



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

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Vet Center Inspection of  
Continental District 4 Zone 2  
and Selected Vet Centers



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**Figure 1.** Continental district 4 zone 2 vet centers inspected.  
Source: VA OIG 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
VISN	Veterans Integrated Service Network



## Report Overview

The 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. The inspection focused on Continental district 4 zone 2 (district 4 zone 2) and four vet centers—the Alexandria Vet Center in Louisiana and Houston Southwest, Laredo, and Mesquite Vet Centers in Texas.<sup>1</sup>

VCIP inspections are one element of the OIG’s oversight to ensure that the nation’s veterans receive high-quality and timely mental health care and VA services. This inspection covers key clinical and administrative processes that are 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>2</sup>

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

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<sup>1</sup> A new policy, VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021, was issued after the OIG’s inspection period of VCIP operations discussed in this report. The new directive rescinded and replaced multiple VHA guidelines and policies addressing Readjustment Counseling Service operations that were in effect during the inspection period. The OIG compared the rescinded guidelines and policies with the newly issued directive to identify modifications.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 in the report, requirements in the new directive use the same or similar language as those that were rescinded. 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.

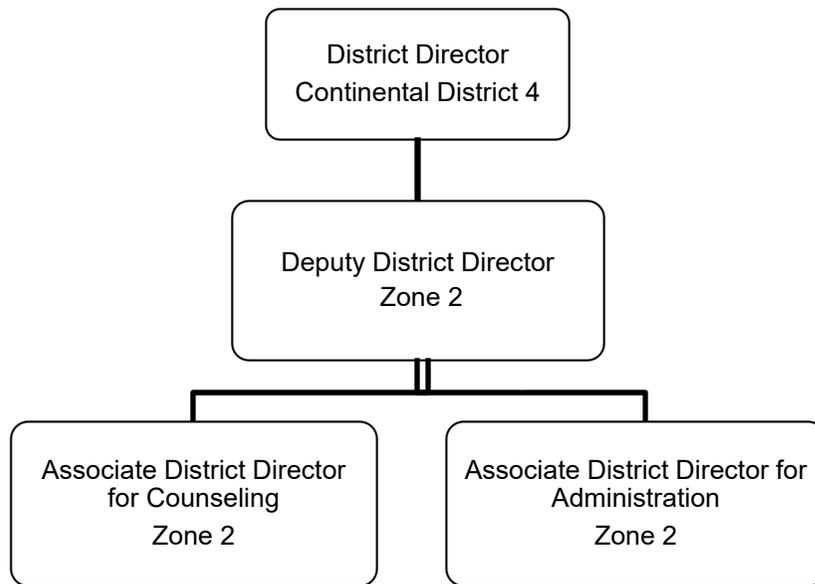
<sup>2</sup> VHA Directive 1500(1), 2021. Vet centers provide counseling interventions for psychological and psychosocial readjustment problems related to specific types of military deployment stressor. Readjustment counseling services are “designed by law to be provided without a medical diagnosis.” 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.

The complexity of vet center services limits the OIG’s ability to assess all areas of risk. 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. The OIG findings 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 the district office.

The leadership team of district 4 zone 2 consists of a District Director, Deputy District Director, Associate District Director for Counseling, and Associate District Director for Administration (see figure 2).<sup>3</sup>



**Figure 2.** District 4 zone 2 leaders.

*Source: VA OIG analysis of district organizational chart.*

At the time of the OIG interviews, three of the four district leaders had been working together for nearly two and a half years. The District Director was appointed in August 2018. The Deputy District Director was assigned in January 2018, the Associate District Director for Counseling

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<sup>3</sup> For the purposes of this report, district leaders refer to district 4 zone 2’s District Director, Deputy District Director, Associate District Director for Counseling, and Associate District Director for Administration. VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 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.

served in the position since June 2020, and the Associate District Director for Administration was assigned in September 2018.

Generally, district leaders spent about nine hours a week engaged in quality improvement activities across the zone. District leaders were knowledgeable about the basic concepts of healthcare quality improvement and were generally able to speak in detail about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and client experiences. The District and Deputy District Director had knowledge of a just culture and provided examples of how the district leaders were receptive to employees, noting open-door communication and collaboration between zone 1 and zone 2.<sup>4</sup>

The All Employee Survey is an annual, voluntary survey of VA workforce experiences. District leaders correctly identified the top three fiscal year 2020 All Employee Survey priorities as growth, communication, and innovation.<sup>5</sup>

The OIG reviewed Vet Center Service Feedback survey results and found national scores were exceeded and indicated overall client satisfaction with appointment availability, staff courtesy, and vet center services. Results for the leadership and organizational risks review generally do not rise to the level of findings.

## Quality Reviews

Quality reviews included analysis of vet center clinical and administrative annual quality reviews and critical incident quality reviews. Vet centers are required to have an annual clinical and administrative quality review completed to ensure compliance with policy and procedures. The Readjustment Counseling Service requires critical incident quality reviews (currently known as morbidity and mortality 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.

The OIG found the Associate District Directors of Counseling and Administration noncompliant with requirements for the completion and timeliness of quality reviews and remediation plans as well as critical incident quality reviews for serious suicide attempts.

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<sup>4</sup> Health Quality Council of Alberta, *Just Culture*, accessed March 2, 2021, <https://hqca.ca/healthcare-provider-resources/just-culture/>. "Just culture is an atmosphere of trust in which healthcare workers are supported and treated fairly when something goes wrong with patient care. Just culture is important to patient safety as it creates an environment in which people (healthcare workers and patients) feel safe to report errors and concerns about things that could lead to patient adverse events."

<sup>5</sup> Fiscal year 2020 was October 1, 2019, through September 30, 2020.

## COVID-19 Response

The COVID-19 response review results were obtained through a zone-wide questionnaire to staff and interviews with district leaders and vet center directors (VCD) from the four selected vet centers. This review is designed primarily to gather information from leaders and staff within the zone and to draw general conclusions. Results for the COVID-19 response review typically do not rise to the level of findings.

The OIG interviewed district leaders and VCDs of the four selected vet centers about the following areas—emergency planning, supplies and infrastructure, access and client care, and client screening including referral. District leaders were also interviewed about communication and field guidance. The OIG sent a COVID-19 voluntary questionnaire to 152 employees at the 23 zone 2 vet centers. The district leaders and four VCDs felt supplies were adequate; masks were worn in the vet centers; hand washing and hand sanitizer stations were available; and safe social distancing was practiced throughout the zone. Overall, employees' responses to the COVID-19 questionnaire showed that communication from district leaders and VCDs was adequate to ensure the safety of clients and staff.

## 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.<sup>6</sup>

The OIG identified deficiencies related to clinician coordination and consultation with support VA medical facilities for high risk clients as well as adherence to client confidentiality requirements.<sup>7</sup> The OIG found deficiencies with clinical staff consultation following lethality status changes and completion of crisis reports in cases of suicide completions, attempts, gestures, and interventions and homicide attempts, completions, and interventions.

The OIG found the four vet centers inspected were compliant with required availability of nontraditional hours for appointments and updated crisis plans. All VCDs were also compliant with the requirement to review the High Risk Suicide Flag SharePoint monthly. The four selected vet centers and their support VA medical facilities did not have shared clients who died

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<sup>6</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 separate OIG report—*Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021.

<sup>7</sup> Support VA medical facilities are facilities that have been identified to assist vet centers with client mental health care.

by suicide during the OIG review period; therefore, staff at those vet centers did not participate on root cause analysis panels. The OIG found that none of the four vet centers were participating on the support VA medical facility mental health council.<sup>8</sup> None of the four vet centers were able to provide evidence they received or requested the required Office of Mental Health and Suicide Prevention list of clients with an increased predictive risk for suicide. The four vet centers did not identify a standardized communication process of collaboration with the support VA medical facility suicide prevention coordinators.

## 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 four vet centers inspected complied with requirements for having a clinical liaison and external clinical consultant from the VA medical facility mental health or social work service. The external clinical consultants were appropriately licensed as were the required mental health professionals on staff at each vet center. Vet centers were deficient with the requirement of an external clinical consultant providing at least four hours of consultation per month.

Vet center directors were not compliant with the requirement of providing one hour a week of supervision to clinical staff and the auditing of records. Overall, three of the four vet centers' staff were noncompliant with completing training requirements.<sup>9</sup>

## Environment of Care

Environment of care reviews evaluated the four selected vet centers with results and recommendations specific only to those sites. The four vet centers inspected generally complied with environment of care requirements for the physical environment, general safety, and privacy. However, none of the four vet centers inspected had Architectural Barriers Act-compliant exit signs.<sup>10</sup> The OIG found one vet center deficient in having a crisis management plan with all required components and an incidence of unsecured personally identifiable information at one vet center.

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<sup>8</sup> VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010. "Vet Center staff need to participate on all VA Medical Center Mental Health Councils." Also noted in the handbook, "Upon request from Veterans, Vet Centers will maintain non-traditional appointment schedules, after normal business hours during the week and on weekends, to accommodate working Veterans and family members." 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."

<sup>9</sup> S.A.V.E. is an acronym that stands for Signs, Ask, Validate, Encourage and Expedite and is a training video collaboration with VA and PsychArmor Institute.

<sup>10</sup> Architectural Barriers Act of 1968 (codified as amended at 42 U.S.C. § 4151 et seq).

## 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 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.

## Comments

The Chief Officer and District Director concurred with recommendations 1–3, 6–14, and 16–20, and concurred in principle with recommendations 4, 5, and 15. An action plan was provided (see responses within the body of the report for the 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 that 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 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 Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021. Vet centers provide counseling interventions for psychological and psychosocial readjustment problems related to specific types of military deployment stressor. 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.

<sup>2</sup> VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010. The 2010 handbook, which was in effect during the OIG’s inspection period, was rescinded and replaced by VHA Directive 1500(1), 2021. Unless otherwise specified, the requirements in the 2021 directive contain the same or similar language as the rescinded September 2010 handbook. Policy Memorandum RCS-CLI-003, *Revised Clinical Site Visit (CSV) Protocol*, January 25, 2019.

<sup>3</sup> VHA Handbook 1500.01, September 2010; VHA Directive 1500 (1), 2021. “Vet Center Eligibility,” VA Vet Centers (Readjustment Counseling), accessed March 24, 2021, <https://www.vetcenter.va.gov/Eligibility.asp>. Post Deployment Health Reassessments are used to screen and evaluate the health of those returning from combat.

<sup>4</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010. The policy, which was in effect during the OIG’s inspection period, was rescinded and replaced by VHA Directive 1500(1), 2021. Unless otherwise specified, requirements in the 2021 directive use the same or similar language as the rescinded November 2010 guidelines. Readjustment counseling is a counseling service provided by readjustment counselors to assist with combat-related psychological and psychosocial readjustment.

American Psychiatric Association recognized posttraumatic stress disorder (PTSD) 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 including families and active service members. From 1979 through 1985, an estimated 305,000 clients received services at vet centers; and by fiscal year 2019, RCS Central Office reported 307,737 clients were seen in a single fiscal year.<sup>6</sup> In an attempt to serve the growing veteran population, the number of vet centers expanded from 91 in 1979 to 300 vet centers as of June 2018.<sup>7</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>8</sup>

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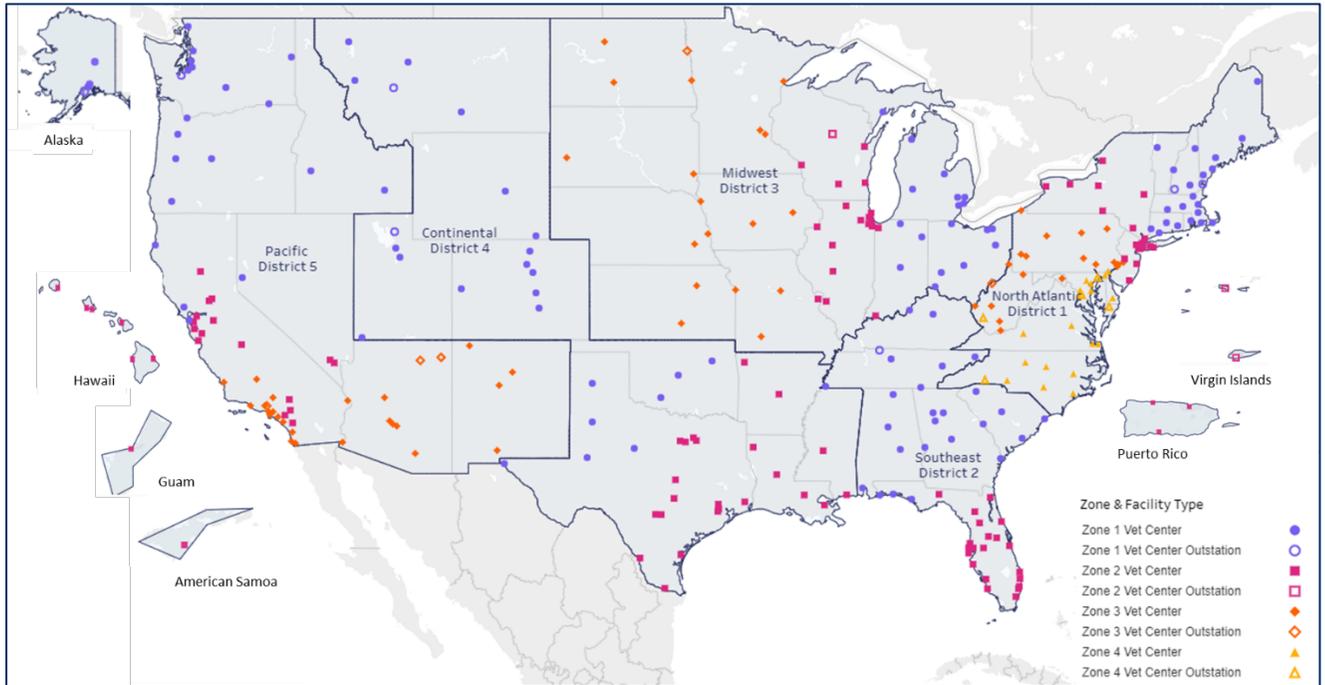
<sup>5</sup> Mayo Clinic, “Post-traumatic stress disorder (PTSD),” accessed December 10, 2020, <https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967>.

