, accessed December 9, 2020, <https://pubmed.ncbi.nlm.nih.gov/11728849/>. "A psychological autopsy synthesizes the information from multiple informants and records." VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. A psychological autopsy is completed after a suicide or homicide attempt or completion that documents pertinent information related to the client's case such as family, social and military history, presenting problems, clinical case information and other factors related to the incident.

<sup>66</sup> RCS policy does not define a serious suicide attempt; in the absence of an RCS definition of a serious suicide attempt, the OIG considered the client being transferred to the hospital an indicator of a serious suicide attempt that would have met the criteria for completion of a critical incident quality review.

District leaders told the OIG they consider any suicide attempt as serious. The Deputy District Director stated a critical incident quality review for a client with a completed suicide was a formal review of the event, whereas review of a serious suicide attempt was done through an evaluation of the client record and documentation in a routine progress note. The Deputy District Director stated at a minimum the required participants for a critical incident quality review for a serious suicide attempt are the VCD and vet center counselor; however, the event may also be discussed with an external clinical consultant and Associate District Director for Counseling. The Associate District Director for Counseling told the OIG, vet center staff complete crisis reports for serious suicide attempts but stated there were opportunities for improvement for completion of critical incident quality reports for serious suicide attempts.

### **Recommendation 4**

The District Director determines the reasons critical incident quality reviews (currently known as mortality and morbidity review) for serious suicide attempts including analysis for corrective action were not completed, ensures completion, and monitors compliance.

District Director response: Concur in principle.

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

Status: Ongoing

Target date for completion: May 31, 2022

### **COVID-19 Response**

On March 11, 2020, because of the spread of COVID-19 globally, the World Health Organization declared a pandemic.<sup>67</sup> On March 16, 2020, in an effort to ensure continuity of services and to protect uninfected clients and staff acquiring COVID-19, RCS began to require vet centers to screen all visitors for COVID-19, document screening results, and refer clients

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<sup>67</sup> VHA – OEM, *COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan, Version 1.6*, March 23, 2020. World Health Organization, accessed on August 20, 2020, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>. “A pneumonia of unknown cause detected in Wuhan, China was first reported to the World Health Organization (WHO) Country Office in China on 31 December 2019.” The virus was later named “SARS-CoV-2” and the disease it causes named “coronavirus disease 2019.” Merriam Webster, *Definition of pandemic*. A pandemic is an outbreak of a disease that occurs over a wide geographic area and affects an exceptionally high proportion of the population, accessed on June 23, 2021, <https://www.merriam-webster.com/dictionary/pandemic>.

with positive screens to appropriate level of care. RCS issued guidance for telephone and walk-in screening procedures:

- Complete telephone screenings 24 hours prior to all scheduled appointments
- Refer client calls back to vet centers for screening completion
- Institute appointment reminder calls to complete screenings<sup>68</sup>
- Work with local VA medical facility and community health partners to determine appropriate referrals for visitors with positive screens<sup>69</sup>

On March 20, 2020, RCS issued COVID-19 operational assessment guidance focused on client needs and local environment for its operational decisions. RCS required districts to report vet center operation levels to its centralized operations office daily; deputy district directors to communicate guidance and operational plans within zones; and VCDs to provide COVID-19 updates to employees during staff meetings.<sup>70</sup>

In response to the pandemic, on March 23, 2020, VHA's Office of Emergency Management issued the *COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan* (COVID-19 Response Plan), that detailed steps for providing access to and delivery of health care while protecting veterans and employees from COVID-19. The COVID-19 Response Plan states that during the pandemic, "RCS will ensure continuity of access to and delivery of readjustment counseling, outreach, and care coordination to Veterans, Service members and their families, first responders and the public, as appropriate, to the COVID-19 outbreak."

In an effort to keep staff safe and to mitigate equipment barriers that might interfere with client services, RCS issued telework guidance on March 23, 2020.<sup>71</sup> The guidance encouraged designating as many telework eligible staff as appropriate but stated decisions must be made in response to local environments. District directors were tasked to ensure that all vet center staff were telework-ready and were given authority to place staff on telework status as appropriate.<sup>72</sup> An RCS memorandum issued on March 31, 2020, stated "As the population risk of COVID-19 exposure increases, so will our need to leverage telework and telehealth to meet the needs of

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<sup>68</sup> RCS-OPS-001, *Vet Center Novel Coronavirus Screening (COVID-19)*, March 16, 2020.

<sup>69</sup> RCS-OPS-001, March 16, 2020.

<sup>70</sup> RCS-OPS-004, *COVID-19 Readjustment Counseling Service (RCS) Operational Level Assessment*, March 20, 2020.

<sup>71</sup> RCS-ADM-005, *COVID-19 Readjustment Counseling Service (RCS) Guidance for Telework and Duty Location*, March 23, 2020.

<sup>72</sup> RCS-ADM-005, March 23, 2020. RCS defines telework-ready as an employee who is eligible to telework, has an approved written telework agreement, and has taken required training.

those we serve.”<sup>73</sup> In addition to using VA Video Connect RCS permitted the use of a VANTS teleconferencing for group therapy sessions.<sup>74</sup>

To evaluate district and vet center preparedness for mitigation of and response to potential impacts from the COVID-19 pandemic, the OIG review examined the five following areas:

- Emergency planning
- Communication and field guidance (*district leaders only*)
- Supplies and infrastructure
- Access and client care—telework and telehealth
- Client screening including referral

## **District Leaders**

The OIG interviewed district leaders to discuss the five topics noted above. The information provided in this section is based on those interviews.

### *Emergency Planning*

District leaders handled the pandemic the best they could, given the unforeseen circumstances. The biggest barrier initially was getting staff computer network access for telework. However, at the time of inspection, all telework-approved staff had computer network access through Citrix.<sup>75</sup>

### *Communication and Field Guidance*

RCS Central Office provided timely and adequate guidance. The District Director shared information with employees as soon as it was available and held daily meetings to communicate information. VHA’s Office of Emergency Management COVID-19 Response Plan and the Centers for Disease Control and Prevention data was used daily to gauge operational levels for vet center threat assessments.<sup>76</sup> District leaders initially met daily until the summer of 2020 when

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<sup>73</sup> RCS-OPS-005, *COVID-19 Response: Use of VANTS for Group Counseling*, March 31, 2020.

<sup>74</sup> VA Video Connect (VVC) is a VHA online platform used for the provision of video telehealth, including mental health services. VVC uses computer webcams, smart phones, and tablets to administer telehealth-based therapy to veterans. VANTS is the Veterans Affairs National Telecommunications System used for conference calls (it is no longer operational).

<sup>75</sup> Citrix is a remote computer access option for VA staff without a government furnished computer, accessed on April 20, 2021, <https://www.oit.va.gov/resources/remote-access/>.

<sup>76</sup> *Veterans Health Administration – Office of Emergency Management COVID-19 Response Plan*, Version 1.6 March 23, 2020. VHA leadership uses a response model to determine the need for initiating activities when a threat to public health is detected.

they moved to twice weekly, and as leaders became more equipped with the pandemic meetings in January 2021 decreased to weekly. At the time of the OIG interviews, leaders met weekly.

### *Supplies and Infrastructure*

There was an initial delay in staff receiving personal protective equipment because of shortages. At the time of the OIG interviews, there were adequate supplies, including an overstock of masks that led to outreach to VA medical facilities in need of supplies to offer unused personal protective equipment. District leaders immediately implemented a vet center daily operational check list for data and information such as daily staffing, leave status, telework-ready staff, on hand personal protective equipment including hand sanitizer and masks, and operational levels. In turn, district leaders shared this data and information with RCS Central Office. Needed supplies were shipped and volunteers also donated supplies. Since the pandemic, standards were implemented for the amount of supplies that vet centers should have on hand at all times.

### *Access and Client Care—Telework and Telehealth*

All staff were trained on VA Video Connect for the provision of client telehealth services. Staff used alternative technology for providing client services including telephonically, Webex, Zoom (used during initial onset), and VANTS.<sup>77</sup> Staff received a computer software application that enabled their desk phones to be connected to their computer so calls to the office could be received while teleworking.

### *Client Screening Including Referral*

Client screenings were completed 24 hours prior to scheduled appointments, and referral pathways were followed when clients screened positive for COVID-19 symptoms. Screenings were conducted for all vet center visitors.

## **Vet Center Directors**

The OIG interviewed the VCDs of the four selected vet centers and asked about emergency planning, supplies and infrastructure, access and client care—telework and telehealth, and client screening including referral. The information provided in this section is based on those interviews.

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<sup>77</sup> Webex is designed for video and audio communication and can be used by VA staff as an emergency response platform to initiate calls to clients, accessed on April 21, 2021, <https://www.oit.va.gov/services/cloud-software/catalog/item/itemid/50>. Zoom is an operating system for video, voice, content sharing, and text communications for mobile devices, desktops, and telephones, accessed on April 21, 2021, <https://zoom.us/about/>.

## *Emergency Planning*

Casper and Denver VCDs were adequately prepared to respond to the pandemic. The district office provided the Casper, Denver, and El Paso vet centers with adequate support, including masks and supplies. The Casper and El Paso Vet Centers had emergency plans in place when the pandemic was declared and had since evaluated its effectiveness. The Denver VCD reported not having an emergency plan previously. The Midland Vet Center had an emergency plan, but it was not vet center specific. The Casper, Denver and El Paso Vet Centers provided examples of data that was useful during the pandemic such as Centers for Disease Control and Prevention information, guidance from district leaders for when staff could see clients in the office, and infection rate statistics. The Casper VCD wanted additional information at the onset of the pandemic for safety protocols, infection rates, and the El Paso VCD reported websites to track cases would have been helpful. The Casper, Denver, and El Paso Vet Centers had established referral mechanisms for clients with COVID-19 positive screens with support VA medical facilities and community health partners and worked with community stakeholders to assist during the pandemic. The El Paso VCD partnered with a local clinic serving military families and arranged counseling for children of vet center clients. One did not collaborate with the support VA medical facility or community partners but instead referred clients who screened positive for COVID-19 to their respective medical providers.

## *Supplies and Infrastructure*

RCS Moving Forward Plan states that in a culture of safety, all staff should follow cleaning, and distancing guidelines established by Centers for Disease Control and Prevention, VHA, and federal guidance.<sup>78</sup> The Casper and Denver Vet Centers had adequate cleaning supplies and hand sanitizers at the onset of the pandemic. The El Paso Vet Center implemented a cleaning and disinfecting plan, including the cleaning of high touch surfaces. At the time of the OIG interviews, all four vet centers had soap and water stations for hand washing and arranged organized communal areas to encourage social distancing.

## *Access and Client Care—Telework and Telehealth*

RCS Moving Forward Plan outlined considerations for both virtual and traditional care to safeguard clients and staff. The Casper, Denver, and El Paso VCDs had trained and approved staff to provide telehealth services at the onset of the pandemic. The Midland VCD was the only vet center staff approved to telework. Telehealth services and equipment were available at the vet centers, and clients who were unable to be seen in person were offered alternative services such as telehealth, teleconferencing, or telephone counseling services.

