



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Vet Center Inspection of
Pacific District 5 Zone 1 and
Selected Vet Centers



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Figure 1. Pacific district 5 zone 1 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 Pacific district 5 zone 1 and four vet centers—Bellingham and Tacoma in Washington, Central Oregon in Bend, and Wasilla in Alaska.¹

VCIP inspections are one element of the OIG’s oversight to ensure that the nation’s veterans receive high-quality and timely mental health care and VA services. The inspection covers key clinical and administrative processes associated with promoting quality care. The OIG selects and evaluates specific areas of focus each year.

To examine risks or potential risks to clients, the OIG inspection focused on six reviews that influence the quality of client care and service delivery at vet centers:²

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

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

¹ 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 The new directive rescinded and replaced multiple VHA guidelines and policies addressing Readjustment Counseling Service operations that were in effect during the inspection period. The OIG compared the rescinded guidelines and policies with the newly issued directive to identify modifications.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.

² VHA Directive 1500(1), 2021. Vet centers provide counseling interventions for psychological and psychosocial readjustment problems related to specific types of military deployment stressors. Readjustment counseling services are “designed by law to be provided without a medical diagnosis.” Therefore, those receiving readjustment services are not considered patients. To be consistent with Vet Center policy and terminology, the OIG refers to veterans receiving such services as clients in this report.

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 district 5 zone 1 leadership team consists of the District Director, Deputy District Director, Associate District Director for Counseling, and Associate District Director for Administration (see figure 2).³

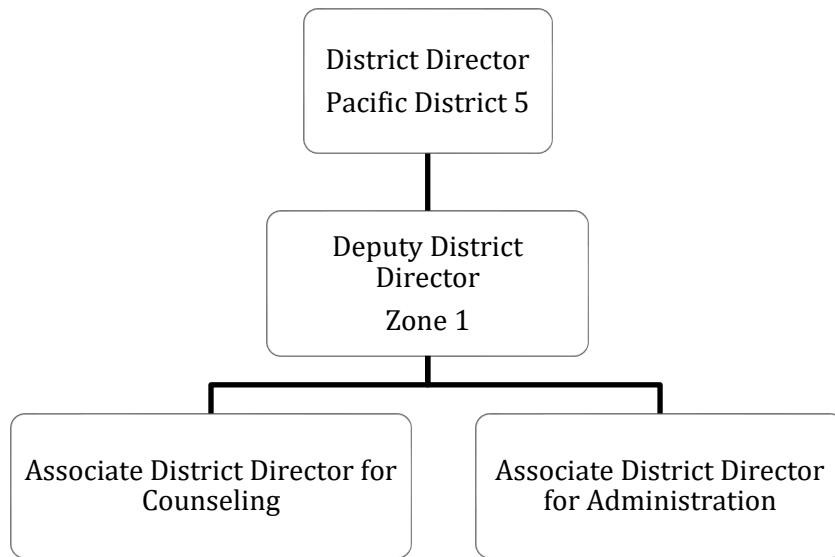


Figure 2. Pacific district 5 zone 1 leaders.
Source: VA OIG analysis of district organizational chart.

At the time of the inspection, district leaders had been working together as a group for almost three years. The District Director was appointed in September 2016. The Deputy District Director was assigned in January 2018, the Associate District Director for Counseling served in the position since October 2017, and the Associate District Director for Administration was assigned in August 2017.

District leaders had a good understanding of the basic concepts of quality improvement and perceived their roles as important to driving and overseeing quality improvement activities.

³ For the purposes of this report, district leaders refer to the District Director, and 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 23, 2010. VHA Directive 1500(1), 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.

District leaders spent varying times engaging in quality improvement activities, with one leader reporting an average of between five and ten hours a week.

The All Employee Survey is an annual, voluntary survey of VA workforce experiences. District leaders provided examples of district-wide initiatives implemented in response to feedback from the 2019 fiscal year All Employee Survey results. The OIG identified the district 5 zone 1 top three fiscal year 2020 All Employee Survey priorities as growth, innovation, and workload.⁴ The District Director and Deputy District Director had working knowledge of the 2020 fiscal year All Employee Survey results but had not implemented changes at the time of the OIG's inspection.

The OIG reviewed Vet Center Service Feedback survey results for fiscal year 2020, generally noting all but one area was higher than the Readjustment Counseling Service (RCS) national average scores. District leaders reported concern regarding the lower score in the area of access to appointment times to meet client needs and verbally shared examples of performance improvement actions taken to strengthen processes in this area. Results from the leadership and organizational risks review generally do not rise to the level of findings.

Quality Reviews

Quality reviews by district leaders 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 RCS policy and procedures. RCS requires critical incident quality reviews for client safety events 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 completion of clinical and administrative quality review remediation plans, and critical incident quality reviews for serious suicide attempts. The OIG issued four recommendations specific to the three topics.

COVID-19 Response

The COVID-19 response review results were obtained through interviews with district leaders and VCDs from the four selected vet centers and a zone-wide, voluntary questionnaire to staff. Results for the COVID-19 response review generally do not rise to the level of findings.