“Post-traumatic stress disorder (PTSD) is a mental health condition that's triggered by a terrifying event—either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event.” VHA Handbook 1500.01, September 2010; VHA Directive 1500(1), 2021.

<sup>6</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; Government Accountability Office, *Readjustment Counseling Service: Vet Centers Address Multiple Client Problems, but Improvement Is Needed*, Report No. GAO/HEHS-96-113, July 1996. The OIG defines fiscal year as October 1 of every given year through September 30, of the following year.

<sup>7</sup> Blank Jr., Arthur S. “Apocalypse Terminable and Interminable: Operation Outreach for Vietnam Veterans.” *Hospital and Community Psychiatry*. Volume 33, Number 11, November 1982.

<sup>8</sup> VHA Directive 1500(1), 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 on the map is not representative of their actual geographical locations.<sup>9</sup>

Source: Developed by the VA OIG using VA Site Tracking (January 19, 2021) and RCS data (as of March 2, 2021).

Vet center services and eligibility expanded starting 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>10</sup> Table 1 shows the expansion of vet center eligibility.

<sup>9</sup> VA News Release, *VA Deploying 20 New Mobile Vet Centers*, January 4, 2012. Pacific District 5 includes Alaska, Hawaii, Guam, and American Samoa. Southeast District 2 includes Puerto Rico and the Virgin Islands. Not on the map are the locations of mobile vet centers used to provide counseling or outreach services to the community.

<sup>10</sup> “Who We Are,” VA 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 Operation Enduring Freedom (OEF) Veterans of Operation Iraqi Freedom (OIF) Veterans of Global War on Terrorism (GWOT)
2011	Federally activated National Guard and Reserve forces who served in active military in Operation Enduring Freedom or Operation Iraqi Freedom
2013	Family members of deployed service members for support 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 Family members of deployed service members for support
2014	Amended VA's authority to provide counseling, care and services to active duty service members reporting sexual assault or harassment without a Tricare referral
2020	Forces who served on active service in response to a national emergency or national 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

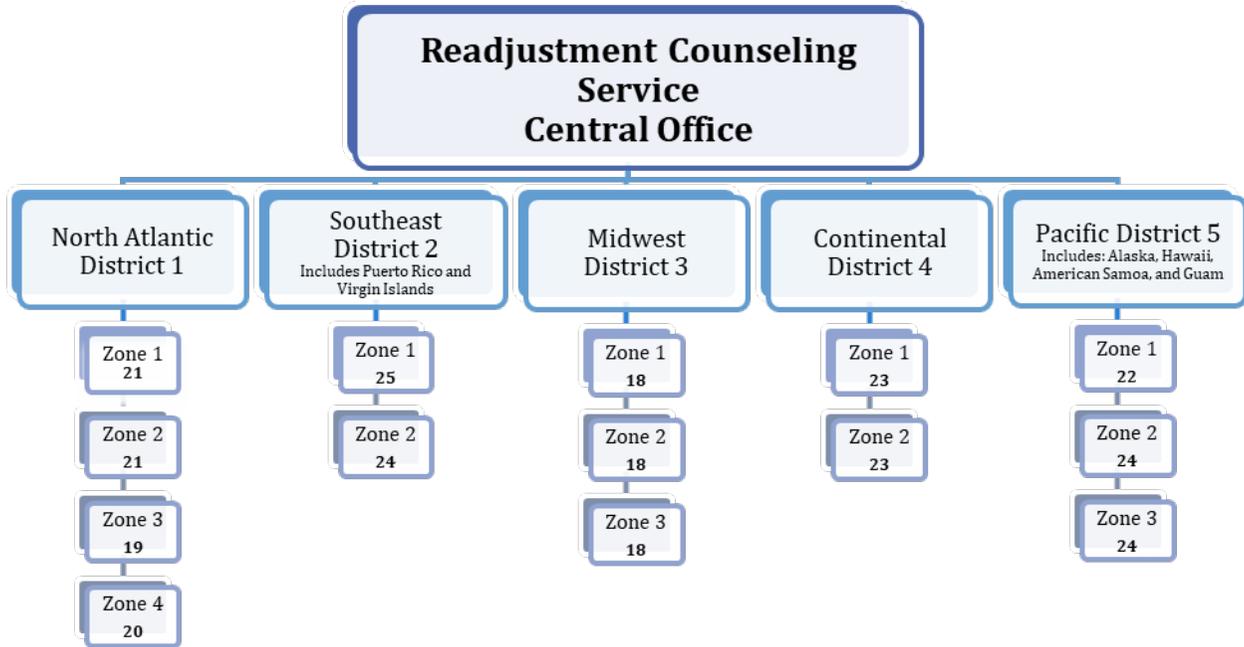
Source: VA OIG analysis of vet center eligibility expansion information. *Vet Center Eligibility*, accessed June 4, 2019, <https://www.vetcenter.va.gov/Eligibility.asp>. National Defense Authorization Act for Fiscal Year 2013, Pub. L. No. 112-239 (2013).

\*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>11</sup> RCS establishes clinical and administrative policies for vet center operations.<sup>12</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. A zone is

composed 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>13</sup>



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

Source: Developed by VA OIG after analysis of RCS data.

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.

## Electronic Client Record

Vet center services are not required to be recorded in the client’s VA electronic health record.<sup>14</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 there is a signed release of information.<sup>15</sup> The RCS National Service Support leader reported working with Cerner

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

<sup>14</sup> VHA Directive 1500(1), 2021.

<sup>15</sup> VHA Handbook 1500.01, September 2010; VHA Directive 1500(1), 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.

Corporation and VA's Office of Electronic Health Record Modernization for the development of an RCS-specific electronic client record system.<sup>16</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>17</sup> The support VA medical facility director in coordination with the VCD assigns a clinical and administrative liaison.<sup>18</sup> The VA medical facility clinical liaison coordinates services for complex and shared clients.<sup>19</sup> The VA medical facility administrative liaison provides support for procurement, engineering functions, commuter benefits, general post funds and fleet management for U.S. government vehicles.<sup>20</sup> As required, vet center staff 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>21</sup>

## Purpose and Scope

The purpose of the 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 Continental district 4 zone 2 (district 4 zone 2) 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 RCS leaders so informed decisions can be made on improving care.

The OIG findings are a snapshot of a zone and vet center's performance within identified focus areas. Although it is difficult to quantify the risk of adverse impact to clients served at vet

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<sup>16</sup> VHA Directive 1500, September 2010; VHA Directive 1500(1), 2021. Per an RCS National Service Support leader, modernization of the RCSnet as the electronic client record system for vet centers was being considered and a determination had not been made. "Federal Government," Cerner Corporation, Cerner Government Services, accessed June 29, 2021, <https://www.cerner.com/solutions/federal-government>. According to the website, Cerner is a corporation that promotes secure modern technology to improve healthcare operations, create solutions, and connect healthcare communities.

<sup>17</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021.

<sup>18</sup> Support VA medical facilities are facilities that have been identified to assist vet centers with client mental health care.

<sup>19</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021. For the purposes of this report, the OIG uses the term VA medical facility instead of VA medical center and VHA medical facility.

<sup>20</sup> VHA Directive 1500(1), 2021.

<sup>21</sup> VHA Handbook 1500.01, September 2010; VHA Directive 1500(1), 2021. Vet Centers provide representation on RCA panels when a client who completes suicide is a shared client with the VA medical facility.

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>22</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>23</sup>
- Suicide prevention
- Consultation, supervision, and training
- Environment of care

## Methodology

The OIG announced the inspection to RCS district 4 zone 2 leaders (district leaders) on January 25, 2021, and conducted virtual site visits from January 25, 2021, through February 12, 2021.<sup>24</sup> The OIG interviewed district leaders and four VCDs at the selected vet centers. Due to travel restrictions during the COVID-19 pandemic, the inspection was conducted virtually.<sup>25</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 after the OIG's inspection period of VCIP operations (November 1, 2019–October 31, 2020) discussed in this report.<sup>26</sup> The new directive rescinded and replaced multiple VHA guidelines and policies addressing RCS operations that

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<sup>22</sup> The underlined terms are hyperlinks to a glossary/other section of the report. To return to the point of origin, press “alt” and “left arrow” keys.

<sup>23</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. “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.” 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>.

<sup>24</sup> For the purposes of this report, district leaders refer to district 4 zone 2’s District Director, Deputy District Director, Associate District Director for Counseling and Associate District Director for Administration.

<sup>25</sup> “Travel During COVID-19,” Centers for Disease Control and Prevention, accessed March 24, 2021, <https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-during-covid19.html>.

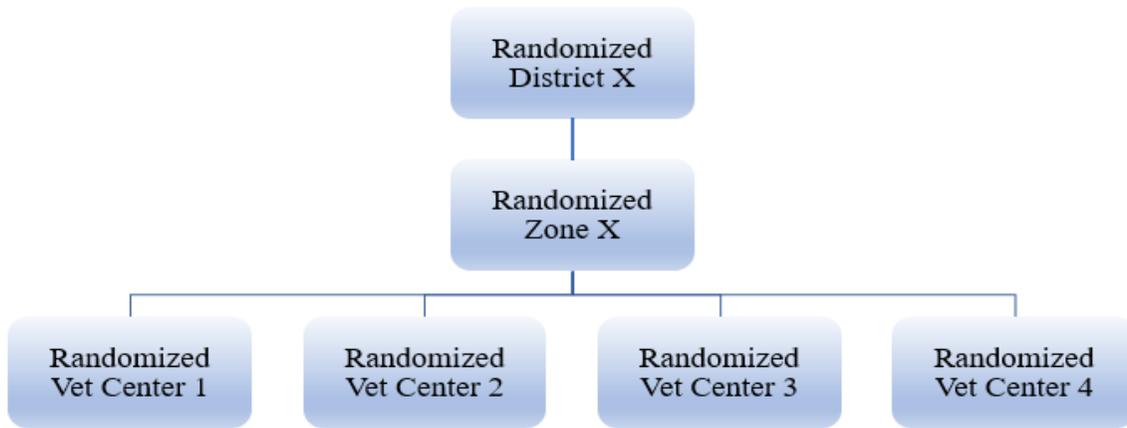
<sup>26</sup> VHA Directive 1500(1), 2021.

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 in the report, requirements in the new directive use the same or similar language as the rescinded RCS-related guidelines and policies under discussion. 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, which focused on quality improvement activities, was sent to all VCDs in the zone. The second questionnaire regarding COVID-19 response by RCS was sent to all staff within the zone. The OIG did not assess responses for accuracy or completeness.

### District and Zone Selection

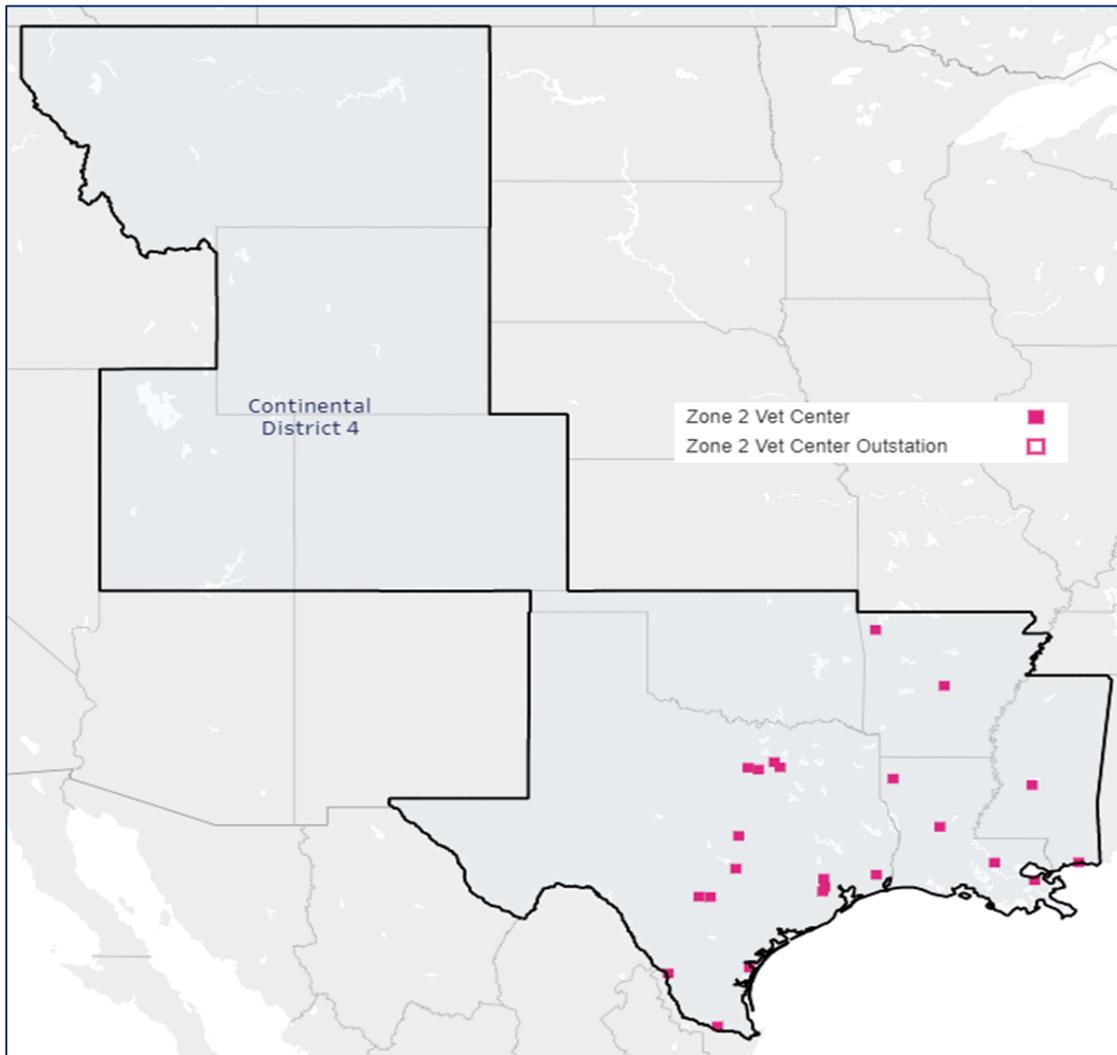
Site selection was completed through randomization, beginning sequentially with the district, zone, and vet centers respectively (see figure 5).