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<sup>78</sup> RCS, *RCS Moving Forward Plan, Balancing Readjustment Counseling Services in the COVID-19 Era*. July 11, 2020.

### *Client Screening Including Referral*

Beginning on March 16, 2020, vet centers were required to initiate both telephone and walk-in screenings for all visitors to vet centers, including screenings 24 hours prior to all scheduled appointments. All positive screens were to be referred to local VA medical facilities and community partners and reported to district office for further coordination.<sup>79</sup> The Casper and El Paso Vet Centers completed both telephone and walk-in screenings for all visitors, including screening 24 hours before scheduled appointments. The Denver VCD reported most clients were seen virtually therefore screenings in advance of appointments was not needed and the Midland VCD did not contact clients prior to appointments. All referred clients with positive COVID screenings to local VA medical facilities and community partners, and all visitors and walk-in clients were screened.

### **Zone-Wide Staff Questionnaire Responses**

The OIG sent a COVID-19 voluntary questionnaire to zone 1 vet center staff. Of the 147 questionnaires sent, 135 (92 percent) were returned with responses. The questionnaire had 14 questions about personal and patient safety, leadership communication, personal protective equipment, work assignments, telework, and employee assistance. The questionnaire included open-ended questions that asked what the vet center did well, what needed improvement, and lessons learned during the pandemic. The information provided in this section is based on those questionnaire responses.

Respondents indicated that district leaders and VCDs provided routine communication and guidance that helped with employee and client safety. The OIG asked if staff were given new work assignments such as conducting COVID-19 phone screenings or deploying a mobile vet center in support of COVID-19 during the pandemic.<sup>80</sup> Responses showed that 49 (33 percent) were given new work assignments during the pandemic. Most respondents stated telework was offered, telework agreements were completed, and teleworked was implemented. Of 131 respondents, 102 (78 percent) indicated employee assistance or other types of assistance were available. Qualitative responses to “what went well” included

- enhanced cleaning and screening procedures,
- limiting the number of staff in the office to reduce the risk of exposure, and
- weekly conference calls with district leaders who shared information and encouraged questions from the field staff.

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<sup>79</sup> RCS-OPS-001, March 16, 2020.

<sup>80</sup> This closed-ended question did not ask about new work assignment duties.

Respondents indicated that “lessons learned” included the adaptability and flexibility of vet centers to safely serve clients through telehealth. For “what went wrong/needed improvement,” respondents indicated agency communication.

## COVID-19 Response Conclusion

The OIG found supplies and infrastructure were adequate and continued to be monitored during the OIG inspection. Precautionary measures were implemented with COVID-19 screenings for vet center visitors. Visitors with positive screenings were referred to local care pathways. An initial barrier reported was getting staff computer network access for telework; however, the barrier was overcome, and all eligible staff had network access at the time of the inspection. Overall, staff responses to the COVID-19 questionnaire showed that COVID-19 safety protocols succeeded and agency communication needed improvement.

## Suicide Prevention

The VA *National Suicide Data Report* published in the fall of 2018 found that in 2016 the suicide rate was 1.5 times greater for veterans than for nonveteran adults.<sup>81</sup> VA’s national strategy for preventing veteran suicide states, “Suicide prevention is VA’s highest priority, and VA has made great strides in Veteran suicide prevention, especially in crisis intervention.”<sup>82</sup> “VA supports a national goal of reducing suicide in the U.S. by 20 percent by the year 2025” through implementation of a public health model.<sup>83</sup>

RCS was identified as an important part of VA’s overall suicide prevention strategy.<sup>84</sup> On August 28, 2017, a memorandum of understanding between the Office of Mental Health and Suicide Prevention and RCS (Memorandum of Understanding) was signed that required a shared responsibility for suicide prevention between RCS, the Office of Mental Health and Suicide Prevention, and VHA suicide prevention coordinators.<sup>85</sup> The Memorandum of Understanding

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<sup>81</sup> VA Office of Mental Health and Suicide Prevention, *VA National Suicide Data Report 2005-2016*, September 2018. The suicide rate included in the report is adjusted for age and gender.

<sup>82</sup> VA Office of Mental Health and Suicide Prevention, “National Strategy for Preventing Veteran Suicide 2018–2028,” accessed November 1, 2018, [https://www.mentalhealth.va.gov/suicide\\_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf](https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf).

<sup>83</sup> VA Office of Mental Health and Suicide Prevention, “National Strategy for Preventing Veteran Suicide 2018–2028,” accessed November 1, 2018, [https://www.mentalhealth.va.gov/suicide\\_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf](https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf).

<sup>84</sup> Deputy Under Secretary for Health for Operations and Management (10N), “Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services.” November 13, 2017.

<sup>85</sup> Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding, August 15, 2017

defines operations for the identification, notification, and treatment of high risk for suicidal veterans and quality reviews related to veteran suicides for active clients.<sup>86</sup>

Staff at the VA medical facility are responsible for identifying high-risk individuals and activating a patient record flag in the client's VA electronic health record, visible to RCS counselors. VHA has the following requirement for caring for high-risk or suicidal veterans:

Each VA medical center must establish a high risk for suicide list and a process for establishing a Category II Patient Record Flag (PRF) to help ensure that patients determined to be at high risk for suicide are provided with follow up for all missed mental health and substance abuse appointments.<sup>87</sup>

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

- Psychosocial and lethality risk assessments (*zone wide*)
- Care coordination and collaboration with VHA—RCS and VHA facility shared high risk for suicide clients (*zone wide*)
- Access (*four selected vet centers*)
- Care coordination and collaboration with VA medical facilities (*four selected vet centers*)
- High-risk suicide flag client disposition (*four selected vet centers*)
- Crisis plans (*four selected vet centers*)
- Root cause analysis participation and feedback (*four selected vet centers*)

## **Psychosocial Assessment and Lethality Risk Assessments (Zone-Wide)**

RCS states, “the client record is one of the most important components of clinical practice. Properly maintained, the clinical record reflects the quality of treatment.”<sup>88</sup> RCS requires a psychosocial assessment including an intake and military history to be completed by the fifth visit, unless an extension is granted by a supervisor with documentation of a contraindicating clinical circumstance that would prevent completion of these portions in the required time

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<sup>86</sup> Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding, August 15, 2017

<sup>87</sup> VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

<sup>88</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Client Records*, November 23, 2010.

frame.<sup>89</sup> Psychosocial assessments are used to gather information about the client “presenting issues and level of functioning” to complete a clinical evaluation.<sup>90</sup>

RCS also requires the completion of a lethality risk assessment, including the clinician’s rationale for the rating, to be “identified by documentation within the first clinical note.”<sup>91</sup> An RCS Central Office leader reported that effective October 2020, RCS replaced the lethality risk assessment within the psychosocial assessment with a “Comprehensive Suicide Risk Assessment and Safety Plan.” The new assessment follows the VA/DoD Clinical Practice Guideline by incorporating common terminology used for suicide risk evaluation and consultation practices that are familiar to other clinical providers.<sup>92</sup>

### *Electronic Client Records*

The OIG used zone-wide data extracted from the RCSnet database to evaluate vet center staff compliance with completion of psychosocial and lethality risk assessments.<sup>93</sup> The OIG randomly selected two samples of clients new to vet centers from November 1, 2019, through October 31, 2020.<sup>94</sup> The samples included

- 60 client records with five or more visits, and
- 40 clients with four or less visits.<sup>95</sup>

The OIG reviewed electronic client records to determine whether intake and military histories were completed and finalized within the required five visits. If the required intake assessment or military history was not completed, the OIG reviewed electronic client records for extenuating circumstances. The OIG reviewed electronic client records to determine timely completion of lethality risk assessments by evaluating the first clinical note for either a rationale for a lethality

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<sup>89</sup> RCS-CLI-003, January 25, 2019; VHA, *Readjustment Counseling Service Guidelines and Instruction for Client Records*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

<sup>90</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Client Records*, November 23, 2010.

<sup>91</sup> RCS-CLI-003, January 25, 2019.

<sup>92</sup> *Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services (RCSnet)*, September 19, 2020; *VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients At Risk For Suicide*, May 2019.

<sup>93</sup> The OIG used a 90 percent benchmark to evaluate the client record reviews for compliance with selected RCS requirements for psychosocial assessments (including intake and military histories) and lethality risk assessments.

<sup>94</sup> Sub-population size was randomly selected and weighted for the two samples.

<sup>95</sup> RCS-CLI-003, January 25, 2019. The OIG stratified the population sample given RCS requires completion of the intake and military histories by the fifth visit and lethality by the first visit. The sample of 60 client records (excluding veteran outreach specialist visits, group, family, telephone (non-clinical), and bereavement visits) was reviewed for completion of the intake, military history, and lethality risk assessment. The sample of 40 client records was used to only evaluate completion of the lethality risk assessment since this client group had less than five visits and, therefore the completion of the psychosocial assessment was not required.

rating or reference to and completion of a lethality or risk assessment.<sup>96</sup> The OIG team used a 90 percent benchmark to evaluate electronic client records for compliance with selected RCS requirements for psychosocial assessments (including intake and military histories) and lethality risk assessments.

The OIG was able to review the RCSnet electronic client record and determine if intake and military histories were completed. However, the OIG was unable to determine through RCSnet the date of completion for each section. Therefore, completion of the documentation by the fifth visit could not be evaluated.<sup>97</sup>

The OIG was able to determine timely completion of lethality assessments through the electronic client record review if the assessment was documented in its entirety in the first clinical note. However, the OIG was unable to determine when the lethality portion of the intake assessment and the new risk assessment was completed.

Despite the OIG having access to the RCSnet database, dates of completion for the lethality portion in the intake assessment and the new risk assessment were unidentifiable. Due to RCSnet limitations, the OIG reviewed the first clinical note and visit in the electronic client record for documentation that the clinician completed one of the following:

- A full lethality assessment
- The lethality portion of the intake assessment
- The new risk assessment<sup>98</sup>

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<sup>96</sup> For clients seen before October 12, 2020, the OIG reviewed electronic client records for clinical rationales for the inclusion of lethality section questions from the RCS intake assessment that assessed for suicidal thoughts, family history of suicide, feelings of hopelessness and despair, access to weapons, physical and sexual abuse history, alcohol and drug use, and serious medical issues. For clients seen on or after October 12, 2020, the OIG reviewed clinical rationales for inclusion of narrative sections from the new RCS risk assessment that assessed for suicidal ideation, suicidal history, risk and protective factors, and warning signs. Timely completion refers to completion of the note or assessment within two business days of client contact.

<sup>97</sup> The intake assessment and military history included creation dates but did not have completion dates in RCSnet or the database.

<sup>98</sup> The lethality portion of the intake assessment and the new risk assessment included creation dates but did not have completion dates in RCSnet or the database.