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

For this inspection, district 4 zone 2 was randomly selected. Within district 4 zone 2, the Alexandria Vet Center in Louisiana and Houston Southwest, Laredo, and Mesquite Vet Centers in Texas were randomly selected. Geographical locations of district 4 zone 2 vet centers are noted in figure 6. For demographic profiles of district 4 zone 2 and the four selected vet centers, see [appendixes B](#) and [C](#). The OIG provided one-day notice to each vet center prior to formal evaluation.<sup>27</sup>

<sup>27</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021. Vet centers are composed of small multidisciplinary teams.



**Figure 6.** Map of Continental district 4 zone 2 vet centers.

Source: Developed by VA OIG using VA Site Tracking.

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

- leadership stability,
- quality improvement activities,
- VA All Employee Survey,
- 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 an evaluation of all zone (1) vet center clinical and administrative oversight reviews and (2) 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 leaders and staff within the zone and to draw general conclusions. Results for the COVID-19 questionnaire response and interview questions 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 related to the four vet center sites.<sup>28</sup>

Consultation, supervision, and training and environment of care reviews 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 at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with 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.

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<sup>28</sup> For vet center clients shared with support VA medical facilities, the OIG also reviewed VHA electronic health records.

## 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.

### Leadership and Organizational Risks

Leadership and organizational risks can affect a healthcare system's ability to provide safe and sustainable care.<sup>29</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>30</sup>

The OIG assessed leadership and organizational risks for district 4 zone 2 by evaluating the following:

- District leadership position stability
- Quality improvement activities
- VA All Employee Survey results
- Vet Center Service Feedback survey
- Leadership and organizational risk questionnaire results<sup>31</sup>

### District Leadership Position Stability

The RCS district director oversees the deputy district director who is responsible for an assigned zone (one deputy per zone). The deputy district director supervises the 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 the deputy district director and are responsible for the overall vet center operations including staff supervision,

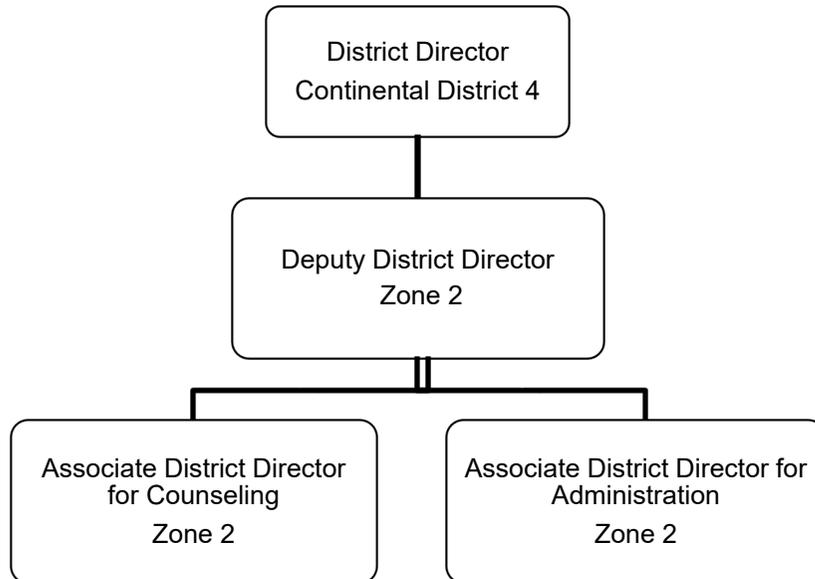
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<sup>29</sup> Botwinick, L., Bisognano, M., Haraden, C. *Leadership Guide to Patient Safety*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2006.

<sup>30</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>31</sup> The leadership and organizational risk questionnaire is a tool the OIG developed and used to ask zone-wide VCDs about quality management to evaluate knowledge and practices.

administrative and fiscal operations, outreach events, community relations, hiring staff and clinical programs.<sup>32</sup> Figure 7 shows the leadership organizational structure for district 4 zone 2.



**Figure 7.** District leaders.

Source: VA OIG analysis of district organizational chart.

At the time of the OIG interviews, three of the four district leaders had been working together for nearly two and a half years. The District Director joined the leadership team in 2018 and reported at that time, two regions had merged into the current district.<sup>33</sup> The District Director, the Deputy District Director, and the Associate District Director for Administration had worked together since 2018. The District Director stated that the position of Associate District Director for Counseling was vacant for a year; however, the individual who provided coverage during the time of the vacancy was hired into the role in June 2020.

For the 12 months prior to the date of the inspection, one of 23 zone 2 VCD positions was vacant for one and a half months. The Deputy District Director confirmed an acting VCD was assigned during the vacancy.

## Quality Improvement Activities

To assess knowledge about healthcare quality improvement principles and practices, the OIG interviewed district leaders. Generally, district leaders spent about nine hours a week engaged in quality improvement activities across the zone. District leaders were knowledgeable about the

<sup>32</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Handbook 1500.01, September 2010; VHA Directive 1500(1), 2021.

<sup>33</sup> RCS previously used regions to categorize vet center geographic areas that are now called districts.

basic concepts of quality improvement and were generally able to speak in detail about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and client experiences. The District and Deputy District Director had knowledge of a just culture and provided examples of how the district leaders were receptive to employees, noting open-door communication and collaboration between zone 1 and zone 2.<sup>34</sup> Overall, leaders listed general characteristics of a just culture and gave examples of how it was promoted with staff.

## 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 All Employee Survey is an annual, voluntary survey of VA workforce experiences. Responses are confidential and data anonymous. Since 2001, the instrument has been updated in response to operational inquiries by VA leadership on organizational health relationships and VA culture.<sup>35</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.

District leaders correctly identified the top three fiscal year 2020 All Employee Survey priorities as growth, communication, and innovation. District leaders discussed the need for promotional growth. The OIG asked district leaders how the All Employee Survey results were prioritized and what changes were made. District leaders reported implementing actions including but not limited to the following:

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<sup>34</sup> Health Quality Council of Alberta, *Just Culture*, accessed March 2, 2021, <https://hqca.ca/healthcare-provider-resources/just-culture/>. "Just culture is an atmosphere of trust in which healthcare workers are supported and treated fairly when something goes wrong with patient care. Just culture is important to patient safety as it creates an environment in which people (healthcare workers and patients) feel safe to report errors and concerns about things that could lead to patient adverse events." The OIG asked leaders to "Describe how you promote a just culture in which staff can experience the psychological safety necessary to bring issues forward."

<sup>35</sup> 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. "Healthy organizations are places where employees want to work and customers want to receive services." 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.

- [Director's] Corner – reoccurring email sent to all staff<sup>36</sup>
- District SharePoint
- VA virtual Whole Health training<sup>37</sup>
- NAP [not a podcast] chats<sup>38</sup>
- All Employee Survey leadership training<sup>39</sup>

## 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 100 days and other select criteria are met.<sup>40</sup> The Vet Center Service Feedback survey includes feedback from clients and family members. In addition to the requirements described in the report for sending Vet Center Service Feedback, RCS uses the following criteria:

- Clients agree to participate in questionnaire
- Clients are 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. The RCS national database system maintains all client survey feedback and compiles district and national data into summary reports.

The OIG found district 4 zone 2 feedback results were favorable.<sup>41</sup> Overall, fiscal year 2020 (October 1, 2019 September 30, 2020) Vet Center Service Feedback scores for district 4 zone 2 exceeded national scores. Clients reported overall average satisfaction with a welcoming

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<sup>36</sup> The District Director stated emails were sent to all staff on a reoccurring basis to share district information and updates to improve communication based on feedback from the 2020 All Employee Survey.

<sup>37</sup> “Whole Health,” VA, accessed June 29, 2021, <https://www.va.gov/wholehealth/>. Due to COVID-19, the district conducted the annual in-service training virtually. Whole Health refers to VA’s approach to supportive care for a veteran’s health and well-being.

<sup>38</sup> The District Director and Associate District Director for Counseling reported developing a podcast-like communication tool for the whole district to increase communication—the acronym NAP, derived from not a podcast, was used to describe the communications.

<sup>39</sup> The District Director asked a representative from the VHA National Center for Organization Development to review the All Employee Survey results and to walk district leaders through each section of the All Employee Survey. In turn, Associate District Director for Counseling and Administration met with VCDs and communicated the information to them.

<sup>40</sup> VHA Directive 1500(1), 2021.

<sup>41</sup> The OIG considered the Vet Center Service Feedback survey results favorable because scores averaged greater than four and exceeded RCS national averages in all categories.

environment, recommendation of services, and appointment availability. Table 2 details the results of the Vet Center Service Feedback survey.

**Table 2. District 4 Zone 2 Vet Center Service Feedback Survey Results  
October 1, 2019 September 30, 2020**

Feedback Survey Item	District 4 Zone 2 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.	4.69	4.59
I would likely recommend the vet center to another Veteran, service member, or family member.	4.86	4.55
The Vet Center services were located conveniently in my community.	4.44	4.39
I feel better as a result of the services provided by the Vet Center staff.	4.81	4.39
How satisfied were you with the overall quality of services at the Vet Center?	4.67	4.48

*Source: Developed by VA OIG based on RCS National Service Support data provided by RCS (received January 25, 2021). The OIG did not assess RCS's data for accuracy or completeness.*

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

All district leaders provided examples of actions taken that were made to positively affect client and family feedback scores, such as new employee training, providing opportunities for growth, staff development, and modernizing the vet centers to have a home-like atmosphere. Additional actions included making feedback forms available to clients and holding community of practice calls for complex client cases. District leaders were proud of the work being done by the vet centers' staff and the scores received.

### **Leadership and Organizational Risks Questionnaire**

The OIG sent a leadership and organizational risks questionnaire to all district 4 zone 2 VCDs consisting of seven questions to evaluate the perspectives of VCDs about select quality improvement activities and organizational health. Of the 23 questionnaires distributed, 23 were returned. The OIG reviewed and categorized VCD responses for general themes.

Overall, district leaders were identified as a resource and support structure for vet center quality improvement activities. VCDs had a good understanding of quality management and perceived their role as important to leading quality improvement activities. The majority of VCDs reported spending less than five hours per week engaged in quality functions. VCDs cited various ways to achieve psychological safety in the workplace including staff engagement, an open-door policy,

individual supervision, weekly supervision, transparency, and treating all staff fairly. VCDs used the fiscal year 2020 All Employee Survey results for establishing vet center goals and strategic planning. VCDs were asked how district leaders supported quality planning. Responses indicated leaders supported quality planning through engagement, open communication, and empowerment of VCDs to lead. No client safety concerns were identified.

One VCD indicated concerns about psychological safety, but there were no specific examples provided and the concerns were outside the scope of the OIG review. The OIG followed up with the survey respondent and provided resources in order to pursue these concerns further if necessary.

## **Leadership and Organizational Risks Conclusion**

The district leadership team appeared stable and cohesive across the district and zone, with sufficient coverage in place for position vacancies. District leaders and VCDs had a general understanding of quality management and perceived their role as important to driving and overseeing quality improvement activities. District leaders implemented district-wide quality improvement programs in response to the 2020 All Employee Survey results and VCDs used the results for strategic planning with staff. The District Director asked a representative from the VHA National Center for Organization Development to review the All Employee Survey results and to walk district leaders through each section of the All Employee Survey. In turn, the Associate District Director for Counseling and Administration met with VCDs and communicated the information to them. Two of the district leaders acknowledged that there was a lot of change occurring within RCS. Questionnaire responses indicated VCDs took action to create a safe environment for staff to bring issues forward.

## **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>42</sup> In its effort to ensure quality of care, client safety, and oversight, RCS policy outlines the use of various tools to monitor its wide range of psychosocial and psychological services to clients.<sup>43</sup>

The OIG evaluated quality oversight in district 4 zone 2 in the following areas:

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<sup>42</sup> VA, *Veterans Health Administration's Blueprint for Excellence – Fact Sheet*, September 2014.

<sup>43</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021.

- 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 provision and administration of readjustment counseling services.<sup>44</sup> Annual quality reviews are composed of separate clinical and administrative reviews.

Clinical quality reviews included multiple areas of evaluation:

- Vet center team composition
- Access to vet center services
- Readjustment counseling services
- Active client caseloads
- Clinical productivity
- Customer feedback<sup>45</sup>

Administrative quality reviews included multiple areas of evaluation:

- Vet center key staff
- Vet center physical site
- Administrative operations
- Privacy and information security management
- Quality management
- Fiscal management<sup>46</sup>

RCS policy requires district directors ensure annual vet center clinical and administrative quality reviews are conducted.<sup>47</sup> Deputy district directors are responsible for approving annual quality

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<sup>44</sup> VHA Handbook 1500.01, September 2010; VHA Directive 1500(1), 2021. Vet Center Contract for Fee (CFF) Program uses “contract service providers to provide readjustment counseling to eligible individuals and their families in communities distant from established vet centers.” Vet centers managing a CFF program must also have a CFF annual quality review.

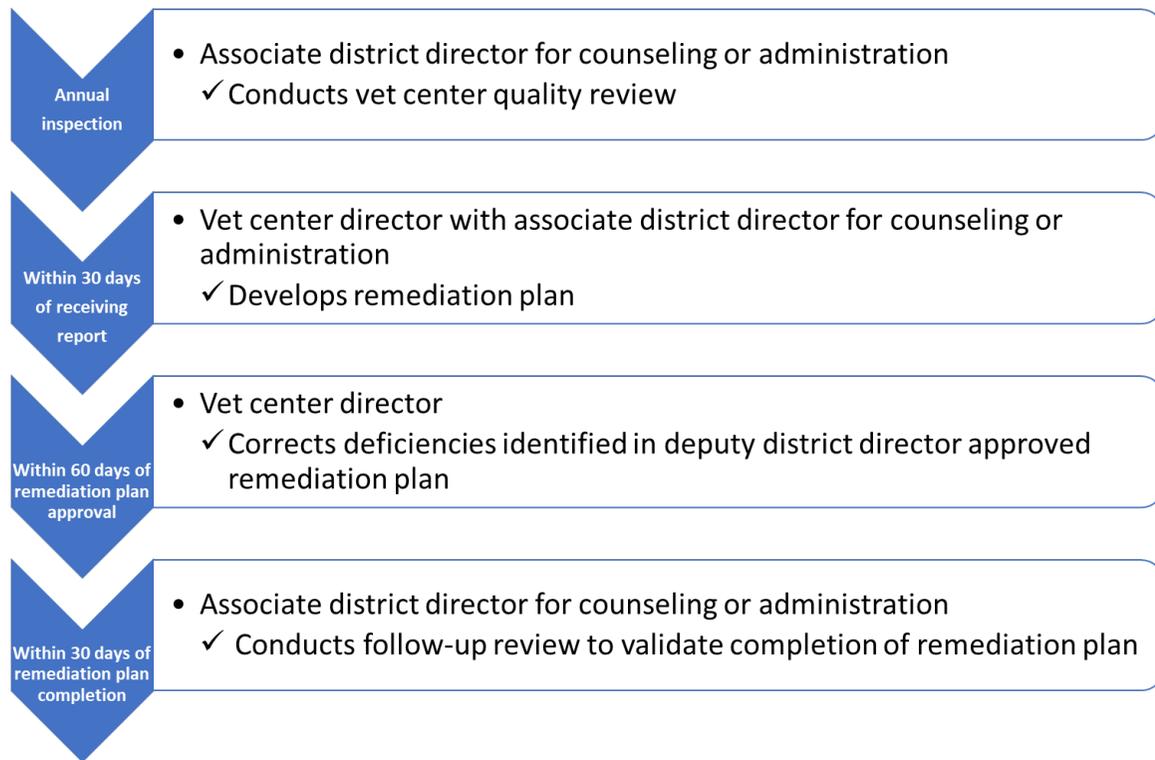
<sup>45</sup> RCS-CLI-003, *Revised Clinical Site Visit (CSV) Protocol*, January 25, 2019.

<sup>46</sup> Readjustment Counseling Service, *District 1 Vet Center Administrative Quality Review Template*, sections I to VI, revised October 24, 2016.

<sup>47</sup> RCS-CLI-001, *Vet Center Clinical and Administrative Site Visits*, November 2, 2018; VHA Directive 1500(1), 2021.

reviews and remediation plans.<sup>48</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>49</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>50</sup> Within 60 days from the date the deputy district director approves the remediation plan, the VCD is responsible for resolving all deficiencies.<sup>51</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>52</sup> Figure 8 depicts the annual vet center quality review process.



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

Source: Developed by VA OIG using RCS-CLI-001, November 2, 2018 and VHA Directive 1500(1), January 26, 2021, amended May 3, 2021. RCS-CLI-001 was not rescinded by the 2021 directive; while the 2021 directive does not include a step for the deputy district director’s approval of the remediation plan; the requirement remains per RCS-CLI-001.

<sup>48</sup> RCS-CLI-001; RCS-CLI-003.

<sup>49</sup> RCS-CLI-001; RCS-CLI-003.

<sup>50</sup> RCS-CLI-001.

<sup>51</sup> RCS-CLI-001; RCS-CLI-003.

<sup>52</sup> RCS-CLI-001.

The OIG evaluation for the clinical and administrative review processes for all district 4 zone 2 vet centers included interviewing district leaders and review of

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

The Deputy District Director told the OIG the Associate District Directors for Counseling and Administration completed the vet center quality reviews and remediation plans. The clinical and administrative quality site reviews are similar processes which follow the same timeframes and policy, but are completed independently, produce separate reports, and are documented differently.<sup>53</sup> The Associate District Directors for Counseling and Administration were knowledgeable of the clinical oversight process and discussed deficiency resolution at those vet centers where deficiencies were identified.

### **Clinical Quality Reviews Findings**

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>54</sup> At the time of the OIG's inspection, RCS required deputy district director approval of remediation plans to establish the 60-day time frame for deficiency resolution. The OIG found that remediation plans in RCSnet did not have a location or process step to record a leader's signature or date of approval. District leaders explained the clinical quality review process included deputy district director approval of remediation plans, but approval could not be validated because approval was not documented in RCSnet. The OIG was able to determine that there was documentation of deficiency resolution, however, the RCSnet remediation plan did not indicate the date of resolution when items were completed. Due to these limitations, the OIG was not able to determine if the clinical deficiencies were resolved within the required time frame of 60 days from deputy district director approval of the remediation plan.

Clinical quality reviews were completed for all vet centers. On average, the clinical site visit reports were approved within 12 days of the site visit; two of the 23 reports exceeded the 30-day time frame by less than seven days. Of the 23 completed clinical quality site visit reports, 21 vet centers had clinical deficiencies identified; all had remediation plans with documentation of resolution (see table 3).

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<sup>53</sup> RCS-CLI-004, *Implementation of Automated Vet Center Clinical Site Visit (CSV) Operations*, November 4, 2019; VHA Directive 1500(1), 2021.

<sup>54</sup> RCS-CLI-004.

**Table 3. District 4 Zone 2 Vet Center Clinical Quality Reviews  
November 1, 2019–October 31, 2020**

Requirement	Expected Reports	Completed Reports
Annual Clinical Quality Reviews	23	23
Clinical Quality Remediation Plans	21	21

*Source: VA OIG analysis based on district 4 zone 2 documents.*

The OIG identified the following findings:

- The Deputy District Director approval date for clinical site visit remediation plans could not be determined resulting in no clear time frame for deficiency resolution.
- Date of clinical deficiency resolution could not be identified.

Overall, the OIG found district 4 zone 2 compliant with requirements for clinical quality reviews. The Associate District Director for Counseling monitored the quality of care delivered to clients and their families through its vet center clinical quality reviews. Clinical quality review responsibilities were primarily managed by the Associate District Director for Counseling with the Deputy District Director responsible for final approval of quality review reports.<sup>55</sup>

### **Administrative Quality Reviews Findings and Recommendations**

The Associate District Director for Administration is responsible for quality reviews and the Deputy District Director is responsible for final approval of remediation plans.<sup>56</sup> The OIG found district 4 zone 2 to be noncompliant with requirements for administrative quality reviews.

For each vet center, the Associate District Director for Administration completed an administrative quality site review. On average, the administrative site visit reports were approved within eight days of the site visit; all reports were approved within 30 days of the administrative site visit. Of the 23 completed administrative quality site visit reports, 16 vet centers had administrative deficiencies identified; 15 of the 16 vet centers had remediation plans (see table 4). For the one vet center that did not have a remediation plan, the Associate District Director for Administration was able to provide documentation that steps had been taken to address the identified deficiency; however, the documentation did not meet the remediation plan requirements.<sup>57</sup> Across the 16 vet centers, deficiencies were identified in the administrative quality reviews. Not all vet centers completely addressed identified deficiencies in the remediation plans.

<sup>55</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021; RCS-CLI-003.

<sup>56</sup> RCS-CLI-001.

<sup>57</sup> RCS-CLI-001.

**Table 4. District 4 Zone 2 Vet Center Administrative Quality Reviews  
November 1, 2019–October 31, 2020**

Requirement	Expected Reports	Completed Reports
Annual Administrative Quality Reviews	23	23
Administrative Quality Remediation Plans	16	15

*Source: VA OIG analysis based on district 4 zone 2 documents.*

The OIG identified the following findings:

- Not all administrative quality review remediation plans were approved by the Deputy District Director.
- District leaders did not provide documentation to demonstrate all deficiencies were resolved.
- Time frames of deficiency resolution could not be determined for all identified administrative deficiencies.

Administrative quality remediation plans were provided for 15 of 16 vet centers with identified deficiencies. The Associate District Director for Administration identified administrative deficiencies across the 16 vet centers; deficiencies were not completely addressed in the remediation plans. The OIG was unable to determine if identified administrative deficiencies were resolved within the required remediation time frame due to the lack of documentation of resolution on the remediation plan.

### **Recommendation 1**

The District Director determines reasons administrative quality reviews were not completed, ensures completion, and monitors compliance.

District Director response: Concur

RCS requires that every Vet Center receive an administrative and clinical oversight visit within a given Fiscal Year (FY). The administrative quality review process remains a manual process and is scheduled monthly for review with trackers in place. Electronic signature validation will be required and monitored/tracked as part of the validation process, from the Vet Center Director (VCD), Associate District Director for Administration (ADD/A), and Deputy District Director (DDD). The District will monitor compliance.

Status: Ongoing

Target date for completion: March 2022

## Recommendation 2

The District Director evaluates the administrative quality review report approval process to determine if a timeliness measure is needed and takes actions as indicated.

District Director response: Concur

The District's manual monitoring of the timeline for completing administrative site visits will include the timelines specified in RCS policy. Prior to approval, resolved deficiencies will be reviewed and staffed to ensure resolution prior to submission to the DDD for approval.

Status: Ongoing

Target date for completion: March 2022

## Recommendation 3

The District Director determines reasons administrative quality review remediation plans did not include documentation of deficiency resolution and the time frame of resolution, takes indicated actions to ensure completion, and monitors compliance.

District Director response: Concur

The District Office lacked a standardized process for validating corrected deficiencies after the VCD's notification of completed reviews. The District will include a review process into the monitoring of site visits as described in response 2 above.

Status: Ongoing

Target date for completion: March 2022

## Critical Incident Quality Reviews

As noted in VHA policy, careful investigation and analysis of client safety events (events not primarily related to the natural course of the client's illness or underlying condition), as well as evaluation of corrective action, are essential to reduce risk and prevent adverse events.<sup>58</sup> RCS requires the VCD to complete a crisis report within 24 hours of a serious suicide or homicide

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<sup>58</sup> VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

attempt or when a client dies by suicide or homicide, with notification to the district and the RCS Central Office within 48 hours.<sup>59</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>60</sup> Veterans who are shared clients with VA medical facilities should have the mortality and morbidity review completed by the VA medical facility.<sup>61</sup> A critical incident quality review was to be completed after a RCS psychological autopsy protocol was done to evaluate actions taken and make recommendations to improve the effectiveness of vet center suicide prevention activities.<sup>62</sup>

To examine the quality oversight process, the OIG requested critical incident quality reviews, reviewed documents, interviewed district leaders, and evaluated crisis reports completed for clinical critical events that occurred during the review period.<sup>63</sup> A total of 11 crisis reports were reviewed—four were for suicide attempts, five for a client death by suicide, and two were for homicide-related events.

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

The OIG found four crisis reports for clinical critical events listed as suicide attempts. All four reported suicide attempts resulted in the client being transported to a hospital for further evaluation and treatment.<sup>64</sup> A critical incident quality review was not completed for the four serious suicide attempts, as required.

The OIG found district 4 zone 2 compliant with requirements for critical incident quality reviews for homicides and deaths by suicide. The OIG confirmed that district leaders followed

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<sup>59</sup> VHA Handbook 1500.01, September 2010; VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021.

<sup>60</sup> VHA Handbook 1500.01, September 2010; VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021. The term critical incident quality review is not currently used, all such reviews are referred to as morbidity and mortality reviews in the 2021 directive.

<sup>61</sup> VHA Handbook 1500.01, September 2010.

<sup>62</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 2010. 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>63</sup> VHA Directive 1500(1), 2021. Crisis reports are used to document clinical critical events in RCSnet.

<sup>64</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.

psychological autopsy protocol to evaluate actions taken and make recommendations for improvement of vet center suicide prevention activities for clinical critical events related to suicide and homicide completion. However, the Associate District Director for Counseling noted there was not a process in place at the district level to complete a critical incident quality review for serious suicide attempts.

If a client is shared with a VA medical facility, the Associate District Director for Counseling noted the importance of collaboration and stated that it was the vet center's responsibility to initiate communication with the VA medical facility when a shared client dies by suicide. The OIG found, in the review period, a total of five client deaths by suicide, and two deaths by homicide. Five of the seven critical incidents had critical incident quality reviews. When asked about the two incidents without completed critical incident quality reviews, the Associate District Director for Counseling was able to provide information regarding the cases and valid reasons for the reviews not being completed.<sup>65</sup>

According to a review of critical incident quality reviews documents, the OIG determined that vet center staff did not participate in a root cause analysis completed by the support VA medical center for a shared client.<sup>66</sup> The lack of vet center staff on this root cause analysis investigation reduced their ability to contribute to and learn from the events or actions that may have led to the patient's suicide.

#### **Recommendation 4**

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

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<sup>65</sup> The Associate District Director for Counseling provided examples of when a critical incident quality review would not need to be completed—if a shared client had not been seen at the vet center for more than three years and the client's case was closed, or in the case of a homicide, the client was the victim of the homicide not the perpetrator.