## **Psychosocial Assessment and Lethality Risk Assessments Findings and Recommendations (Zone-Wide)**

The OIG determined that zone 1 vet center clinicians completed 88 percent of military histories and were noncompliant with requirements for completion of intake and lethality assessments (summarized in table 5).<sup>99</sup>

The OIG asked the Associate District Director for Counseling if lethality assessments were completed on the first visit as required.<sup>100</sup> The leader stated that prior to October 2020, the lethality assessment was in the intake that was due on the fifth visit and most counselors understood its completion was not due until then.

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<sup>99</sup> Based on the statistical analysis, the OIG determined there was not a finding for military history. Required elements for the electronic record review are noncompliant only when the entire confidence interval falls below 90 percent.

<sup>100</sup> RCS-CLI-003, January 25, 2019.

**Table 5. District 4 Zone 1 Vet Centers RCSnet Electronic Client Record Review Psychosocial Assessment and Lethality Risk Assessments (November 1, 2019–October 31, 2020)**

Electronic Client Record Section	Number of Records Reviewed	Estimated Percentage Completed Zone Wide	95% Confidence Interval* (Lower, Upper)
Intake	60	46.7	(33.3, 60.0)
Military History	60	88.3	(80.0, 95.0)
Lethality Risk Assessment	98 <sup>†</sup>	30.8	(21.5, 40.6)

Source: VA OIG district 4 zone 1 RCSnet record reviews.

\* The estimate and confidence interval for the lethality risk assessment were calculated using sampling weights based on the proportions of each population sampled. Merriam-Webster, Confidence interval is “a group of continuous or discrete adjacent values that is used to estimate a statistical parameter (such as a mean or variance) and that tends to include the true value of the parameter a predetermined proportion of the time if the process of finding the group of values is repeated a number of times,” accessed on January 21, 2021, <https://www.merriam-webster.com/dictionary/confidence%20interval>.

<sup>†</sup> Two clients were excluded from the lethality risk assessment sample because they were seen for administrative (not clinical) visits.

For the records reviewed, the OIG identified that vet centers did not consistently complete the following:

- Intake portions of the psychosocial assessment
- Lethality risk assessments with the first individual clinical visit

### Recommendation 5

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

District Director response: Concur

The District provided training to Vet Center Director’s (VCD’s) and Readjustment Counselors on completion of the intake portion of the psychosocial assessment as well as methods for monitoring compliance training for the VCD’s. Compliance to be monitored through monthly chart audits and regular RCSnet report reviews by the VCD’s and the Associate District Director for Counseling (ADD/C).

Status: Ongoing

Target date for completion: May 31, 2022

## Recommendation 6

The District Director ensures lethality risk assessments are completed and monitors compliance across all zone vet centers.

District Director response: Concur

The District provided training to the field on electronic monitoring of lethality risk assessment (now referred to as “Risk Assessment”). The VCD’s and District leadership will monitor compliance monthly.

Status: Ongoing

Target date for completion: May 31, 2022

## Recommendation 7

The District Director in collaboration with Readjustment Counseling Service Central Office evaluates the limitations of current tools and tracking methods including reasons completion dates are not visible in RCSnet and ensures compliance with standards for timely completion of intake assessments, military histories, and lethality risk assessments.

District Director response: Concur

The District provided training to the VCD’s on how to appropriately monitor completion dates of intake assessments, military histories, and service plans during the monthly chart audit process. Compliance is monitored in monthly chart audits conducted by the VCD’s and monthly Quality Assurance reports conducted by the ADD/C.

Status: Ongoing

Target date for completion: May 31, 2022

## Suicide Prevention and Intervention (Zone-Wide)

### *Care Coordination and Collaboration with VHA—RCS and VA Medical Facility Shared High-Risk Clients*

As outlined in the 2017 Memorandum of Understanding, there is a “shared responsibility for suicide prevention among the Office of Mental Health and Suicide Prevention (OMHSP), Suicide Prevention Coordinators (SPCs), and Readjustment Counseling Service (RCS).”<sup>101</sup> Further, RCS requires clinical staff to consult and coordinate care with the support VA medical facility for all clients who are high risk for suicide, and to provide timely notification to suicide

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<sup>101</sup> Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding, August 15, 2017.

prevention coordinators when clients pose a significant safety risk.<sup>102</sup> Vet center staff are required to follow confidentiality requirements when coordinating care with the VA medical facility.<sup>103</sup> Effective June 1, 2019, RCS required vet center counselors to seek consultation from the VCD, external clinical consultant, or the support VA medical facility suicide prevention coordinator for all clients with lethality assessment changes.<sup>104</sup> Prior to October 12, 2020, RCSnet lethality designations included of non-lethal, mild, moderate, and severe. According to the RCS Deputy Chief Officer, effective October 12, 2020, RCSnet lethality designations included low, intermediate, and high.

### *Electronic Client Records*

The OIG evaluated suicide prevention and intervention by reviewing 57 randomly selected high-risk clients seen at vet centers throughout the zone between November 1, 2019 and August 31, 2020. The selected clients were also flagged as high risk for suicide by the support VA medical facility.<sup>105</sup> RCS confirmed that lethality history was not available in the section of RCSnet used by vet center staff. The OIG was also unable to view the lethality history in RCSnet, and therefore extracted client lethality history from the RCSnet database.

The OIG evaluated each client record for compliance with:

- Consultation and coordination of services with support VA medical facility for shared clients within 60 days after high risk for suicide flag placement<sup>106</sup>
  - Adherence to confidentiality requirements if consultation and coordination occurred

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<sup>102</sup> Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding, August 15, 2017.

<sup>103</sup> 38 C.F.R. § 17.2000.

<sup>104</sup> RCS-CLI-003, January 25, 2019. “Vet Center counselors seek consultation from the Vet Center Director, the External Clinical Consultant (assigned by the nearest VAMC), the VHA Suicide Prevention Coordinator, or any combination thereof, for all clients who are assessed as at mild-risk or greater, consistent with the most recent publication of VHA Directive 1500.” Effective October 12, 2020, RCS issued new requirements for completion of the risk assessment in accordance with the new publication of VHA Directive 1500(1), January 26, 2021, amended May 3, 2021, which states “For individuals assessed to be at Intermediate to High-Risk either acute, chronic, or both: (a) The Vet Center counselor will seek consultation on the case through the Vet Center Director, ADD/C, VA assigned External Clinical Consultant, and/or other VHA mental health professionals to include the Suicide Prevention Coordinator at the support VA medical facility.” The OIG evaluated both the old lethality assessment and the new risk assessment.

<sup>105</sup> The OIG extracted all high risk for suicide (newly activated and reactivated) clients from all zone 1 vet centers associated administrative parent VA medical facilities and cross referenced the clients with RCSnet database to identify shared clients. A random sample was taken from all shared clients identified. Data extraction period was adjusted (shortened by two months from review period) to allow time for RCS clinical staff to complete required care coordination following high risk flag placement, lethality status changes, and crisis events.

<sup>106</sup> For the purpose of this report, the OIG utilized 60 days as the time frame to complete consultation and coordination.

- Timely notification to VA medical facility suicide prevention coordinator if clients posed a significant safety risk<sup>107</sup>
  - Adherence to confidentiality requirements if notification occurred
- Consultation with the VCD, external clinical consultant or suicide prevention coordinator within 30 days of lethality assessment change<sup>108</sup>
- Progress notes within the review period in the electronic client record documenting suicide or homicide completions, attempts, gestures or interventions exist, and whether each progress note has a corresponding crisis report<sup>109</sup>

## **Suicide Prevention and Intervention Findings and Recommendations (Zone-Wide)**

The OIG found vet centers in district 4 zone 1 were not compliant with requirements of coordination of shared clients for suicide prevention and intervention. The OIG was unable to determine whether zone 1 was compliant with timely notification when the client posed a significant safety risk due to the client sample being too small.<sup>110</sup>

The OIG excluded 13 of 57 client records. Exclusions included 10 clients with closed cases, two clients not seen at a vet center during the review period, and one excluded for administrative reasons. Overall, the OIG found the 44 records reviewed in zone 1 noncompliant with RCS requirements for consultation and communication for shared clients with VA medical facilities as noted in table 6 below.

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<sup>107</sup> The OIG defined significant safety risk as suicide and homicide attempts and imminent risk of suicide or homicide. For the purpose of this report, timely is defined as notification occurring as soon as pertinent information that would promote safety is available.

<sup>108</sup> The OIG and utilized 30 days as the time frame within which consultation should occur.

<sup>109</sup> RCS-CLI-003, *Revised Clinical Site Visit (CSV) Protocol*, January 25, 2019. “Vet Center counselors seek consultation from the Vet Center Director, the External Clinical Consultant (assigned by the nearest VAMC), the VHA Suicide Prevention Coordinator, or any combination thereof, for all clients who are assessed as at mild-risk or greater, consistent with the most recent publication of VHA Directive 1500.” Effective October 12, 2020, RCS issued new requirements for completion of the risk assessment in accordance with the new publication of VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021 which states “For individuals assessed to be at Intermediate to High-Risk either acute, chronic, or both: (a) The Vet Center counselor will seek consultation on the case through the Vet Center Director, ADD/C, VA assigned External Clinical Consultant, and/or other VHA mental health professionals to include the Suicide Prevention Coordinator at the support VA medical facility.” The OIG evaluated both.

<sup>110</sup> The OIG identified only seven clients whose vet center records indicated they were a significant safety risk. The OIG did not complete calculations for the electronic record review requirements when the number of clients is less than 11.

**Table 6. Suicide Prevention and Intervention  
(November 1, 2019–October 31, 2020)**

Electronic Client Record Review Question	Number of Records Reviewed	Estimated Percentage Compliant	95% Confidence Interval (Lower, Upper)
Vet center staff consulted with and coordinated services with the support VA medical facility for care of shared clients flagged as high risk.	44	51%	(39.25, 60.95)
Vet center staff followed confidentiality requirements when consulting with and coordinating services with the shared VA medical facility.	44	10%	(2.66, 19.66)
A vet center counselor assigned or documented a lethality change of mild or greater, and the counselor consulted with the VCD, external clinical consultant, or VHA suicide prevention coordinator at the support VA medical facility.	34	56%	(42.20,68.96)
Progress notes in the electronic client record documenting death by suicide or homicide, attempts, gestures, or interventions exist, and each progress note has a corresponding crisis report.	17	20%	(4.21,38.45)

Source: VA OIG analysis of District 4 Zone 1, RCSnet electronic client record reviews.

For the clients reviewed, the OIG identified the following findings for zone 1:

- Vet centers did not consult or coordinate with VA medical facilities on shared clients who were flagged high risk for suicide.
- For clients where coordination occurred with VA medical facilities, vet centers did not consistently follow confidentiality requirements.<sup>111</sup>
- Vet centers that had clients with a documented lethality change of mild or greater did not consult with a VCD, external clinical consultant, or VA support medical facility suicide prevention coordinator.

<sup>111</sup> “The Vet Center supports prompt and open communication of readjustment counseling information with VA medical facility and other community providers by obtaining a voluntary written Release of Information (ROI) form from the eligible individual as required for client confidentiality.” VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

- Vet centers did not complete a crisis report when a corresponding progress note indicated a suicide or homicide completion, attempt, gesture, or intervention existed.

### **Recommendation 8**

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

District Director response: Concur

The District provided training to clinical staff regarding the importance of collaborating and coordinating care with VAMC [VA Medical Center] providers on all shared clients, especially those with increased risk. Compliance is monitored during monthly chart audits conducted by the VCD's and ADD/C.

Status: Ongoing.

Target date for completion: May 31, 2022

### **Recommendation 9**

The District Director ensures clinical staff follow confidentiality requirements when consulting and coordinating care with shared support Veterans Affairs medical facility for shared clients who are flagged as high risk for suicide and monitors compliance across all zone vet centers.

District Director response: Concur

The District provided training to the clinical staff on the importance of communicating the benefits of consultation and coordination of care with VAMC providers to the client at the beginning of Vet Center services and to obtain permission for this collaboration through a Release of Information form. Compliance is monitored through monthly chart audits conducted by the VCD's and the ADD/C.

Status: Ongoing

Target date for completion: May 31, 2022

### **Recommendation 10**

The District Director ensures clinical staff consult with the vet center director, external clinical consultant or suicide prevention coordinator following a lethality status change as required and monitors compliance across all zone vet centers.

District Director response: Concur

The District provided training to clinical staff on ensuring regular and ongoing consultation with either the VCD, the External Consultant, or the Suicide Prevention Coordinator when there are changes in risk levels as authorized by RCS privacy rules. Compliance is monitored through monthly chart audits conducted by the VCD's and the ADD/C.

Status: Ongoing

Target date for completion: May 31, 2022

### **Recommendation 11**

The District Director ensures clinical staff complete crisis reports as required and monitors compliance across all zone vet centers.

District Director response: Concur

The District office provided training to the VCDs and clinical staff on the importance of completing a crisis report and when it was appropriate to do so. The VCD and ADD/C will monitor compliance during monthly chart audits and yearly oversight visits.

Status: Ongoing

Target date for completion: May 31, 2022

### **Vet Center Suicide Prevention**

The remainder of the report provides inspection findings at the following four randomly selected vet centers in district 4 zone 1:

- Casper Vet Center, Wyoming
- Denver Vet Center, Colorado
- El Paso Vet Center, Texas
- Midland Vet Center, Texas

### **Access**

According to the Memorandum of Understanding signed on August 28, 2017, between the VHA Office of Mental Health and Suicide Prevention and the VHA Readjustment Counseling Service, RCS core values includes providing veterans with appointments outside of regular business hours and consists of appointment availability in the mornings, evenings, and weekends at all of

its vet centers.<sup>112</sup> To assess for compliance, the OIG interviewed VCDs and reviewed documents provided of available nontraditional hours at each vet center.

### *Care Coordination and Collaboration with VA Medical Facilities*

To help with care coordination for clients, a vet center designee is required to attend all support VA medical facility Mental Health Council meetings.<sup>113</sup> The 2017 Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding, outlines the following responsibilities:

- Standardizing a communication process between RCS and support VA medical facility suicide prevention coordinators
- Sharing lists of flagged veterans at high risk for suicide between support VA medical facilities and RCS
- Notifying suicide prevention coordinators of clients with significant safety risks in a timely manner<sup>114</sup>
- Training for RCS staff
- Disseminating a list from the Office of Mental Health and Suicide Prevention to RCS identifying veterans at increased predictive risk of suicide<sup>115</sup>
- Identifying those who were receiving RCS counseling services<sup>116</sup>

The OIG interviewed the four VCDs and requested the following:

- Evidence of the VCD's or designee's participation on VA medical facility mental health council meetings
- Office of Mental Health and Suicide Prevention lists received
- VA medical facility high risk for suicide flag lists received

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<sup>112</sup> Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding, August 15, 2017.

<sup>113</sup> VHA Handbook 1500.01, September 8, 2010; VHA Handbook 1160.01. Mental health councils at "Each VA medical center must establish and maintain a Mental Health Executive Council that includes representation from core mental health professional disciplines and specialty VA mental health programs with administrative support from the medical center."

<sup>114</sup> Timely was defined by the OIG as notification that occurs as soon as pertinent information that would promote safety is available.

<sup>115</sup> The Office of Mental Health and Suicide Prevention list refers to Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH-VET). REACH-VET identifies veterans who have a higher risk for suicide through predictive analytics.

<sup>116</sup> Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding, August 15, 2017.

- Documents supporting a standardized communication process with the support VA medical facility suicide prevention coordinator

### *High-Risk Suicide Flag Client Disposition*

Isolation and social disconnectedness may leave some clients more vulnerable to self-harm, particularly those who are identified at high risk for suicide.<sup>117</sup> To help monitor these clients, RCS staff created a High-Risk Suicide Flag SharePoint site for VA medical facility-identified flagged high risk for suicide clients who currently receive or have received vet center services within the past 12 months.<sup>118</sup> As of May 11, 2020, VCDs are required to review the SharePoint site monthly for clients seen at their vet center, determine if outreach is needed, and document a disposition.

To assess for compliance, the OIG requested documentation of clients from each vet center identified on the High-Risk Suicide Flag SharePoint site and any documented dispositions from May 11, 2020, through October 31, 2020.

### *Crisis Plans*

RCS serves clients who can be at a higher risk for violence and suicide based on certain factors. According to RCS guidelines,

Characteristics which may render clients at risk include: gender (the majority of completed suicides are males); age (risk increases with age); familiarity with weapons (guns are often used in suicides); and disproportionate percentage of psychological problems (PTSD [posttraumatic stress disorder], substance abuse), risk increases with the number and severity of psychiatric diagnoses.<sup>119</sup>

RCS has several preparatory steps required to reduce the occurrence of a crisis event and minimize the severity should one occur.<sup>120</sup> One requirement is for vet centers to have a written plan addressing how staff responds to crisis situations.<sup>121</sup> The OIG requested and reviewed vet

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<sup>117</sup> RCS-CLI-006, *High Risk Flag Suicide Outreach*, April 27, 2020.

<sup>118</sup> Microsoft, Definition of SharePoint. A website to securely store, organize, share, and access information, accessed July 15, 2021, <https://support.microsoft.com/en-us/office/what-is-sharepoint-97b915e6-651b-43b2-827d-fb25777f446f>.

<sup>119</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

<sup>120</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010.

<sup>121</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November E23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

center crisis plans from the four selected vet centers to evaluate compliance with RCS preparatory steps for crisis events.

### *Root Cause Analysis Participation and Feedback*

Root cause analysis is a review of systems and processes that surround an adverse event or a close call.<sup>122</sup> The review consists of an interdisciplinary team of individuals familiar with the event and staff with varying educational backgrounds and experience. The team works together to understand the “what” and “why” of the events and identify changes that could be made to reduce the likelihood of reoccurrence.<sup>123</sup>

### *Vet Center Suicide Prevention Findings and Recommendations*

The OIG found the four selected vet centers complied with nontraditional hours and reviewing the high-risk suicide flag SharePoint and documenting dispositions for clients. The four vet centers each had updated crisis plans. The OIG found that the Midland VCD was unaware that the high-risk suicide flag SharePoint site housed shared clients with the support VA medical facility who were designated high risk for suicide. The VCD believed the site was populated by vet center counselors with names of clients they felt were at high risk. None of four selected vet centers had shared clients with support VA medical facilities who died by suicide during the OIG review period, and therefore vet center staff did not participate on root cause analysis panels.

The OIG identified deficiencies in the following areas:

- Vet center participation in mental health council meetings
- Receipt of the Office of Mental Health and Suicide Prevention list identifying veterans at increased predictive risk for suicide<sup>124</sup>
- Receipt of the VA medical facility flagged high risk for suicide list
- Standardized communication processes between vet centers and suicide prevention coordinators at support VA medical facilities

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<sup>122</sup> VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 2011. Adverse events are defined as “untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical facility, outpatient clinic, or other VHA facility.” A close call is “an event or situation that could have resulted in an adverse event, but did not, either by chance or through timely intervention. Such events have also been referred to as “near miss” incidents.”

<sup>123</sup> VHA Handbook 1050.01, March 2011.

<sup>124</sup> Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH-VET) identifies veterans who have a higher risk for suicide through predictive analytics

### *Mental Health Council*

VA medical facility mental health council meetings are comprised of essential mental health disciplines and specialty programs, and medical centers “are encouraged to include representation from Readjustment Counseling Centers (Vet Centers) in this Council.”<sup>125</sup> VA medical facility mental health councils are responsible for

- “Proposing strategies to improve care and consulting with management on methods for improvement and innovation in treatment programs,”
- coordinating communication, and
- evaluating mental health policy impact.<sup>126</sup>

RCS recognizes the importance of mental health councils with coordinating care for clients between vet enters and VA medical facilities and states “Vet Center staff need to participate on all VA Medical Center Mental Health Councils.”<sup>127</sup> Although RCS requires participation, the OIG reviewed submitted documentation and did not find any vet center policy specifying how participation was ensured and attendance tracked.

The OIG found that the Casper, Denver, and Midland Vet Centers did not have evidence to demonstrate regular participation on VA mental health councils. The acting Casper VCD stated there has been no representation from the vet enter since the former VCD’s departure on August 29, 2020.<sup>128</sup> The Denver VCD had not attended since March of 2019, and reported local VCDs agreed to designate one representative to attend the meetings but the representative did not attend. The VCD also felt the meeting was not relevant and instead used the time to complete staff supervision. The Midland VCD stated the meetings were quarterly, the last meeting the VCD attended was on October 19, 2019. The VCD reported he did not attend the January 2020 meeting, at which time the meetings were stopped and was unaware if they had resumed. The VCD reported no benefit in attending the meeting because the VA medical facility and vet center treatment models conflicted. The El Paso VCD reported becoming aware of this requirement in January of 2020, and inquired with the El Paso VA Clinic (El Paso VA Healthcare System) Chief of Mental Health and clinical liaison officer, but was informed there had not been any Mental Health Council meetings since 2018.

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<sup>125</sup> VHA Handbook 1160.01.

<sup>126</sup> VHA Handbook 1160.01.

<sup>127</sup> VHA Handbook 1500.01, September 8, 2010.

<sup>128</sup> For the remainder of this report, the acting Casper VCD is referred to as the Casper VCD.

## Recommendation 12

The District Director in collaboration with the support Veterans Affairs medical facility clinical or administrative liaison determines the reasons for noncompliance with staff participation on mental health councils at the Casper, Denver, and Midland Vet Centers, and takes actions to ensure compliance with Readjustment Counseling Service requirements.