<sup>66</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010, requires quality review reports to include an evaluation of actions taken and recommendations to improve the effectiveness of vet center suicide prevention activities.

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: March 2022

## **Recommendation 5**

The District Director determines reasons for non-participation with the root cause analysis investigation for shared clients with the support Veterans Affairs medical facility and establishes processes to ensure required vet center participation.

District Director response: Concur in principle

While the importance of participation in root cause analysis investigations for shared clients with the support VA medical center (VAMC) is beneficial to both organizations, there have been barriers to RCS staff inclusion on root cause analysis panels (to include lack of notification from VAMC staff regarding the occurrence of a root cause analysis). VCD's will be directed to engage VAMC administrators regarding the inclusion of Vet Center staff on future root cause analysis on shared clients. Per VHA Directive 1500 (1), 6.J.4 (4), for enrolled Veterans currently receiving care and treatment at a VA medical facility and a Vet Center, Vet Center staff should be included in the root cause analysis (RCA) investigation and receive notification of the relevant outcomes of the RCA report.

Status: Ongoing

Target date for completion: March 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, to ensure continuity of services and to protect uninfected clients and staff from acquiring COVID-19, RCS began to require vet centers to screen all visitors for COVID-19, document screening results, and refer clients with positive screens to the 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 a COVID-19 operational assessment guide focused on client needs and local environment for its operational decisions. In March 2020 RCS issued guidance requiring (1) districts to report vet center operation levels to its centralized operations office daily; (2) deputy district directors to communicate guidance and operational plans within zones, and (3) 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 guidance, the *COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan* (COVID-19 Response Plan), detailing 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,

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<sup>67</sup> VHA Office of Emergency Management, March 23, 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." 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>. Merriam Webster.com Dictionary, "pandemic," accessed June 23, 2021, <https://www.merriam-webster.com/dictionary/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.

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

<sup>69</sup> RCS-OPS-001.

<sup>70</sup> RCS-OPS-004. *COVID-19, Readjustment Counseling Service (RCS) Operational Level Assessment*, March 20, 2020. RCS-ADM-005, *COVID-19 Readjustment Counseling Service (RCS) Guidance for Telework and Duty Location*, March 23, 2020.

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 a March 23 2020 memo, RCS issued guidance related to telework in an effort to keep staff safe and to mitigate against equipment barriers that might interfere with client services.<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 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 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 and response of potential impacts from the COVID-19 pandemic the OIG review examined several 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 report section is based on those interviews.

### *Emergency Planning*

District leaders adjusted and figured out what needed to be done; they were as prepared as possible considering the circumstances. While stumbling blocks occurred, RCS Central Office

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<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 defines telework-ready as an employee who is eligible to telework, has an approved written telework agreement, and has taken required training.

<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 for mental health services. VA Video Connect uses computer webcams, smart phones, and tablets to administer telehealth-based therapy to veterans. VANTs was the Veterans Affairs National Telecommunications System used for conference calls (VANTS is no longer operational).

leaders remained flexible and were able to mobilize telehealth quickly. District leaders were divided in their report about having an emergency operation plan in place prior to the World Health Organization declaration of a pandemic on March 11, 2020; two said a plan was in place and two said there was no plan. Clients were offered alternatives to face-to-face care such as telehealth, teleconferencing, and phone counseling services.

### *Communication and Field Guidance*

RCS Central Office field guidance related to COVID-19 was timely and adequate. The flow of information and communication was good across the district. Initially, there were daily conference calls but as the organization's pandemic response stabilized, the frequency in calls was reduced. Due to multiple sources of guidance, there was some initial confusion regarding steps to take and resources available. As a result, a tool was developed to track and monitor things such as available supplies and the exact number of staff teleworking for the day.

### *Supplies and Infrastructure*

Vet centers had adequate sanitation supplies and face masks for staff. Social distancing guidelines were maintained by staff. When asked about plans in place to determine what needed to be cleaned and disinfected, two district leaders did not think plans were in place at vet centers. One district leader explained that while there was not a specific policy, the VCDs understood what needed to be cleaned, and a process was in place for deep cleaning if a client or staff member tested positive for COVID.

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

All staff were authorized to telework, with approved telework agreements in place for individuals who utilized telework. All vet centers offered telehealth services. All staff were authorized to telework. An internal process was created to track staff telework agreements and telework training requirements.

### *Client Screening Including Referral*

Clients were called by vet centers 24 hours prior to scheduled appointments for screening of COVID-19 symptoms. Screening was conducted when clients entered vet centers, temperatures were taken, and masks provided. If clients chose not to wear masks, telehealth was offered, and the client was not seen in person. When clients screened positive for COVID-19 symptoms, referral pathways were followed.<sup>75</sup>

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<sup>75</sup> If a client screened positive for COVID-19 and an additional evaluation was necessary, the referral pathway was to an appropriate community referral source, such as a VA medical facility or community provider.

## **Vet Center Directors**

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

### *Emergency Planning*

The four VCDs were adequately prepared to respond to the pandemic and each vet center had an emergency plan in place at the onset of the pandemic. Two VCDs reported the plan was not specific to a pandemic. Three of the four VCDs reported effectiveness of the emergency plans was evaluated at the beginning of the pandemic. The other VCD reported not looking at the plan until the OIG inspection. Useful pandemic-related information was received from the VCDs' district office such as Centers for Disease Control and Prevention reports and county statistics. One VCD reported an employee contracted COVID-19; the district office responded quickly, and a deep cleaning of the workplace was arranged. One district office sent out county COVID-19 statistics and provided a tutorial on how to look up COVID-19 information in each state. One of the four VCDs indicated that maintaining emotional well-being, and transitioning to virtual treatment modalities would have been beneficial at the onset of the pandemic. Three of the four VCDs established referral mechanisms with local VA medical facilities and community health partners for clients with positive screens for COVID-19; the fourth VCD received information from the support VA medical facility but did not speak to anyone specifically about the referral process. Three of four VCDs worked with community partners and stakeholders during the pandemic.

### *Supplies and Infrastructure*

The COVID-19 Response Plan noted routine cleaning and disinfection for frequently touched surfaces.<sup>76</sup> RCS's Moving Forward Plan states that in a culture of safety, all staff should follow cleaning, and distancing guidelines established by the Centers for Disease Control and Prevention, VHA, and federal guidance.<sup>77</sup> All four vet centers had adequate cleaning supplies at the onset of the pandemic; three vet centers stated a plan was in place to determine what needed to be cleaned and disinfected. The other vet center took active steps to clean and disinfect common areas, but the plan was not formalized. All four vet centers took steps to encourage social distancing and had soap and water stations for hand washing. Two of the four vet centers had staff on rotation, either working in the office or telework, in order to provide appropriate social distancing within the office space.

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<sup>76</sup> VHA Office of Emergency Management, March 23, 2020.

<sup>77</sup> RCS, *RCS Moving Forward Plan, Balancing Readjustment Counseling Services in the COVID-19 Era*, July 11, 2020.

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

The RCS Moving Forward Plan outlines considerations for both virtual and traditional care to safeguard clients and staff. All clinical staff were trained and approved to provide telehealth services following the onset of the pandemic. Telehealth equipment was available at each vet center and clients who were unable to be seen in person were offered alternative services such as telehealth, teleconferencing, or phone counseling services.

### *Client Screening Including Referral*

All clients were called and screened for COVID-19 symptoms 24 hours prior to their scheduled appointment. Additionally, all visitors and unscheduled walk-in clients were screened for COVID-19 symptoms upon arrival. Clients with a positive COVID-19 screen were referred to the appropriate level of care (client was referred to local VA medical facility or community provider or client was directed to urgent care, an emergency department, or a local health department).

### **District 4 Zone 2 Staff Responses to COVID-19 Questionnaire**

The OIG sent a COVID-19 voluntary questionnaire to 152 employees at the 23 district 4 zone 2 vet centers. Of the 152 questionnaires sent, 134 (88 percent) were returned with responses. The questionnaire had a series of 14 questions about personal safety, patient safety, communication with district and VCD leaders, COVID-19 mask resources, work assignments, telework, and the availability of employee assistance services. The questionnaire contained open-ended questions regarding what staff thought the vet center did well, what needed improvement during the vet centers' pandemic response, and lessons learned. The information provided in this report section is based on the questionnaire responses.

District leaders and VCDs were prepared and provided communication to ensure employee and client safety. The OIG determined 42 (31 percent) respondents specified new work assignments were given during the pandemic, telework agreements were established, and telework was implemented to most staff.<sup>78</sup> Of the 134 respondents, 93 (69 percent) indicated employee assistance or other types of assistance were available to them during the pandemic. Best practices that occurred during the pandemic were identified to include telework availability, alternate modalities for clinical services, COVID-19-safety protocols, and leadership action. Qualitative responses to lessons learned during the pandemic included

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<sup>78</sup> Examples of new work assignment included COVID-19 screenings, change in work locations for coverage, remote work, welfare checks, and telework.

- the importance of COVID-19 safety measures implemented at vet centers,
- a need for enhanced safety practices and preparedness for emergencies, and
- the usefulness of flexibility in treatment delivery so client care could continue.

## COVID-19 Response Review 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. Clients and visitors with positive screenings were referred to local care pathways. Since the pandemic, telework expanded and vet centers increased reliance on telehealth technology for counseling services. The four VCDs reported following COVID-19 safe practice guidelines and taking appropriate steps to protect the safety of employees and clients. Adequate supplies, and masks as well as hand washing and hand sanitizer stations were available. Safe social distancing was practiced during the OIG’s virtual inspections of selected vet centers. Overall, employees’ responses to the COVID-19 questionnaire showed that communication from district leaders and VCDs was adequate to ensure the safety of clients and staff. The majority of employees indicated that the implementation of telehealth and telework was a positive action that worked well for the vet center clients and employees.

## Suicide Prevention

The VA *National Suicide Data Report* published in the fall of 2018 found that the suicide rate in 2016 was 1.5 times greater for veterans than for non-veteran adults.<sup>79</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>80</sup> As noted in the *National Suicide Data Report*, “VA supports the national goal of reducing the annual suicide rate in the U.S. 20 percent by the year 2025 and is implementing a public health approach to achieve this mission.”<sup>81</sup>

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<sup>79</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>80</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>81</sup> VA Office of Mental Health and Suicide Prevention, “National Strategy for Preventing Veteran Suicide 2018-2028,” accessed December 30, 2019, [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).

RCS has been identified as an important part of VA’s overall suicide prevention strategy.<sup>82</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>83</sup> The Memorandum of Understanding defines operations for the identification, notification, and treatment of high risk or suicidal veterans and quality reviews related to veteran suicides for active clients.<sup>84</sup>

The VA medical center is responsible for identifying high risk individuals and activating a flag in the veteran’s VA electronic health record that is visible to RCS counselors. VHA policy includes 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>85</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 VA medical facilities (*zone-wide*)
- RCS and VA medical facility shared high risk for suicide clients (*zone-wide*)
- Access (*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*)

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<sup>82</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>83</sup> Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017.

<sup>84</sup> Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017.

<sup>85</sup> VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, amended November 16, 2015.

## Psychosocial Assessment and Lethality Risk Assessments

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>86</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 a timely manner.<sup>87</sup> Psychosocial assessments are used to gather information about the client “presenting issues and level of functioning” to complete a clinical evaluation.<sup>88</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>89</sup> An RCS Central Office leader reported that effective October 2020, the lethality risk assessment within the psychosocial assessment was replaced with a “Comprehensive Suicide Risk Assessment and Safety Plan Application.” The new assessment follows VA/DoD Clinical Practice Guidelines by incorporating common terminology used for suicide risk evaluation and consultation practices that are familiar to other clinical providers.<sup>90</sup>

### *Electronic Client Record*

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. The OIG randomly selected two samples of clients new to vet centers from November 1, 2019, through October 31, 2020.<sup>91</sup> The samples included

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<sup>86</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010.

<sup>87</sup> RCS-CLI-003, *Revised Clinical Site Visit (CSV) Protocol*, January 25, 2019; VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021.

<sup>88</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Client Records*, November 2010; VHA Directive 1500(1), 2021.

<sup>89</sup> RCS-CLI-003, 2019.

<sup>90</sup> *VA/DoD Clinical Practice Guidelines For The Assessment And Management Of Patients At Risk For Suicide*, May 2019.

<sup>91</sup> The sub-population size was randomly selected and weighted for the two samples.

- 60 client records with five or more visits, and
- 40 clients with four or less visits.<sup>92</sup>

The OIG reviewed the 60 client records with five or more visits and only retained clients if they had five or more individual counseling visits (excluding veteran outreach specialist visits, group, family, non-clinical telephone calls, and bereavement visits). Clients were excluded from the lethality risk assessment sample if the first visit and only encounter was completed by a non-clinician. The OIG reviewed RCSnet electronic client records to determine if intakes 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 records for extenuating circumstances.<sup>93</sup> The OIG reviewed electronic client records to determine timely completion of lethality risk assessments by evaluating the first clinical note for either a clinical rationale for a lethality rating or reference to and completion of a lethality or risk assessment.<sup>94</sup>

While the OIG was able to review the RCSnet record and determine if intake and military histories were completed, dates of completion were lacking. Therefore, completion of the documentation by the fifth visit could not be evaluated. The OIG reviewed all 100 randomly selected electronic client records for the first clinical note and visit 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>95</sup>

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<sup>92</sup> RCS-CLI-003, 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. One client was excluded from lethality risk assessment sample if the first visit and only encounter was completed by a non-clinician. 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.

<sup>93</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.