District Director response: Concur

The District provided training to the VCD's on the importance of mental health council participation and a document to track attendance. Compliance is monitored monthly by the VCD's and the ADD/C.

Status: Ongoing

Target date for completion: May 31, 2022

### *Office of Mental Health and Suicide Prevention List*

The Office of Mental Health and Suicide Prevention is responsible for sharing with RCS a monthly list of veterans who have an increased predictive risk for suicide, so vet centers can identify clients on the list who are receiving counseling services and better coordinate care with VA medical facilities.<sup>129</sup>

The OIG found the four VCDs did not receive the list from the Office of Mental Health and Suicide Prevention. The Casper VCD told the OIG about not knowing that receiving the list was a requirement. The Denver VCD stated not receiving an Office of Mental Health and Suicide Prevention list and was unaware that there was a list. The El Paso VCD reported that he had not been provided a copy of the Office of Mental Health and Suicide Prevention list and did not know why they were not in receipt of the list. The Midland VCD shared with the OIG that they did not receive a list and the vet center had not had any shared clients with the support VA medical facility.

In its inaugural Vet Center Inspection Program report, published in September 2021, the OIG made a recommendation on this matter to the Under Secretary for Health:

The Under Secretary for Health ensures that the Chief Officer collaborates with the Office of Mental Health and Suicide Prevention to determine reasons for noncompliance with vet centers' receipt of the monthly Office of Mental Health and Suicide Prevention list of clients with an increased predictive risk for suicide, ensures coordination of care with VA medical facilities for vet center clients on the list, and monitors compliance.

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<sup>129</sup> Increased predictive risk for suicide was developed by VA's REACH VET program to determine veterans who have a higher risk for suicide through predictive analytics. Office of Mental Health and Suicide Prevention and Readjustment Counseling Service Memorandum of Understanding.

Therefore, the OIG does not make a recommendation related to clients with an increased predictive risk for suicide in this report.<sup>130</sup>

The Memorandum of Understanding states that Office of Mental Health and Suicide Prevention will share an updated list of clients who have been designated as high risk for suicide by the VA medical facility. This list is shared to improve clinical care and management of these clients, this may include initiating services at vet centers, but also encourages vet center referrals to VA medical facilities when appropriate.<sup>131</sup>

Overall, the OIG found the four vet centers were noncompliant with receiving a high risk for suicide list from the Office of Mental Health and Suicide Prevention. Two of four VCDs reported receiving the list from local suicide prevention coordinators. The Denver VCD began receiving the list in October 2020 through coordination with the support VA medical facility Suicide Prevention Coordinator. The Midland VCD received lists from the support VA medical facility Suicide Prevention Coordinator until March 2020. The VCD returned to the office in June 2020 and did not restart receipt of the list because he believed it included only VA medical facility clients. The Casper VCD and El Paso VCD were not aware that receiving the high risk for suicide list from the Office of Mental Health and Suicide Prevention was a requirement and confirmed they were not in receipt of the list.

In its inaugural Vet Center Inspection Program report, published in September 2021, the OIG made a recommendation on this matter to the Under Secretary for Health:

The Under Secretary for Health ensures that the Chief Officer collaborates with the Office of Mental Health and Suicide Prevention to determine the reasons updated lists of clients designated as high risk for suicide were not received by vet centers, and ensures a process for vet centers' receipt of the list in accordance with the Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding.

Therefore, the OIG does not make a recommendation related to clients designated for high risk for suicide in this report.<sup>132</sup>

### *Standardized Communication Process*

In the 2017 Memorandum of Understanding, RCS was identified as a crucial entity in the VA's suicide prevention strategy. Standardizing communication between suicide prevention

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<sup>130</sup> VA OIG Report, Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers, Report No. 20-02014-270, September 30, 2021.

<sup>131</sup> Office of Mental Health and Suicide Prevention and Readjustment Counseling Service Memorandum of Understanding, August 15, 2017.

<sup>132</sup> VA OIG Report. Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers. Report No. 20-02014-270, September 30, 2021.

coordinators and vet center staff was a component of the Memorandum of Understanding that sought to formalize the relationship between the Office of Mental Health and Suicide Prevention, suicide prevention coordinators, and RCS.<sup>133</sup>

The OIG found that each of the inspected vet centers had informal contact with the suicide prevention coordinators at the support VA medical facility, however none of the four vet centers provided a standardized communication process. The Denver and El Paso Vet Centers reported having monthly meetings with the suicide prevention coordinators from the support VA medical facilities however, they were not formalized with a written policy process, or local memorandum of understanding. The Casper VCD stated that there was not a standardized process for communication and collaboration with the suicide prevention coordinator but was working with the Associate District Director for Counseling to formalize a process. The Midland VCD reported no formalized process and stated they only collaborated with the support VA medical facility when there was a suicidal client.

In its inaugural Vet Center Inspection Program report, published September 2021, the OIG made a recommendation on this matter to the Under Secretary for Health:

The Under Secretary for Health ensures that the Chief Officer collaborates with the Office of Mental Health and Suicide Prevention to determine reasons for noncompliance with a standardized communication and collaboration process between suicide prevention coordinators and vet centers in accordance with the Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding, and initiates action as necessary.

Therefore, the OIG does not make a recommendation related to standardized communication and collaboration processes between suicide prevention coordinators and vet centers.<sup>134</sup>

## Consultation, Supervision, and Training

Each vet center is assigned a clinical liaison and an external clinical consultant from the support VA medical facility.<sup>135</sup> Clinical liaisons help coordinate care for shared clients with the support VA medical facility, whereas external clinical consultants provide guidance on complex and shared cases.<sup>136</sup>

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<sup>133</sup> Office of Mental Health and Suicide Prevention and Readjustment Counseling Service Memorandum of Understanding, August 15, 2017.

<sup>134</sup> VA OIG Report. Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers. Report No. 20-02014-270, September 30, 2021.

<sup>135</sup> VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

<sup>136</sup> VHA, Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

Vet centers are comprised of small multidisciplinary teams, are community-based, and traditionally located outside of VA medical facilities. Vet center teams are at least four staff consisting minimally of a VCD, an office manager, and two or more counselors.<sup>137</sup> Vet centers are required to have at least one VHA qualified licensed mental health professional on staff.<sup>138</sup>

VCDs are accountable for the clinical and administrative oversight of readjustment counseling that include the following therapies: individual and group counseling, family counseling for military-related issues, bereavement counseling for family members, and counseling for conditions related to military sexual trauma.<sup>139</sup> VCDs provide staff supervision, participate or designate staff to attend VA medical facility mental health councils, maintain VA and community partnerships, and supervise staff.

In 2014, VHA released a report suggesting an average of 20 veterans died by suicide daily. Of those 20 veterans, six had used VHA care in the year of, or the year prior to their death. In February 2016, the VA Under Secretary for Health stated the need for continued review and certification of suicide prevention training annually for all VA medical facility employees.<sup>140</sup> Following the initial mandated training, staff were required to complete the corresponding refresher course for their positions.<sup>141</sup> On October 15, 2020, VHA updated the suicide prevention training course and refresher requirements for clinicians.<sup>142</sup>

Military sexual trauma is reported to VHA providers at a rate of one in four for women and one in 100 for men. RCS clinical staff are required to complete military sexual trauma training.<sup>143</sup>

RCS requires vet center staff to have a basic level of cross training to promote its mission of assisting veterans' post-war social and psychological readjustment, and to enhance small team

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<sup>137</sup> "Some vet centers depending on demographic needs may also be assigned a Global War on Terrorism outreach technician or a veteran outreach specialist." VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. For vet centers assigned a mobile vet center, staffing includes a driver and counselor.

<sup>138</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. A VHA qualified licensed mental health professional is licensed in a state and appropriately credentialed and privileged through a VA medical facility.

<sup>139</sup> RCS policy states the team leader is responsible for vet center operations including staff supervision, administration, and clinical programs. The OIG learned in December 2019 during communications with vet center and district office leaders that the team leader position was referred to as a vet center director. VHA Handbook 1500.01.

<sup>140</sup> VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017.

<sup>141</sup> VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017.

<sup>142</sup> VHA Memorandum, "Agency-Wide Required Suicide Prevention Training (VIEWS 3346983)," October 15, 2020

<sup>143</sup> VHA Directive 1115.01, *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017.

functionality. Vet center staff are required to complete annual in-service training that includes cross training in 16 core curriculum topics.<sup>144</sup> Additional training may be required based on position assignment. The annual in-service training curriculum includes all major vet center service components and administrative functions.<sup>145</sup>

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

- Clinical liaison
- External clinical consultation
- Internal licensed independent practitioners in clinical consultation
- Supervision
- Staff training

## Consultation

### *Clinical Liaison*

RCS policy states that the clinical liaison is assigned by the support VA medical facility for care collaboration.

### *External Clinical Consultation*

External clinical consultants are appointed from either the support VA medical facility or, if unavailable, the private sector, to provide a minimum of four hours per month of consultation. They are required to be licensed and VHA qualified mental health professionals credentialed through the support VA medical facility. External clinical consultants provide consultation when a client presents as suicidal or homicidal to assess the probability of suicide or homicide and

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<sup>144</sup> The 16 topics include veterans postwar social and psychological readjustment problems, assessment and counseling for war-related PTSD, assessment and counseling for military-related sexual trauma, vet center administrative and fiscal functions, VHA facility administrative support services, vet center clinical assessment and record keeping, diverse service needs of special veteran populations, vet center community outreach practices, crisis response and suicide prevention, individual, group and family readjustment counseling, building relationships in the community to promote veterans access to care, working with the media to promote the vet center program, and veterans' contribution to country and community, military history, culture and experience specific to the vet center eligible combat theaters, staff and experience profile (STEP), working knowledge of VHA health care services and VBA benefits, and vet center bereavement services.

<sup>145</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

develop an intervention. They also complete peer case reviews and assist vet center counselors in the treatment of complex and emergent veteran cases.<sup>146</sup>

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

- Vet center staffing spreadsheet
- Documentation demonstrating external clinical consultation required four hours a month<sup>147</sup>

### *VHA Qualified Mental Health Professional on Staff*

Each vet center is required to maintain one licensed and credentialed VHA qualified mental health provider. To assess for compliance the OIG completed the following steps:

1. A staffing summary was requested from the four selected vet centers listing all VHA qualified staff employed from November 1, 2019, through October 31, 2020.
2. If a vet center had more than one VHA qualified mental health provider on staff
  - a. The OIG randomly selected one employee, and
  - b. Requested credentialing documentation for the employee from RCS's Centralized Human Resource Management Organization.

## **Supervision**

RCS requires VCDs use supervision and staff meetings to accomplish objectives including staff cohesion, problem solving, case coordination, and collaboration with VA medical facilities. The VCD schedules weekly one-hour supervision with clinical staff and conducts weekly staff meetings composed of vet center staff to accomplish the objectives.<sup>148</sup> If the VCD is not a VHA qualified mental health professional, a clinical designee who is licensed will provide individual supervision to clinical staff.<sup>149</sup> VCDs must also complete a monthly chart audit of 10 percent of every counselor's active client records.

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<sup>146</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

<sup>147</sup> A staffing spreadsheet was requested from each vet center requesting information on appointed liaisons and consultants and what service line they were appointed from.

<sup>148</sup> RCS-CLI-003, *Revised Clinical Site Visit (CSV) Protocol*, January 25, 2019. The 2021 directive requires the VCD provide "individual supervision to all Vet Center staff, counselors, outreach workers, and office managers on an ongoing basis."

<sup>149</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

To assess for compliance, the OIG conducted interviews virtually with the four selected VCDs and reviewed documentation of:

- weekly supervision for all counselors on staff from August 1, 2020 through October 31, 2020 (13 weeks per counselor)
- monthly chart audits of 10 percent of each counselor’s caseload from November 1, 2019 through October 31, 2020 (12 months per counselor)

## Training

In December 2017, VHA clinical staff, including RCS staff, were mandated to annually complete Suicide Risk Management Training for Clinicians and non-clinical staff were required to complete the S.A.V.E. training through the VHA Employee Education System.<sup>150</sup> Clinical staff are required to complete either the Suicide Risk Management Training for Clinicians or Skills Training for Evaluation and Management of Suicide training within 90 days of entering their position and a refresher course annually thereafter.<sup>151</sup> In October 2020, VHA updated course requirements for all clinicians and implemented a new Skills Training for Evaluation and Management of Suicide course to be completed within 90 days of hire or as annual refresher training.<sup>152</sup>

All VA medical facilities and vet centers provide military sexual trauma services. RCS clinical staff are required to complete VHA military sexual trauma training within 90 days of entering their position.<sup>153</sup>

All vet center staff, regardless of position, are required to complete in-service training annually. In-service training should include.<sup>154</sup>

The OIG requested VA Talent Management System training records and evidence of attendance for required training completed for all staff employed from November 1, 2019, through October 31, 2020, to evaluate training compliance.<sup>155</sup>

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<sup>150</sup> S.A.V.E. refers to “Signs,” Ask,” “Validate,” and “Encourage” and “Expedite” and is a training video collaboration with VA and PyschArmor Institute.

<sup>151</sup> VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017.

<sup>152</sup> VHA Memorandum, “Agency-Wide Required Suicide Prevention Training (VIEWS 3346983),” October 15, 2020.

<sup>153</sup> VHA Directive 1115.01, *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017.

<sup>154</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

<sup>155</sup> Talent Management System (TMS) is a training resource used by VA staff.

## Consultation, Supervision, and Training Findings and Recommendations

As displayed in table 7, the four selected vet centers showed overall compliance with a clinical liaison appointed from a mental health or social work service. The Casper, Denver, and El Paso Vet Centers each had a licensed external clinical consultant. The Casper Vet Center external clinical consultant was contracted through the community. The Denver and El Paso Vet Center’s external clinical consultants were from the support VA medical facilities. The four selected vet centers had at least one licensed and credentialed VHA qualified mental health professional on staff.

**Table 7. Consultation, Supervision, and Training  
(November 1, 2019–October 31, 2020)**

Review Elements	Findings			
	Casper Vet Center	Denver Vet Center	El Paso Vet Center	Midland Vet Center
<b>VHA Clinical Liaison</b>				
Assigned	Compliant	Compliant	Compliant	Compliant
Social Work or Mental Health Service Department	Compliant	Compliant	Compliant	Compliant
<b>External Clinical Consultant</b>				
Assigned	Compliant	Compliant	Compliant	<b>Noncompliant</b>
Licensed	Compliant	Compliant	Compliant	N/A
Four Hours a Month of External Clinical Consultation	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>	N/A
<b>VHA Qualified Mental Health Provider</b>				
On staff	Compliant	Compliant	Compliant	Compliant
Licensed	Compliant	Compliant	Compliant	Compliant
Credentialed	Compliant	Compliant	Compliant	Compliant
<b>Supervision</b>				
Monthly Audit* November 1, 2019 through October 31, 2020	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>
Clinical Supervision (one hour a week)	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>

August 1, 2020, through October 31, 2020				
<b>Staff Training</b>				
Annual Suicide Risk Management Training for Clinical Staff	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>
Annual Suicide Prevention (S.A.V.E.) Training for Non-Clinical Staff	<b>Noncompliant</b>	<b>Noncompliant</b>	Compliant	Compliant
Military Sexual Trauma Training	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>
Annual In-service Training†	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>

Source: VA OIG analysis of District 4 Zone 1 documents (received November 1, 2019, through October 31, 2020) and interview results

Note: The OIG did not assess RCS's data for accuracy or completeness.

\*10 percent of each counselor's caseload.

† District leaders told the OIG that Whole Health training met RCS annual training requirements for the review period.

The OIG identified deficiencies in the following:

- Assigned external clinical consultant
- External clinical consultant hours
- Clinical supervision requirements
- Required monthly auditing of counselor caseload
- Staff training

### ***External Clinical Consultant***

Vet centers are assigned an external clinical consultant from the support VA medical facility.<sup>156</sup> The Midland Vet Center did have an external clinical consultant for most of the review period. The consultant left the support VA medical facility in October of 2020, and the VCD reported making no efforts to replace the consultant. The VCD stated vet centers have licensed counselors, he did not see the need for external clinical consultation and continued to have monthly consultation meetings whether an external clinical consultant was present or not.

<sup>156</sup> VHA Handbook 1500.01, September 8, 2010.

### **Recommendation 13**

The District Director determines reasons an external clinical consultant was not assigned as required at the Midland Vet Center and ensures compliance.

District Director response: Concur

The Midland Vet Center currently has the Suicide Prevention Coordinator and a VA Psychiatrist providing external consultation four hours per month. The VCD and ADD/C will monitor compliance during monthly audits and yearly oversight visits.

Status: Ongoing

Target date for completion: May 31, 2022

#### ***External Clinical Consultation***

RCS requires four hours of external clinical consultation monthly.<sup>157</sup> The OIG found the four vet centers were noncompliant with this requirement. Despite not meeting the requirement, the Casper and Midland Vet Centers did have a tracking mechanism to record when consultation was completed each month. The Casper VCD provided billing invoices that documented dates and times the consultant met with vet center staff. The Midland VCD provided meeting minutes that included the date, client cases reviewed, staff present, and a signature from the external clinical consultant.

### **Recommendation 14**

The District Director determines reasons for noncompliance with processes for completing and tracking four hours per month of external clinical consultation at the Casper, Denver, El Paso, and Midland Vet Centers, and ensures that Vet Center Directors implement processes and monitors compliance.

District Director response: Concur

After reviewing the identified finding, the District Director developed training for the VCD's on the importance of external consultation and the use of a document to track the frequency and length of time of all external consultation meetings. Compliance is monitored monthly by the VCD's and the ADD/C.

Status: Ongoing

Target date for completion: May 31, 2022

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<sup>157</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), January 26, 2021, amended May 3, 2021.

## *Supervision*

RCS policy requires regularly scheduled weekly supervision to help with staff cohesion, problem solving, client case coordination, and to assist with coordination of care with VA partners. RCS requires one hour a week of scheduled supervision with each clinical staff member; however, RCS does not specify how weekly supervision is tracked to ensure completion.<sup>158</sup>

The OIG found the four vet centers noncompliant with the provision of weekly staff supervision. The Casper VCD left on August 29, 2020, and the acting VCD reported the Associate District Deputy for Counseling began providing supervision in October 2020. The acting VCD was unable to provide any supervision records or evidence of supervision from the former VCD and the Associate District Director for Counseling provided limited evidence of supervision for the month of October 2020. The Denver VCDs felt supervision was completed weekly, but did not complete an hour if the staff did not need an hour every week. The El Paso VCD reported beginning weekly supervision in January or February 2020, but did not provide any evidence demonstrating supervision was conducted. The Midland VCD reported completing supervision only when staff requested supervision with no specific frequency or evidence of completion.

## **Recommendation 15**

The District Director determines reasons for noncompliance with staff supervision provided by the vet center directors at the Casper, Denver, El Paso, and Midland Vet Centers, ensures that staff supervision occurs as required, and monitors compliance.

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<sup>158</sup> RCS-CLI-003, *Revised Clinical Site Visit (CSV) Protocol*, January 25, 2019. The 2021 directive requires the VCD provide “individual supervision to all Vet Center staff, counselors, outreach workers, and office managers on an ongoing basis.” There were 13 full weeks during the review period. The total number of weeks was calculated using 13 weeks multiplied by the number of counselors on staff during the review period. Calculations were adjusted based on staff who were not employed for the entire review period.

District Director response: Concur in principle

The VHA Directive 1500(1) which was published on January 26, 2021, indicates that the VCD is responsible for “providing individual supervision to all Vet Center staff, counselors, outreach workers, and office managers on an ongoing basis.” The District provided VCD’s with a protocol to track individual supervision with staff. The District provided training to the VCD’s on how to utilize the protocol.

Status: Ongoing

Target date for completion: May 31, 2022

### *Monthly Audit*

Oversight is one of the main responsibilities of a VCD to ensure quality clinical services. A methodology to complete oversight is accomplished through chart audits. RCS policy requires VCDs to complete a 10 percent audit of each counselor’s active client caseload.

The OIG found the four vet centers were unable to provide evidence that chart audits were completed for the entire review period with either some missing months or insufficient evidence of completing a full 10 percent of audits. The Casper VCD provided monthly chart audit records from the former VCD, but the documents did not document the percentage of counselor caseload evaluated. The Denver VCD provided audit records but had months of missing audits and did not document the percentage of counselor caseload audited. The El Paso VCD provided the RCSnet audit report and while the VCD completed monthly audits, he did not audit 10 percent of each counselors’ caseload. However, beginning in June 2020, the VCD completed a 10 percent audit of records for all counselors. The Midland VCD completed monthly chart audits for each counselor and utilized his own tracking tool that captured the required audit components. However, during the months of April and May 2020 there was no evidence provided of completed monthly chart audits.

### **Recommendation 16**

The District Director determines reasons for noncompliance with monthly RCSnet chart audits at the Casper, Denver, El Paso, and Midland Vet Centers, ensures that chart audits are completed as required, and monitors compliance.

District Director response: Concur

After reviewing the identified finding, the District Director determined a need for and ensured training to the VCD's on the importance and process for conducting monthly chart audits. During this training, VCD's were given a document to assist with tracking charts audited and were instructed to document the number of active cases for each counselor to ensure 10% of each caseload is audited monthly. Compliance is monitored monthly by the VCD's and the ADD/C.