<sup>94</sup> For clients seen on or before October 12, 2020, the OIG reviewed clinical rationales for 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 after October 11, 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>95</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

Overall, the OIG found district 4 zone 2 vet centers noncompliant with requirements for completion of intake and lethality assessments (see table 5).<sup>96</sup>

**Table 5. District 4 Zone 2 Vet Centers Electronic Client Record Review  
November 1, 2019–October 31, 2020**

	Number of Electronic Client Records Reviewed	Estimated Compliance (%) Completed Zone-Wide	95% Confidence Interval*
Intake	59	28.8	(17.5, 40.7)
Military History	59	81.4	(71.2, 91.2)
Lethality Risk Assessments	98	51.4	(41.9, 60.9)

Source: VA OIG district 4 zone 2, RCSnet electronic client 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>.

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

- The intake portion of the psychosocial assessment
- The lethality risk assessments with the first individual clinical visit

### Recommendation 6

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

<sup>96</sup> Based on statistical analysis, the OIG determined there was not a finding for military history.

District Director response: Concur

The District provided training to 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: March 2022

### **Recommendation 7**

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: March 2022

### **Recommendation 8**

The District Director, in collaboration with Readjustment Counseling Service Central Office, evaluates the limitations of current tools and tracking methods including why completion dates are not available 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: March 2022

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

### *Care Coordination and Collaboration with VA Medical Facilities—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, suicide prevention coordinators, and readjustment counseling services.”<sup>97</sup> Further, RCS clinical staff were 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 prevention coordinators when clients pose a significant safety risk.<sup>98</sup> Vet center staff are required to follow confidentiality requirements when coordinating care with the VA medical facility. 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>99</sup> Prior to October 12, 2020, RCSnet lethality designations included non-lethal, mild, moderate, and severe. According to the RCS Chief Officer, effective October 12, 2020, RCSnet lethality designations included low, intermediate, and high.

### *Electronic Client Records*

The OIG identified 50 RCS clients who were flagged as high risk for suicide by the support VA medical facility and who were seen at district 4 zone 2 vet centers from November 1, 2019, through October 31, 2020, following the placement of the high risk flag.<sup>100</sup> The OIG extracted each client’s lethality history from the RCS database as RCS confirmed information was not available in the section of RCSnet used by vet center staff and for OIG client record review.

The OIG evaluated each client record for the following:

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<sup>97</sup> Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017.

<sup>98</sup> Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017.

<sup>99</sup> RCS-CLI-003, 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(1).” 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), 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>100</sup> There were only 50 clients at high risk for suicide during this time period in zone 2 therefore no sampling was needed; the whole population was used for the review.

- Consultation and coordination of services with support VA medical facility for shared clients within 60 days from placement of the high risk for suicide flag<sup>101</sup>
  - Adherence to confidentiality requirements if consultation and coordination occurred
- Timely notification to VA medical facility suicide prevention coordinator if client posed a significant safety risk<sup>102</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>103</sup>
- Progress notes in the electronic client record documenting suicide or homicide completions, attempts, gestures, or interventions exist, and whether each progress note had a corresponding crisis report<sup>104</sup>

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

The OIG found vet centers in district 4 zone 2 were not compliant with requirements of coordination of shared clients for suicide prevention and intervention.<sup>105</sup>

The OIG excluded 16 of 50 client records. Exclusions included 12 clients with closed cases and four clients not seen at a vet center during the review period. Overall, the OIG found the 34 records reviewed in district 4 zone 2 noncompliant with RCS requirements for consultation and communication for shared clients with VA medical facilities as noted in table 6.

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<sup>101</sup> For the purpose of this report, the OIG utilized 60 days as the timeframe within which to complete consultation and coordination.

<sup>102</sup> The OIG defined significant safety risk as suicide and homicide attempts and imminent risk of suicide or homicide. For the purposes of this report, timely is defined as notification occurring as soon as pertinent information that would promote safety is available.

<sup>103</sup> The OIG utilized 30 days as the timeframe within which consultation should occur.

<sup>104</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021.

<sup>105</sup> The OIG identified only three clients whose Vet Center records indicated they were a significant safety risk; due to the low number of clients identified, a percentage could not be calculated for this requirement.

**Table 6. District 4 Zone 2 Vet Centers RCSnet Client Record Review  
Suicide Prevention and Intervention—November 1, 2019–October 31, 2020**

Review Area	Number of Client Records Reviewed	Percent Compliant (%)
Vet Center staff consulted with and coordinated services with the support VA medical facility for care of shared clients flagged as high risk.	34	50
Vet Center staff followed confidentiality requirements when consulting with and coordinating services with the shared VA medical facility.	34	9
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 SPC [suicide prevention coordinator] at the support VA medical facility.	27	56
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.	12	25

Source: VA OIG district 4 zone 2, RCSnet record reviews.

For the clients reviewed, the OIG identified the following findings for district 4 zone 2:

- Vet centers did not consistently consult or coordinate with support VA medical facilities on shared clients who were flagged as high risk for suicide.
- For clients whose coordination occurred with VA medical facilities, vet centers did not consistently follow confidentiality requirements.<sup>106</sup>
- Vet centers that had clients with a documented lethality change of mild or greater did not consistently consult with a VCD, external clinical consultant or support VA medical facility suicide prevention coordinator.
- Vet centers did not consistently complete a crisis report when progress notes indicated a death by suicide or homicide, attempt, gesture, or intervention existed.

## Recommendation 9

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

<sup>106</sup> VHA Directive 1500(1), 2021. “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.”

District Director response: Concur

The District provided training to clinical staff regarding the importance of collaborating and coordinating care with VAMC 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: March 2022

### **Recommendation 10**

The District Director ensures clinical staff follow confidentiality requirements when consulting and coordinating care with the support VA 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 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: March 2022

### **Recommendation 11**

The District Director ensures clinical staff consult with the vet center director, external clinical consultant, or VA suicide prevention coordinator following a client's 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: March 2022

## **Recommendation 12**

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 has provided training to clinical staff regarding the completion of a “log a crisis” report in RCSNet for all completed suicides and homicides as well as serious attempts. Compliance is monitored monthly by the VCD's and the ADD/C.

Status: Ongoing

Target date for completion: March 2022

## **Vet Center Suicide Prevention**

The remainder of this report section provides inspection findings at the following randomly selected vet centers located in district 4 zone 2:

- Alexandria Vet Center, Louisiana
- Houston Southwest Vet Center, Texas
- Laredo Vet Center, Texas
- Mesquite Vet Center, Texas

### **Access**

According to the 2017 Memorandum of Understanding, 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 vet centers.<sup>107</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>108</sup> The 2017 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
- Timely notification of clients with significant safety risks to suicide prevention coordinators<sup>109</sup>
- Training for RCS staff
- Dissemination of a list from the Office of Mental Health and Suicide Prevention to RCS identifying veterans at increased predictive risk for suicide<sup>110</sup>, and
- Identifying those who were receiving RCS counseling services<sup>111</sup>

The OIG interviewed the four VCDs and requested the following:

- Documents supporting a standardized communication process with the support VA medical facility suicide prevention coordinator
- VA medical facility high risk for suicide flag lists received

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<sup>107</sup> Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017.

<sup>108</sup> VHA Handbook 1500.01, September 2010. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, 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.”

<sup>109</sup> Timely was defined by the OIG as notification that occurs as soon as pertinent information that would promote safety is available.

<sup>110</sup> Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH-VET) identifies veterans who have a higher risk for suicide through predictive analytics.

<sup>111</sup> Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017.

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

### *High Risk Suicide Flag Client Disposition*

Isolation and social disconnectedness may leave some clients more vulnerable to self-harm, particularly those who are identified as being high risk for suicide.<sup>112</sup> To help monitor these clients, RCS staff created a SharePoint site for VA medical facility-identified high risk suicide flag clients who currently receive or have received vet center services within the past 12 months.<sup>113</sup> As of May 11, 2020, VCDs were required to review the site monthly for clients seen at their vet center, determine if outreach was 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 and any documented disposition 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, substance abuse), risk increases with the number and severity of psychiatric diagnoses.<sup>114</sup>

RCS has several preparatory steps required to reduce the occurrence of a crisis event and minimize the severity should one occur.<sup>115</sup> One requirement is for vet centers to have a written plan addressing how staff responds to crisis situations.<sup>116</sup> The OIG requested and reviewed crisis plans from the four vet centers to assess for compliance.

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<sup>112</sup> RCS-CLI-006, *High Risk Flag Suicide Outreach*, April 27, 2019.

<sup>113</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>114</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021.

<sup>115</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021.

<sup>116</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021.

### *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>117</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>118</sup> If a death by suicide occurs with a shared client and an RCA is conducted, vet center staff should be included in the RCA investigation and receive feedback from the support VA medical facility RCA team when shared cases are reviewed.<sup>119</sup>

The OIG requested a list of all clients from the VISN 16 and 17 offices who died by suicide with a completed RCA during the inspection review period.<sup>120</sup> This list was cross referenced with RCSnet clients to determine if there were any shared clients between support VA medical facilities and the four vet centers inspected. The OIG also requested RCA feedback and documentation from the vet centers reviewed and interviewed VCDs as needed.

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

The OIG found the vet centers complied with offering nontraditional hours to allow clients easier access to vet center services. The OIG found the four VCDs compliant with the requirement in reviewing the High Risk Suicide Flag SharePoint monthly and had updated crisis plans. The Alexandria vet center had one client and the Houston Southwest Vet Center had four clients on the list in the review period and entered a disposition. None of the four 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 RCA panels. The OIG found issues related to

- vet center participation in mental health council meetings,
- receipt of the VA medical facility high risk suicide flag list,

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<sup>117</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>118</sup> VHA Handbook 1050.01.

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

<sup>120</sup> VISN 16 and 17 are composed of all the support VA medical facilities that collaborate with and support vet centers in district 4 zone 2. This methodology may have limitations as it may not have captured all deaths by suicide, only ones with a completed root cause analysis.

- receipt of the Office of Mental Health and Suicide Prevention list identifying veterans at increased predictive risk for suicide, and
- standardized communication process between vet centers and suicide prevention coordinators at support VA medical facilities.

### *Mental Health Council*

VA medical facility mental health council meetings are composed 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>121</sup> VA medical facility mental health councils are responsible for

- proposing strategies to improve care and consulting with management on program improvements and innovations in treatment programs,
- coordinating communication, and
- evaluating mental health policy impact.<sup>122</sup>

RCS recognizes the importance of mental health councils with coordinating care for clients between vet centers and VA medical facilities and states “Vet Center staff need to participate on all VA medical center mental health councils.”<sup>123</sup> Although RCS requires participation, the OIG reviewed submitted documentation and did not find a policy or guidance specifying how attendance is tracked and requested evidence of attendance. The OIG found all four vet centers were noncompliant with attendance at the VA medical center mental health council. The Alexandria VCD reported that council meetings were held monthly. The VCD attended seven meetings and had two unexcused absences. Two meetings were canceled. The Houston Southwest and Laredo Vet Centers did not have evidence to demonstrate participation on the mental health council. The Houston Southwest VCD did not attend mental health council meetings during the review period, but stated attendance started in January of 2021. The Laredo VCD stated that the meetings were canceled due to schedule conflicts and the COVID-19 pandemic. The Mesquite VCD reported the council meetings were held quarterly and was able to provide evidence of attendance at three of the four meetings.

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<sup>121</sup> VHA Handbook 1160.01. *Uniform Mental health Services in VA Medical Centers and Clinics*, amended November 16, 2015.

<sup>122</sup> VHA Handbook 1160.01.

<sup>123</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Handbook 1500.01, September 2010.

### Recommendation 13

The District Director, in collaboration with the support VA medical facility clinical or administrative liaisons, determines the reasons for noncompliance with staff participation on mental health councils at Alexandria, Houston Southwest, Laredo, and Mesquite Vet Centers and takes actions as indicated 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: March 2022

### *High Risk Suicide Flag List*

The Memorandum of Understanding states the 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>124</sup>

The OIG found the Alexandria, Laredo, and Mesquite Vet Centers did not receive the high risk for suicide client lists from the support VA medical facility suicide prevention coordinators. In response to a question about the noncompliance, one VCD stated the VA medical facility did not consider sharing the list. Another VCD did not know why the list was not received. The Houston Southwest VCD reported the list was received but had to ask for it. The last list received was in July of 2020.

In its inaugural VCIP report published in September 2021, the OIG made a recommendation related to the shared high risk for suicide list 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

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<sup>124</sup> Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017.

with the Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding.<sup>125</sup>

Therefore, the OIG does not make a recommendation on the matter in this report.

### *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>126</sup> The OIG found that the four VCDs reported not receiving the list from Office of Mental Health and Suicide Prevention and not having a process to identify clients with an increased predictive risk for suicide currently receiving readjustment counseling services. The Alexandria, Houston Southwest, Laredo, and Mesquite VCDs reported not receiving the list and were unaware of the requirement.

In its inaugural VCIP report published in September 2021, the OIG made a recommendation on the shared list of veterans with an increased predictive risk for suicide 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.<sup>127</sup>

Therefore, the OIG does not make a recommendation on the matter in this report.

### *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 coordinators and vet center staff was a component of the memorandum that sought to formalize

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<sup>125</sup> VA OIG, *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021.

<sup>126</sup> Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017. 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.

<sup>127</sup> VA OIG, *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021.

the relationship with the Office of Mental Health and Suicide Prevention and suicide prevention coordinators, and RCS.<sup>128</sup>

The OIG found while each of the vet centers inspected had informal contact with the suicide prevention coordinators at the support VA medical facility, there was not a standardized communication process. The Alexandria VCD reported speaking with the SPC after receiving the national Memorandum of Understanding. While there was contact at training and outreach events, a standardized communication process was not formalized. During the OIG inspection, the VCD reached out to the VA medical facility suicide prevention coordinator to set up a reoccurring time to meet and discuss clinical cases. The Mesquite VCD stated if a client came in that was high risk for suicide, there was communication with the suicide prevention coordinator and findings were documented in a non-visit progress note. However, there was not a standardized communication in place. The Laredo VCD stated the suicide prevention coordinator at the support VA medical facility was new and most of the communication had been about training opportunities and outreach events. The VCD reported collaboration was more conversational and not formal. The Houston Southwest VCD provided an email outlining the communication process between the VCD and the suicide prevention coordinator. However, the email provided did not indicate that the counselors received this correspondence.