Status: Ongoing

Target date for completion: May 31, 2022

### *Staff Training*

RCS requires completion of mandatory trainings for both clinical and non-clinical staff. The OIG found the four vet centers were noncompliant with completion of annual suicide prevention training and military sexual trauma training for clinical staff summarized in table 7. One non-clinical staff member at the Casper Vet Center was deficient with completing S.A.V.E. or S.A.V.E. refresher training. The Denver Vet Center had two non-clinical staff members who were noncompliant with completing initial S.A.V.E. training within 90 days of entering their positions. The four vet centers were noncompliant with vet center staff completing annual in-service training in fiscal year 2019 (see table 7).<sup>159</sup> The Denver, El Paso, and Midland VCDs reported that they did not assign the trainings nor check them for accuracy but did ensure staff completed assigned training. The Casper VCD was unable to speak to training deficiencies and stated the former VCD was responsible at that time.

District leaders reported that a designated district administrative staff assigned VA Talent Management System trainings. Two district leaders stated VCDs also assigned trainings and two stated VCDs monitored staff completion of training. One leader stated they believed Centralized Health Resource Management Organization assigned S.A.V.E. and military sexual trauma trainings.

### **Recommendation 17**

The District Director determines reasons for errors in training assignments for staff at the Casper, Denver, El Paso, and Midland Vet Centers, ensures all staff complete mandatory trainings, and monitors compliance.

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<sup>159</sup>All face-to-face training conference were canceled in fiscal year 2020 due to COVID-19; alternate trainings were made available but were not required.

District Director response: Concur

After reviewing the identified finding, the District Director is developing process to establish guidelines for the assignment, tracking and follow-up of mandatory trainings. The District will work with the RCS national training manager to identify the required trainings and ensure electronic assignment are established and monitored for compliance.

Status: Ongoing

Target date for completion: May 31, 2022

## Environment of Care

VHA defines environment of care as “the building or space, including how it is arranged and the special features that protect patients [clients], visitors, and staff; equipment used to support patient [client] care or to safely operate the building or space; and people, including those who work within the hospital, patients [clients], and anyone else who enters the environment, all of whom have a role in minimizing risks.”<sup>160</sup> RCS requires that the interior layout and design of a vet center is welcoming and promotes access to readjustment counseling services and support in a non-institutional setting.<sup>161</sup>

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

### Physical Environment

To assess compliance with physical environmental cleanliness, the OIG virtually inspected the exterior to assess if it appeared clean, neat, and presentable and reviewed interior furnishings for cleanliness, and determine whether they were in good repair, serviceable, and welcoming or non-institutional. The OIG also assessed if the waiting area was large and comfortable, able to accommodate clients and their families, and that the interior was decorated with items that depicted military appreciation.<sup>162</sup>

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<sup>160</sup> VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.

<sup>161</sup> VHA Handbook 1500.01, September 8, 2010.

<sup>162</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021.

## General Safety

The Architectural Barriers Act of 1968 applies to buildings or facility spaces leased in whole or in part by the United States after August 12, 1968.<sup>163</sup> Facilities subject to the Architectural Barriers Act must comply with the Architectural Barriers Act Accessibility Standard.<sup>164</sup> The OIG assessed whether vet centers complied with the Architectural Barriers Act Accessibility Standard for compliant entrances and designated parking spaces that are accessible to people with disabilities, and exit signs.<sup>165</sup>

Vet centers are also required to have a current emergency and crisis plan that addresses “contingencies for phone and computer disruptions, weather/national disaster emergency plan, site/facility emergency plan, site/facility temporary relocation plan, management of disruptive behavior, violence in the workplace, and handling of suspicious mail and bomb threats.”<sup>166</sup> The OIG assessed if crisis and emergency management plans were comprehensive and current.

## Privacy

“Vet centers provide a safe and confidential place for veterans to talk that helps mitigate the effects of stigma on combat and sexually traumatized veterans.”<sup>167</sup> Vet centers are required to have an office space for the VCD and each counselor, as well as a group counseling room, that is soundproof and appropriate for confidential counseling. The office manager is required to have a separate space that affords privacy for sensitive duties, while being able to access the waiting area to receive clients.<sup>168</sup> Any documents or items displaying protected health information must be secured. Confidential records must be stored in a room that is double-locked that complies with VHA security requirements.<sup>169</sup> The OIG virtually assessed each vet center’s offices, group counseling rooms, and storage rooms to determine compliance with privacy requirements.

## Environment of Care Findings and Recommendations

The OIG virtually inspected areas within the designated vet centers and found general compliance with exterior and interiors being clean and presentable. Interior designs were

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<sup>163</sup> Architectural Barriers Act of 1968 (codified as amended at 42 U.S.C. § 4151 et seq.).

<sup>164</sup> 41 C.F.R. § 102–76.65(a).

<sup>165</sup> Architectural Barriers Act Accessibility Standard (codified at Appendices C and D to 36 C.F.R. part 1191).

<sup>166</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010.

<sup>167</sup> VHA Handbook 1500.01, September 8, 2010.

<sup>168</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010.

<sup>169</sup> VHA Handbook 0730/4, *Security and Law Enforcement*, March 29, 2013, requires floor to ceiling security, per VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010.

welcoming and non-institutional. Waiting areas were large and comfortable with furnishings that were clean, in good repair, and serviceable. The four vet centers complied with the Architectural Barriers Act Accessibility Standard for entrances and designated parking spaces that are accessible to people with disabilities. The four vet centers were compliant with having private office spaces for the director and counselors, and at least one group counseling room. The OIG found the Casper Vet Center did not meet the RCS requirement for “A separate office which affords privacy for sensitive duties for the Office Manager with open access to the waiting area to accommodate the reception of veterans.”<sup>170</sup> At the time of the inspection, the office manager shared an office with either the visiting Veteran’s Service Officer or a work study student. The Casper VCD corrected the deficiency that day, and therefore the OIG did not make a recommendation for this element. Table 8 details the findings of the environment of care review.

**Table 8. Environment of Care**

Review Elements	OIG Findings			
	Casper Vet Center	Denver Vet Center	El Paso Vet Center	Midland Vet Center
<b>Physical Environment</b>				
Clean Exterior	Compliant	Compliant	Compliant	Compliant
Neat Exterior	Compliant	Compliant	Compliant	Compliant
Presentable Exterior	Compliant	Compliant	Compliant	Compliant
Interior Design and Furnishings Clean	Compliant	Compliant	Compliant	Compliant
Interior Design and Furnishings in Good Repair	Compliant	Compliant	Compliant	Compliant
Interior Design and Furnishings Serviceable	Compliant	Compliant	Compliant	Compliant
Interior Design and Furnishings Appropriate, Welcoming, and Non-Institutional	Compliant	Compliant	Compliant	Compliant
Large Waiting Area	Compliant	Compliant	Compliant	Compliant
Comfortable Waiting Area	Compliant	Compliant	Compliant	Compliant
<b>General Safety</b>				
Entrance Accessible for People with Disabilities	Compliant	Compliant	Compliant	Compliant
Designated Parking for People with Disabilities	Compliant	Compliant	Compliant	Compliant

<sup>170</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010.

Exit Signs Architectural Barriers Act Accessibility Standard Compliant	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>
Crisis Management Plan	Compliant	<b>Noncompliant</b>	Compliant	<b>Noncompliant</b>
Objects Potentially used as Weapons Minimal	Compliant	Compliant	Compliant	Compliant
<b>Privacy</b>				
Private, Soundproof Office Space for Confidential Counseling (Counselors and Director)	Compliant	Compliant	Compliant	Compliant
Group Counseling Room	Compliant	Compliant	Compliant	Compliant
Office Manager Space Private and Accessible to Clients	<b>Noncompliant</b>	Compliant	Compliant	Compliant
Personal Information Secured	Compliant	Compliant	Compliant	Compliant
Secure Double-Locked Room for Client Records	Compliant	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>

Source: VA OIG analysis of environment of care inspections conducted from January 25, 2021 to February 11, 2021

The OIG identified the following findings:

- Architectural Barriers Act exit signage
- Updated emergency and crisis plans
- Storage of confidential client records

### *Architectural Barriers Act Accessibility Standard*

The OIG found the four vet centers noncompliant in one element of general safety. Specifically, RCS requires that each vet center follow Architectural Barriers Act Accessibility Standard and each egress have signage and “doors at exit passageways, exit discharge, and exit stairways shall be identified by *tactile* signs complying with 703.1, 703.2, and 703.5.”<sup>171</sup> The OIG found the four vet centers did not have a tactile sign posted near any of the exit doors in the vet centers.

### **Recommendation 18**

The District Director evaluates and determines reasons tactile (braille) signage was not posted at all exit doors at the Casper, Denver, El Paso, and Midland Vet Centers and ensures all exit doors are compliant with the Architectural Barriers Act.

<sup>171</sup> 36 C.F.R. § Pt. 1191, App. D.; Architectural Barriers Act (ABA) Standards (2015).

District Director response: Concur

Braille signage is added to the Casper, Denver, El Paso, and Midland Vet Centers.

Status: Closed

Target date for completion: NA

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

### *Emergency and Crisis Plans*

Vet centers are required to have a current emergency and crisis plan. The OIG found Casper and El Paso, Vet Centers had updated emergency and crisis plans and the Denver and Midland Vet Centers did not. The Denver Vet Center did provide the OIG with an emergency plan, but it was not dated and the OIG was unable to determine whether it was current. The Midland VCD reported they took direction from the support VHA facility on what to do during a crisis and based his decisions on current circumstances, rather than a policy.

### **Recommendation 19**

The District Director reviews the reasons an updated emergency and crisis plan was not available at the Denver and Midland Vet Centers and ensures an updated plan is accessible to all staff.

District Director response: Concur

After reviewing the identified finding, the District Director ensure the Denver VCD completed and submitted an emergency and crisis plan containing all required components and date. The DDD completed and submitted an emergency and crisis plan containing all required components and date for the Midland Vet Center.

Status: Closed

Target date for completion: NA

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

### *Privacy*

Confidential records must be stored in a room that is double-locked.<sup>172</sup> The Denver, El Paso, and Midland Vet Centers did not store confidential clients records in a double-locked storage room.

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<sup>172</sup> VHA Handbook 0730/4 requires floor to ceiling security, per VHA, *RCS Guidelines and Instructions for Vet Center Administration*, November 23, 2010.

The Denver and El Paso Vet Centers were no longer using their storage rooms for file storage. The Denver VCD reported that since they ceased using paper files, records were scanned into RCSnet and storage was not needed. The El Paso VCD reported most records had been scanned, several remaining confidential files were stored in a locked file cabinet in the office manager's room, and the room remained unlocked when the vet center was open. The Midland Vet Center did have a locked storage room with locking file cabinets, but there were client records stored in cabinets without locks. These records were secured behind one lock only.

## **Recommendation 20**

The District Director reviews reasons for noncompliance with client record storage at the Denver, El Paso, and Midland Vet Centers and ensures all client records are stored as required.

District Director response: Concur in principle.