In its inaugural VCIP report, published in September 2021, the OIG made a recommendation related to standardized communication between suicide prevention coordinators and vet center staff 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.<sup>129</sup>

Therefore, the OIG does not make a recommendation on the matter in this report.

## **Consultation, Supervision, and Training**

Each vet center is assigned a clinical liaison and an external clinical consultant from the support VA medical facility.<sup>130</sup> Clinical liaisons help coordinate care for shared clients with the support

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<sup>128</sup> Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017.

<sup>129</sup> VA OIG, *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021.

<sup>130</sup> VHA Handbook 1500.01, September 2010; VHA Directive 1500(1), 2021.

VA medical facility whereas external clinical consultants provide guidance on complex and shared cases.<sup>131</sup>

Vet centers, traditionally located outside of VA medical facilities, are composed of small multidisciplinary teams and community-based. A Vet center team consists minimally of a VCD, an office manager, and two or more counselors.<sup>132</sup> Vet centers are required to have at least one VHA-qualified licensed mental health professional on staff (see table 7).<sup>133</sup>

VCDs are accountable for the clinical and administrative oversight of readjustment counseling services 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>134</sup> VCDs provide staff supervision, participate in VA medical facility mental health councils, maintain VA and community partnerships, and supervise staff.

In 2014, VHA released a report indicating 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 VHA Under Secretary for Health stated the need for continued review and certification of suicide prevention training annually for all VHA employees. Following the initial mandated training, staff were required to complete the corresponding refresher courses for their positions.<sup>135</sup> On October 15, 2020, VHA updated the suicide prevention training course and refresher requirements for clinicians.<sup>136</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>137</sup>

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<sup>131</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021.

<sup>132</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. “Some vet centers depending on demographic needs may be assigned a Global War on Terrorism outreach technician or a veteran outreach specialist.” For vet centers assigned a mobile vet center, staffing includes a driver and counselor.

<sup>133</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021.

<sup>134</sup> VHA Handbook 1500.01, September 2010. 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.

<sup>135</sup> VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017. In 2020, VHA released a report which found in 2018 an average of 18 veterans died by suicide daily. Of those 18 veterans, seven had recently used a VA medical facility in the year of, or the year prior to their death. US Department of Veterans Affairs, *2020 National Veteran Suicide Prevention Annual Report*. Office of Mental Health and Suicide Prevention. 2016 (updated August 2017).

<sup>136</sup> VHA Memorandum, *Agency-Wide Required Suicide Prevention Training (VIEWS 3346983)*, October 15, 2021.

<sup>137</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.

RCS requires vet center staff to have a basic level of cross training to (1) promote its mission of assisting veterans' post-war social and psychological readjustment and (2) enhance small team functionality. Vet center staff are required to complete annual in-service training that includes cross training in 16 core curriculum topics.<sup>138</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>139</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 officer consultation
- External clinical consultation
- Internal licensed independent practitioners in clinical consultation
- Supervision
- Staff training

## **Consultation**

### *Clinical Liaison*

The clinical liaison is either from the support VA medical facility's mental health or social work service.

### *External Clinical Consultant*

External clinical consultants are appointed from either the support VA medical facility, or the private sector if unavailable, to provide a minimum of four hours per month of consultation. The external clinical consultants 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 develop an intervention. External clinical consultants also complete peer

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<sup>138</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, VA medical 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>139</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021.

case reviews and assist vet center clinicians in the treatment of complex and emergent veteran cases.<sup>140</sup>

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

- Vet center staffing spreadsheet
- Documentation demonstrating external clinical consultation four hours a month<sup>141</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 each vet center listing all VHA-qualified staff employed from November 1, 2019, through October 31, 2020.
2. If the vet center had more than one VHA-qualified mental health provider on staff
  - a. One individual was randomly selected, and
  - b. Credentialing documentation of that individual was requested 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>142</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>143</sup> VCDs must also complete a monthly chart audit of 10 percent of every counselor's active client records.

To assess compliance with supervision, the OIG interviewed the four VCDs virtually and requested the following documentation:

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<sup>140</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*. November 2010; VHA Directive 1500(1), 2021.

<sup>141</sup> A staffing spreadsheet was requested from each vet center requesting information on appointed liaisons and consultants and the appointee's service line.

<sup>142</sup> RCS-CLI-003, 2019; VHA Directive 1500(1), 2021. 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>143</sup> VHA, *Readjustment Counseling Service, Guidelines and Instructions for Vet Center Administration*. November 2010; VHA Directive 1500(1), 2021.

- 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, all VA medical facility 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>144</sup> Non-clinical staff must complete S.A.V.E. or S.A.V.E. refresher training, and clinical staff are required to complete Suicide Prevention for Clinicians training within 90 days of entering their position and annually thereafter.<sup>145</sup>

All VA medical facilities and vet centers provide military sexual trauma services. Clinical staff are required to complete VHA military sexual trauma training within 90 days of entering their positions.<sup>146</sup>

All vet center staff, regardless of position, are required to complete regional in-service training annually. In-service training should include Vet Center service components and administrative functions. As noted above, staff must have a basic level of cross training in various topics to promote a unified Vet Center mission and effective team functioning.<sup>147</sup>

To determine compliance, the OIG requested VA Talent Management System training records and proof of attendance for required training completed for all staff employed from November 1, 2019, through October 31, 2020.<sup>148</sup>

## Consultation, Supervision and Training Findings and Recommendations

The four vet centers showed overall compliance with clinical liaison and external clinical consultant appointments from mental health or social work services and licensing of external

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<sup>144</sup> S.A.V.E. refers to “Signs,” Ask,” “Validate,” and “Encourage” and “Expedite” and is a training video collaboration with VA and PsychArmor Institute.

<sup>145</sup> VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017.

<sup>146</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>147</sup> VHA, *Readjustment Counseling Service, Guidelines and Instructions for Vet Center Administration*. November 2010; VHA Directive 1500(1), 2021.

<sup>148</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*. November 2010; VHA Directive 1500(1), 2021.

clinical consultants. VCDs could identify who the external clinical consultant was and in what circumstances the consultation was to be conducted. The OIG found the four vet centers had at least one licensed and credentialed VHA-qualified mental health professional on staff.

The OIG found deficiencies in several areas (see table 7):

- External clinical consultation hours
- Clinical supervision requirements
- Required monthly auditing of counselor caseload
- Staff training completion

**Table 7. Consultation, Supervision, and Training  
November 1, 2019 October 31, 2020\***

Elements Reviewed	Findings			
	Alexandria Vet Center	Houston Southwest Vet Center	Laredo Vet Center	Mesquite Vet Center
<b>VHA Clinical Liaison Officer</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	Compliant
Licensed	Compliant	Compliant	Compliant	Compliant
Four Hours a Month of External Clinical Consultation	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>
<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 (10 percent) of Each Counselor's Caseload	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>
Clinical Supervision (one hour a week) August 1, 2020–October 31, 2020	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>
<b>Staff Training</b>				
Annual Suicide Risk Management Training for Clinical Staff	<b>Noncompliant</b>	Compliant	<b>Noncompliant</b>	<b>Noncompliant</b>
Annual Suicide Prevention (S.A.V.E) Training for Non-Clinical Staff	Compliant	Compliant	<b>Noncompliant</b>	Compliant
Military Sexual Trauma Training	<b>Noncompliant</b>	Compliant	Compliant	<b>Noncompliant</b>
Annual In-service Training †	Compliant	Compliant	<b>Noncompliant</b>	<b>Noncompliant</b>

Source: VA OIG analysis of district 4 zone 2 documents and interview results.

\* The OIG did not assess RCS data for accuracy or completeness.

† District leaders indicated that the virtual Whole Health training was counted as the annual in-service training for the fiscal year.

### *External Clinical Consultant*

RCS requires four hours of external clinical consultation monthly.<sup>149</sup> The OIG found all four VCDs documented some, but not all external consultation hours through an internal RCSnet tracking system. In addition, the Mesquite VCD submitted documentation that provided Veteran Information Form number (a number assigned to the client by the Vet Center), external clinical consultant recommendation, and duration of consultation. However, none of the vet centers met the required four hours of external clinical consultation per month. The Alexandria VCD stated, after COVID-19, documentation became less formal for the meetings with the external clinical consultant. The Houston Southwest VCD stated knowledge of the requirement and was unsure of why the requirement was not being met. The VCD hypothesized there were no cases to present. The Laredo VCD stated the external clinical consultant was not available or had scheduling conflicts. The Mesquite VCD stated when the external clinical consultant canceled, they tried to reschedule the meetings, depending on availability of the counselors.

### **Recommendation 14**

The District Director determines reasons a process for completing and tracking four hours of external clinical consultation per month did not occur at the Alexandria, Houston Southwest, Laredo, and Mesquite Vet Centers, ensures vet center directors implement processes, and monitors compliance.

District Director response: Concur

The District provided training to 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: March 2022

### *Supervision*

RCS policy requires regularly scheduled weekly supervision to help with staff cohesion, problem solving, client case coordination, and to assist with the 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>150</sup>

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

<sup>150</sup> RCS-CLI-003, 2019.

The OIG found that all four vet centers were noncompliant with the provision of weekly staff supervision. The Alexandria VCD had 32 of 39 weeks of documented weekly supervision. The Alexandria VCD reported supervision was very informal and constantly talked to staff. The VCD kept paper documentation but stopped when COVID-19 began. The Houston Southwest VCD had 6 of 52 weeks of documented weekly supervision. The Houston Southwest VCD stated the one hour of supervision per week was “overkill” and was an area to be “sacrificed.” The 12 weeks of documented weekly supervisions submitted by the Laredo VCD did not include the duration; therefore, the OIG was unable to determine if the supervision met the requirement of 60 minutes. The Laredo VCD stated not all supervision was completed because of time management and “taskers” from district and central office. The Mesquite VCD had 11 of 39 weeks of documented weekly supervision.<sup>151</sup> Mesquite VCD discussed documenting supervision electronically and with a hardcopy. The VCD reported that if the logged time was less than 60 minutes it was a documentation error made by staff.

### **Recommendation 15**

The District Director determines reasons for noncompliance with staff supervision provided by the vet center directors at the Alexandria, Houston Southwest, Laredo, and Mesquite Vet Centers, ensures staff supervision occurs as required, and monitors compliance.

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: March 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.<sup>152</sup> The OIG

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<sup>151</sup> 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.

<sup>152</sup> RCS-CLI-003, 2019.

found that the Alexandria, Houston Southwest, Laredo, and Mesquite VCDs were noncompliant in conducting case audits.

A report (audit report) from an internal audit tracking system within RCSnet provides the number of charts audited, active clients, and percent completed. All four VCDs submitted their RCSnet audit reports to the OIG to demonstrate compliance with the 10 percent requirement. According to additional information provided by three vet centers under review, the OIG found that the Houston Southwest, Laredo, and Mesquite submitted audits and believed they had met the 10 percent requirement but the OIG was unable to determine if 10 percent of the case load had been met. Both Laredo and Mesquite VCDs were missing active client case load numbers on audit forms; therefore, the OIG was unable to determine if 10 percent of the case load was reviewed.

Based on the information provided, the OIG determined that the audit reports contained errors and were not an accurate reflection of caseload. One VCD stated having contact with the district office about the inaccuracy of the audit report and being informed that RCS was aware of the issue but was unsure of who could fix it.

## **Recommendation 16**

The District Director verifies and determines reasons for noncompliance with monthly RCSnet chart audits at the Alexandria, Houston Southwest, Laredo, and Mesquite Vet Centers, ensures chart audits are completed as required, and monitors compliance.

District Director response: Concur

The District provided 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: March 2022

## ***Staff Training***

As noted above, RCS requires completion of mandatory trainings for both clinical and non-clinical staff. The OIG found the Alexandria, Laredo, and Mesquite Vet Centers were noncompliant with completion of annual suicide prevention training. Additionally, the Alexandria and Mesquite Vet Centers were noncompliant with military sexual trauma training for clinical staff. The Laredo vet center had one staff member deficient with completing

S.A.V.E. or S.A.V.E. refresher training. The VCD reported not knowing why the training was not completed. The Laredo and Mesquite Vet Centers were noncompliant with vet center staff completing annual in-service training in fiscal year 2019 and 2020 (see table 7).<sup>153</sup>

### **Recommendation 17**

The District Director determines reasons why completed trainings are not being recorded for employees at the Alexandria, Laredo, and Mesquite Vet Centers, ensures all staff complete mandatory trainings, and monitors compliance.

District Director response: Concur

A new process is in development 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: March 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>154</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>155</sup>

The environment of care review evaluated compliance at the four selected vet centers. The OIG completed virtual inspections with FaceTime video, conducted virtual interviews, and reviewed relevant documents. The OIG evaluated three areas:

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<sup>153</sup> All face-to-face training conferences were canceled in FY20 due to COVID-19; alternate trainings were made available but were not required.

<sup>154</sup> VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016. As noted in the background, RCS refers to patients as clients.

<sup>155</sup> VHA Handbook 1500.01, September 2010; VHA Directive 1500(1), 2021.

- Physical environment
- General safety
- Privacy

## Physical Environment

To assess the physical environment, the OIG virtually inspected multiple items to determine whether

- the exterior was clean, neat, and presentable;
- the interior furnishings were in good repair and serviceable;
- the environment was welcoming and non-institutional;
- the waiting area was large, comfortable, and could accommodate clients and their families; and
- the interior was decorated with items that depicted military appreciation.<sup>156</sup>

## 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>157</sup> Facilities subject to the Architectural Barriers Act must comply with the Architectural Barriers Act Accessibility Standard.<sup>158</sup> The OIG assessed whether vet centers complied with the Architectural Barriers Act Accessibility Standard regarding accessible entrances, designated parking spaces, and exit signs for persons with disabilities.<sup>159</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>160</sup> The OIG assessed if crisis and emergency management plans were comprehensive and current. Vet

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<sup>156</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021.

<sup>157</sup> Architectural Barriers Act of 1968 (codified as amended at 42 U.S.C. § 4151 et seq).

<sup>158</sup> 41 C.F.R. § 102–76.65(a).

<sup>159</sup> Architectural Barriers Act Accessibility Standards (codified at Appendices C and D to 36 C.F.R. part 1191).

<sup>160</sup> Readjustment Counseling Service, *District 1 Vet Center Administrative Quality Review Template*, revised October 24, 2016; VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021.

Center staff are also required to identify and minimize objects that could be potentially used as weapons within the environment.<sup>161</sup>

## Privacy

According to RCS policy, “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>162</sup> Vet centers are required to have 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>163</sup> Any documents or items displaying personally identifiable information must be secured. Confidential records must be stored in a room that is double locked and complies with VHA security requirements.<sup>164</sup> The OIG virtually assessed each vet center’s offices, group counseling rooms, and storage rooms to determine compliance with privacy requirements (see table 8).

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<sup>161</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021.

<sup>162</sup> VHA Handbook 1500.01, September 2010; VHA Directive 1500(1), 2021.

<sup>163</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 2010; VHA Directive 1500(1), 2021.

<sup>164</sup> VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*. November 2010.

**Table 8. Environment of Care**

Elements Reviewed	Findings			
	Alexandria Vet Center	Houston Southwest Vet Center	Laredo Vet Center	Mesquite 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>				
Accessible Entrance	Compliant	Compliant	Compliant	Compliant
Designated Accessible Parking	Compliant	Compliant	Compliant	Compliant
Exit Signs Compliant with Architectural Barriers Act	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>	<b>Noncompliant</b>
Crisis Management Plan	Compliant	Compliant	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	Compliant	Compliant	Compliant	Compliant
Personal Information Secured	Compliant	<b>Noncompliant</b>	Compliant	Compliant
Secure Double Locked Room for Client Records	Compliant	Compliant	Compliant	Compliant

Source: VA OIG analysis of environment of care inspections conducted from January 25, 2021, through February 12, 2021.

## Environment of Care Findings and Recommendations

The OIG virtually inspected all areas within the designated vet centers and found general compliance with the exterior and interior being clean and presentable, and the interior design being welcoming and non-institutional. There were large and comfortable waiting areas, with furnishings that were clean, in good repair, and serviceable. The four vet centers complied with the Architectural Barriers Act standards for an accessible entrance and designated parking spaces. The OIG found one vet center noncompliant in having a crisis management plan with all required components. The OIG found compliance at the four vet centers with private office spaces for the director and counselors, at least one group counseling room, and double locked rooms for storage of confidential client records.

The OIG found deficiencies in the following:

- Architectural Barriers Act-compliant exit signage
- Current emergency and crisis plan
- Secured personally identifiable information

### *Architectural Barriers Act*

The OIG found all four vet centers noncompliant in one element of general safety. 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” (italics in original text).<sup>165</sup> The OIG found three vet centers did not have a tactile (braille) sign posted near any of the exit doors. One vet center had the required tactile sign at the rear exit but did not have one at the front exit.

## Recommendation 18

The District Director evaluates and determines reasons for noncompliance with tactile (braille) signage at the Alexandria, Houston Southwest, Laredo, and Mesquite Vet Centers and ensures all exit doors are compliant with Architectural Barriers Act requirements.

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<sup>165</sup> 36 C.F.R. § Pt. 1191, App. D.

District Director response: Concur

The District will ensure that braille signage is added to all Vet Centers within the District.

Status: In progress

Target date for completion: November 2021

### *Emergency and Crisis Plan*

RCS requires each vet center 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>

Although the Mesquite Vet Center had a crisis management plan, it did not include all the required components.

### **Recommendation 19**

The District Director reviews reasons for noncompliance related to the Mesquite Vet Center’s emergency and crisis plan not containing all required components and ensures compliance.

District Director response: Concur.

The Mesquite Vet Center Director completed and submitted an emergency and crisis plan containing all required components.

Status: Closed

Target date for completion: N/A

OIG Comment: The OIG considers this recommendation open to allow time for submission of documents to support closure.

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<sup>166</sup> Readjustment Counseling Service, *District 1 Vet Center Administrative Quality Review Template*, revised October 24, 2016; VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*. November 2010; VHA Directive 1500(1), 2021.

## *Privacy*

RCS requires that “Confidential/sensitive information is secured.” The Houston Southwest Vet Center did not have sensitive information securely stored. During the virtual inspection, the OIG team entered an unlocked office and identified a piece of paper with personally identifiable information viewable on an unoccupied employee desk.

## **Recommendation 20**

The District Director reviews reasons for noncompliance with securing confidential and sensitive information at the Houston Southwest Vet Center and ensures all vet center employees safely and securely store personally identifiable information.

District Director response: Concur

This instance was an isolated situation involving misplaced documents, which occurred during the Environment of Care virtual review. The involved staff member has been retrained on information security and privacy.

Status: Closed

Target date for completion: N/A

OIG Comment: The OIG considers this recommendation open to allow time for submission of documents to support closure.

## Appendix A: Summary of VCIP District 4 Zone 2 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 system 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. OIG Recommendations According to Associated Requirements**

Quality	Requirement	Recommendation
Quality Reviews	Annual vet center quality review site visit	1. The District Director determines reasons administrative quality reviews were not completed, ensures completion, and monitors compliance.
	VCD and Associate District Director develop remediation plan	2. The District Director evaluates the administrative quality review report approval process to determine if a timeliness measure is needed and takes actions as indicated. 3. The District Director determines reasons administrative quality review remediation plans did not include documentation of deficiency resolution and the time frame of resolution, takes indicated actions to ensure completion, and monitors compliance.
Critical Incident Quality Reviews	Vet centers complete critical incident quality reviews for all serious suicide attempts of active clients	4. The District Director determines reasons why critical incident quality reviews (currently known as morbidity and mortality reviews) or serious suicide attempts were not completed, ensures completion, and monitors compliance. 5. The District Director determines reasons for non-participation with the root cause analysis investigation for shared clients with the support VA medical facility and, establishes processes to ensure required vet center participation.
Suicide Prevention	Requirement	Recommendation
Intake Assessment	Completion of psychosocial assessments within five visits	6. The District Director ensures the intake portion of the psychosocial assessment is completed and monitors compliance across all zone vet centers.
Lethality Risk Assessment	Completion of lethality risk assessments during the first clinical encounter	7. The District Director ensures lethality risk assessments are completed and monitors compliance across all zone vet centers.

Intake Assessment, Military History, Lethality Risk Assessments	Timely completion	8. The District Director, in collaboration with Readjustment Counseling Service Central Office, evaluates the limitations of current tools and tracking methods including why completion dates are not available 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	9. The District Director ensures clinical staff consult and coordinate care with the support VA 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 with VA medical facilities	10. The District Director ensures clinical staff follow confidentiality requirements when consulting and coordinating care with the support VA medical facility for shared clients flagged as high risk for suicide and monitors compliance across all zone vet centers.
	Consultation following lethality status changes	11. The District Director ensures clinical staff consult with the vet center director, external clinical consultant or VA suicide prevention coordinator following a lethality status change as required and monitors compliance across all zone vet centers.
	Completion of crisis reports	12. The District Director ensures clinical staff complete crisis reports as required and monitors compliance across all zone vet centers.
Care Coordination and Collaboration with VA Medical Facility	Participation on VA medical facility mental health council	13. The District Director, in collaboration with the support Veterans Affairs medical facility clinical or administrative liaisons, determines the reasons for noncompliance with staff participation on mental health councils at Alexandria, Houston Southwest, Laredo, and Mesquite Vet Centers, and takes actions as indicated to ensure compliance with Readjustment Counseling Service requirements.
<b>Consultation, Supervision, and Training</b>	<b>Requirement</b>	<b>Recommendation</b>
External Clinical Consultation	Documentation of four hours of external clinical consultation per month	14. The District Director determines reasons a process for completing and tracking four hours of external clinical consultation per month did not occur at the Alexandria, Houston Southwest, Laredo, and Mesquite Vet Centers, ensures 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 Alexandria, Houston Southwest, Laredo, and Mesquite Vet Centers,

		ensures staff supervision occurs as required, and monitors compliance.
	Monthly 10 percent client record audit for each counselor	16. The District Director verifies and determines reasons for noncompliance with monthly RCSnet chart audits at the Alexandria, Houston Southwest, Laredo, and Mesquite Vet Centers, ensures chart audits are completed as required, and monitors compliance.
Training	Completion of all mandatory trainings	17. The District Director determines reasons why completed trainings are not being recorded for employees at the Alexandria, Laredo, and Mesquite Vet Centers, ensures all staff complete mandatory trainings, and monitors compliance.
<b>Environment of Care</b>	<b>Requirement</b>	<b>Recommendation</b>
General Safety	Architectural Barriers Act-compliant exit signage	18. The District Director evaluates and determines reasons for noncompliance with tactile (braille) signage at the Alexandria, Houston Southwest, Laredo, and Mesquite Vet Centers and ensures all exit doors are compliant with Architectural Barriers Act requirements.
	Emergency and Crisis Plan	19. The District Director reviews reasons for noncompliance related to the Mesquite Vet Center's emergency and crisis plan not containing all required components and ensures compliance.
Privacy	Confidential/sensitive information secured	20. The District Director reviews reasons for noncompliance with securing confidential and sensitive information at the Houston Southwest Vet Center and ensures all vet center employees safely and securely store personally identifiable information.

Source: VA OIG recommendations.

## Appendix B: Zone Profile

**Table B.1. District 4 Zone 2 Profile  
October 1, 2019–September 30, 2020**

Profile Element	District 4 Zone 2	
Total Budget Dollars	\$18,861,352	
Unique Clients	10,402	
New Clients	3,157	
Active Duty Clients	398	
Spouse/Family Clients	1,288	
Bereavement Clients	67	
Position	Authorized	Filled
Total Full-time	166	157
District Leaders*	4	4
District and Zone Staff**	3	3
Vet Center Director †	23	23
Clinical Staff	91	86
Veterans Outreach Program Specialist‡	25	22
Vet Center Office Staff	23	22

Source: VA OIG analysis of information from district 4 zone 2 leaders.

\*District leaders include the District Director, Deputy District Director, Associate District Directors for Counseling and Administration. The Pacific District 4 Director is counted in both zones and therefore not included in total full-time row.

\*\*District and zone staff includes the district administration officer, district executive assistant, and zone 2 program support specialist. Two positions are not included in the total full-time row because they span throughout all district zones.

†Note: At the time of inspection, district 4 zone 2 reported 23 vet centers. The District liaison provided zone profile reports for the fiscal year, not the review period for the inspection.

‡Veteran Outreach Program Specialists are responsible for vet center outreach services. Veteran Outreach Program Specialists conduct face-to-face outreach to contact, inform, engage, and bring local eligible individuals into the vet center for needed services.

**Profile Summary:** From October 1, 2019, through September 30, 2020, district 4 zone 2 operated on a total budget of \$18,861,352 and served 10,402 unique clients; 3,157 new clients; 398 active duty service members; 1,288 spouses and family members; and 67 bereavement clients. There was a total of 166 positions with nine total vacancies throughout the zone as of September 30, 2021.

## Appendix C: Vet Center Profiles

The table below provides general background information for the four selected district 4 zone 2 vet centers.

**Table C.1. FY20 Vet Center Profiles\***

Profile Element	Alexandria Vet Center	Houston Southwest Vet Center	Laredo Vet Center	Mesquite Vet Center
Number of:				
• Unique Clients	262	358	288	661
• Bereavement Clients	3	8	1	3
• Active Duty Clients	9	1	10	12
• Spouse/Family Clients	31	73	28	47
• New Clients	64	74	80	183
Total Number of Positions (as of 9/22/20)				
• Total Full-time positions	6	7	4	7
• Total Part-time positions	N/A	N/A	N/A	N/A
• Vet Center Director	1	1	1	1
• Clinical Staff	3	4	1	4
• Veterans Outreach Specialist	1	1	1	1
• Office Staff	1	1	1	1
• Other	N/A	N/A	N/A	N/A

Source: VA OIG analysis of information provided by district 4 zone 2.

\*The OIG did not assess RCS data for accuracy or completeness.

## Appendix D: Chief Readjustment Counseling Officer Memorandum

### Department of Veterans Affairs Memorandum

Date: September 7, 2021

From: Chief Officer, Readjustment Counseling Service (RCS)

Subj: Vet Center Inspection of Continental District 4 Zone 2 and Selected Vet Centers

To: Director, Office of Healthcare Inspections (54MH00)  
Director, GAO/OIG Accountability Liaison (VHA 10 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 2 and Selected Vet Centers. Readjustment Counseling Service (RCS) has reviewed the recommendations and submits action plans to address all findings in the report.
2. 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.
3. 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

## Appendix E: Continental District 4 Zone 2 District Director Memorandum

### Department of Veterans Affairs Memorandum

Date: September 7, 2021

From: District Director, Continental District 4 (RCS4)

Subj: Vet Center Inspection of Continental District 4 Zone 2 and Selected Vet Centers

To: Chief Readjustment Counseling Officer, RCS (VHA 10 RCS Action)  
Director, GAO/OIG Accountability Liaison (VHA 10 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 2 and Selected Vet Centers. The Veterans Health Administration (VHA) concurs with the recommendations and provides comments/action plan in the attachment.
2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at [VHA10BGOALACTION@va.gov](mailto:VHA10BGOALACTION@va.gov).

*(Original signed by:)*

Carrie Crownover, PhD

## 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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