After reviewing the identified finding, the District Director determined that the Denver Vet Center had all client records dispositioned on January 22, 2021 and was compliant. The Denver VCD informed the OIG inspectors during the environment of care walk through that a client record storage area within the Vet Center was no longer being utilized because all client records had been scanned into RCSnet. The El Paso Vet Center secured the four client records awaiting scanning to a doubled locked storage area. The Midland Vet Center secured the 38 client records awaiting scanning to a double locked storage area.

Status: Closed

Target date for completion: NA

RCS Comment: The Denver Vet Center did not have any unsecured client records. All client records at the Denver Vet Center were dispositioned on January 22, 2021.

OIG response: The OIG identified that the Denver Vet Center did not have unsecured records at the time of inspection. However, a deficiency existed because should storage of confidential records be needed prior to scanning, the vet center did not have a secure area to store client records as required. The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

## Appendix A: Summary of Vet Center Inspection Program Recommendations

The intent of the recommendations is for VCDs to use them as a road map to help improve operations and clinical care. The 20 recommendations address systems issues as well as other less critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

**Table A.1. Summary Table of Recommendations**

Quality	Requirement	Recommendation
Quality Reviews	Validation for resolution of deficiencies	<ol style="list-style-type: none"> <li>1. The District Director determines the reasons clinical and administrative quality review remediation plans do not include the Deputy District Director's approval and date of approval as required and ensures compliance.</li> <li>2. The District Director evaluates the clinical and administrative quality review process for resolution of quality review deficiencies and initiates action steps as necessary.</li> <li>3. The District Director evaluates the clinical and administrative quality review report process for determining timeliness in resolving quality review site visit deficiencies and initiates action steps as necessary.</li> </ol>
Critical Incident Quality Reviews	Completion of critical incident quality reviews for all serious suicide attempts of active clients	<ol style="list-style-type: none"> <li>4. The District Director determines the reasons critical incident quality reviews (currently known as mortality and morbidity review) for serious suicide attempts including analysis for corrective action were not completed, ensures completion, and monitors compliance.</li> </ol>
Suicide Prevention (Zone)	Requirement	Recommendation
Intake Assessment	Completion of psychosocial assessments within five visits	<ol style="list-style-type: none"> <li>5. The District Director ensures the intake assessment portion of the psychosocial assessment is completed and monitors compliance across all zone vet centers.</li> </ol>

Lethality Risk Assessment	Completion of lethality risk assessments during the first clinical encounter	6. The District Director ensures lethality risk assessments are completed and monitors compliance across all zone vet centers.
Intake Assessment and Military History	Completion of psychosocial assessments within five visits	7. The District Director in collaboration with Readjustment Counseling Service Central Office evaluates the limitations of current tools and tracking methods including reasons completion dates are not visible in RCSnet and ensures compliance with standards for timely completion of intake assessments, military histories, and lethality risk assessments.
Suicide Prevention and Intervention	High-Risk Shared Client Care Coordination	8. The District Director ensures clinical staff consult and coordinate care with the support Veterans Affairs medical facility for shared clients flagged as high risk for suicide and monitors compliance across all zone vet centers.
	Following confidentiality requirements when coordinating care VA medical facilities	9. The District Director ensures clinical staff follow confidentiality requirements when consulting and coordinating care with shared support Veterans Affairs medical facility for shared clients who are flagged as high risk for suicide and monitors compliance across all zone vet centers.
	Consultation following lethality status changes	10. The District Director ensures clinical staff consult with the vet center director, external clinical consultant or suicide prevention coordinator following a lethality status change as required and monitors compliance across all zone vet centers.
	Completion of crisis reports	11. The District Director ensures clinical staff complete crisis reports as required and monitors compliance across all zone vet centers.
<b>Suicide Prevention (Select Vet Centers)</b>	<b>Requirement</b>	<b>Recommendation</b>
Care Coordination and Collaboration with VA medical facility	Participation on VA medical facility Mental Health Council	12. The District Director in collaboration with the support Veterans Affairs medical facility clinical or administrative liaison determines the reasons for noncompliance with staff participation on mental health councils at the Casper, Denver, and Midland Vet Centers, and takes actions to ensure compliance with Readjustment Counseling Service requirements.
<b>Consultation, Supervision, and Training</b>	<b>Requirement</b>	<b>Recommendation</b>
External Clinical Consultation	Assigned External Clinical Consultant	13. The District Director determines reasons an external clinical consultant was not assigned as required at the Midland Vet Center and ensures compliance.

	Documentation of four hours of external clinical consultation per month	14. The District Director determines reasons for noncompliance with processes for completing and tracking four hours per month of external clinical consultation at the Casper, Denver, El Paso, and Midland Vet Centers, and ensures that Vet Center Directors implement processes and monitors compliance.
Supervision	One-hour weekly supervision with clinical staff members	15. The District Director determines reasons for noncompliance with staff supervision provided by the Vet Center Directors at the Casper, Denver, El Paso, and Midland Vet Centers, ensures that staff supervision occurs as required, and monitors compliance.
	Monthly 10 percent client record audit for each counselor	16. The District Director determines reasons for noncompliance with monthly RCSnet chart audits at the Casper, Denver, El Paso, and Midland Vet Centers, ensures that chart audits are completed as required, and monitors compliance.
Training	Completion of all mandatory trainings	17. The District Director determines reasons for errors in training assignments for staff at the Casper, Denver, El Paso, and Midland Vet Centers, ensures all staff complete mandatory trainings, and monitors compliance.
<b>Environment of Care</b>	<b>Requirement</b>	<b>Recommendation</b>
General Safety	All exit signage Architectural Barriers Act Accessibility Standard compliant	18. The District Director evaluates and determines reasons tactile (braille) signage was not posted at all exit doors at the Casper, Denver, El Paso, and Midland Vet Centers and ensures all exit doors are compliant with the Architectural Barriers Act.
	Current emergency and crisis plan	19. The District Director reviews the reasons an updated emergency and crisis plan was not available at the Denver and Midland Vet Centers and ensures an updated plan is accessible to all staff.
Privacy	Confidential/sensitive information secured	20. The District Director reviews reasons for noncompliance with client record storage at the Denver, El Paso, and Midland Vet Centers and ensures all client records are stored as required.

Source: VA OIG.

## Appendix B: Zone 1 Profile

**Table B.1. Zone 1 Profile  
(October 1, 2019–September 30, 2020)**

Profile Element	Zone 1	
Total budget dollars	\$ 19,071,370	
Unique clients	8,441	
New Clients	2,401	
Active Duty Clients	308	
Spouse/Family Clients	1,368	
Bereavement Clients	75	
Position	Authorized	Filled
Total Full-time	158	152
District Leaders*	4	4
District and Zone Staff†	3	3
Vet Center Directors	23	22
Clinical Staff	82	78
Veterans Outreach Program Specialist‡	24	24
Vet Center Office Staff	25	24

Source: VA OIG analysis of information from district leaders.

Note: At the time of inspection, district 4 zone 1 reported 23 vet centers. The district office provided zone profile reports for the fiscal year, not the review period of the inspection.

\*District leaders includes the District Director, Deputy District Director, Associate District Directors for Counseling and Administration. The Continental District Director is not included in the authorized and filled position total because responsibilities span across the district and zones.

†District and Zone staff includes the administration officer, executive assistant, and a Zone 1 program support specialist (administrative officer and executive assistant positions are not included in the authorized and filled totals because responsibilities span across the district and zones).

‡Veteran Outreach Program Specialists are responsible for vet center outreach services.

**Profile Summary:** From October 1, 2019, through September 30, 2020, district 4, zone 1 operated on a total budget of \$19,071,370 and served 8,441 unique clients, 2,401 new clients, 308 active duty, 1,368 spouses and family members, and 75 bereavement clients. There was a total of 158 authorized full-time positions, with six total vacancies throughout the zone at the time of inspection.

## Appendix C: Selected Vet Center Profiles

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

**Table C.1. Fiscal Year 2020 Vet Center Profiles**

Profile Element	Denver Vet Center	Casper Vet Center	El Paso Vet Center	Midland Vet Center
Number of:				
• Unique Clients	701	176	842	195
• Bereavement Clients	5	0	7	0
• Active Duty Clients	34	2	36	2
• Spouse/Family Clients	63	17	100	52
• New Clients	178	84	284	46
Total Number of Positions (at the time of inspection)	Denver Vet Center	Casper Vet Center	El Paso Vet Center	Midland Vet Center
• Total Full-time positions	10	5	9	5
• Total Part-time positions	N/A	N/A	N/A	N/A
• Vet Center Director	1	0	1	1
• Clinical Staff	7	2	6	2
• Veterans Outreach Specialist	1	1	1	1
• Office Staff	1	1	1	1
• Other	N/A	2*	1*	N/A

Source: VA OIG analysis of information provided by District Office.

Note: The OIG did not assess VA's data for accuracy or completeness.

\*Other includes work study positions.

## Appendix D: Chief Readjustment Counseling Officer Memorandum

### Department of Veterans Affairs Memorandum

Date: October 20, 2021

From: Chief Readjustment Counseling Officer, RCS

Subj: Vet Center Inspection of Continental District 4 Zone 1 and Selected Vet Centers

To: Director, Officer of Healthcare Inspections (54MH00)

Director, GAO/OIG Accountability Liaison (VHA GOAL Action)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, *Vet Center Inspection of Continental District 4 Zone 1 and Selected Vet Centers*.
2. Readjustment Counseling Service (RCS) has reviewed recommendations 1-20 and submits action plans to address all findings in the report.
3. RCS Vet Centers are essential to supporting Veterans, Service members and their families. As Vet Center eligibility broadens, RCS continues to modernize the organization and workforce to include improving staff training opportunities, automating functions, and updating policies and procedures. RCS staff continues to exceed the expectations of those served. RCS values the feedback provided by this review to continue our efforts to improve.
4. Comments regarding the contents of this memorandum may be directed to the RCS Action Group at [VHA10RCSAction@va.gov](mailto:VHA10RCSAction@va.gov).

*(Original signed by:)*

Michael Fisher  
Chief Officer

## **Appendix E: Continental District 4 Director Memorandum**

### **Department of Veterans Affairs Memorandum**

Date: October 20, 2021

From: Carrie Crownover, District Director, Continental District 4

Subj: Vet Center Inspection of Continental District 4 Zone 1 and Selected Vet Centers

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

Director, GAO/OIG Accountability Liaison (VHA 10B GOAL Action)

Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, *Vet Center Inspection of Continental District 4 Zone 1 and Selected Vet Centers*. The Veterans Health Administration (VHA) concurs with the recommendations and provides comments/action plan in the attachment.

Comments regarding the contents of this memorandum may be directed to the Continental District 4 Office at [vharcsdistrict4suspensenotification@va.gov](mailto:vharcsdistrict4suspensenotification@va.gov).

*(Original signed by:)*

Carrie A. Crownover, PhD  
Continental District 4 Director

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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