Interview topics included emergency planning; communication and field guidance; supplies and infrastructure; access and client care—telework and telehealth; and client screening including referral. District leaders and VCDs indicated supplies were adequate; masks were worn in the vet centers; hand washing and hand sanitizer stations were available; and safe social distancing was practiced.

⁴ Fiscal year 2020 is October 1, 2019, through September 30, 2020.

The questionnaire was sent to 136 employees at the 22 zone 1 vet centers. Employee responses reflected that, overall, 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 with results and recommendations to the district director as well as a focused review of the four selected vet centers with results and recommendations to the district director.

All four vet centers inspected were compliant with required availability of nontraditional hours for appointments. Three VCDs were not compliant with the requirement of attending the support VA medical facility's mental health council meetings.⁵

None of the four vet centers were able to provide evidence they received the list of clients with an increased predictive risk for suicide or the required flagged high risk for suicide list from the Office of Mental Health and Suicide Prevention.⁶ None of the four vet centers had a standardized communication process of collaboration with the support VA medical facility suicide prevention coordinators.⁷ One of the four VCDs was noncompliant with the requirement of reviewing the RCS High Risk Suicide Flag SharePoint monthly.

The OIG issued three recommendations specific to the suicide prevention evaluation of the psychosocial assessment, military history, and lethality risk assessments in the electronic client records. Five recommendations were made regarding consultation and collaboration with VA medical facilities, high risk for suicide, and crisis reports. The OIG issued three

⁵ 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." The handbook further stated, "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." The September 2010 handbook was rescinded and replaced by VHA Directive 1500(1), 2021. 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."

⁶ The Office of Mental Health and Suicide Prevention is the VA office responsible for sharing a monthly list of veterans who have an increased predictive risk for suicide with Readjustment Counseling Service so vet centers can identify clients who are receiving counseling services and better coordinate care with VA medical facilities.

⁷ The 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, outlines 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 same matters were directed to the Under Secretary for Health who has authority over both programs in a separate VA OIG report, *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021.

recommendations specific to the four selected vet centers' suicide prevention and intervention processes.

Consultation, Supervision, and Training

The consultation, supervision, and training review evaluated the four selected vet centers with results and recommendations specific to those sites. Two of the four vet centers inspected complied with requirements to have a clinical liaison.⁸ Three of the four vet centers complied with the requirements to have an external clinical consultant from the support VA medical facility mental health or social work service.⁹ The external clinical consultants were appropriately licensed as were the required mental health professionals on staff at each vet center. None of the four vet centers were compliant with the requirement for an external clinical consultant to provide at least four hours of consultation per month.

VCDs were not compliant with the requirement to provide one hour a week of supervision to clinical staff and auditing electronic client records. Overall, staff at the four vet centers were noncompliant with completing training requirements.¹⁰

The OIG issued five recommendations specific to the four selected vet centers.

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. However, one vet center was noncompliant with the exterior being in good repair and none of the four vet centers were compliant with the posting of Architectural Barriers Act tactile exit signs.¹¹ The OIG also identified noncompliance with privacy requirements at two vet centers. The OIG made three recommendations.

Conclusion

The OIG conducted a detailed inspection across six review areas and issued a total of 23 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

⁸ As of April 2021, one of the two noncompliant vet centers was assigned a clinical liaison from the support VA medical facility; therefore, the OIG's recommendation on this matter focuses on the remaining noncompliant vet center.

⁹ As of April 2021, the noncompliant vet center was assigned an external clinical consultant from the support VA medical facility; therefore, the OIG does not make a recommendation on this matter.

¹⁰ 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.

¹¹ Architectural Barriers Act of 1968 (codified as amended at 42 U.S.C. § 4151 et seq.); Architectural Barriers Act (ABA) Standards (2015).

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 RCS Chief Officer and District Director concurred with recommendations 1–3, 5–15, 17, and 19–23, and concurred in principle with recommendations 4, 16, and 18. 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 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.¹ 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.² 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.³

Vet Center History

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.⁴ 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 American Psychiatric Association recognized posttraumatic stress disorder as an official diagnosis in 1980.⁵

¹ 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 stressors. Readjustment counseling services are “designed by law to be provided without a medical diagnosis.” Therefore, those receiving readjustment services are not considered patients. To be consistent with Vet Center policy and terminology, the OIG refers to veterans receiving such services as clients in this report.

² VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010, was in effect during the OIG’s inspection period. VHA Directive 1500 (1) rescinded and replaced multiple VHA guidelines and policies addressing RCS operations that were in effect during the inspection period. Unless otherwise specified, the 2021 directive contains the same or similar language as the September 2010 rescinded handbook. Policy Memorandum RCS-CLI-003, *Revised Clinical Site Visit (CSV) Protocol*, January 25, 2019.

³ VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500 (1), 2021; “Vet Centers (Readjustment Counseling),” VA, 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.

⁴ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010, was in effect during the OIG’s inspection period. It was rescinded and replaced by VHA Directive 1500(1), 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.

⁵ 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, 2010; VHA Directive 1500(1), 2021.

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 RCS Central Office reported 307,737 clients in fiscal year 2019.⁶ 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 2018.⁷ 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.⁸

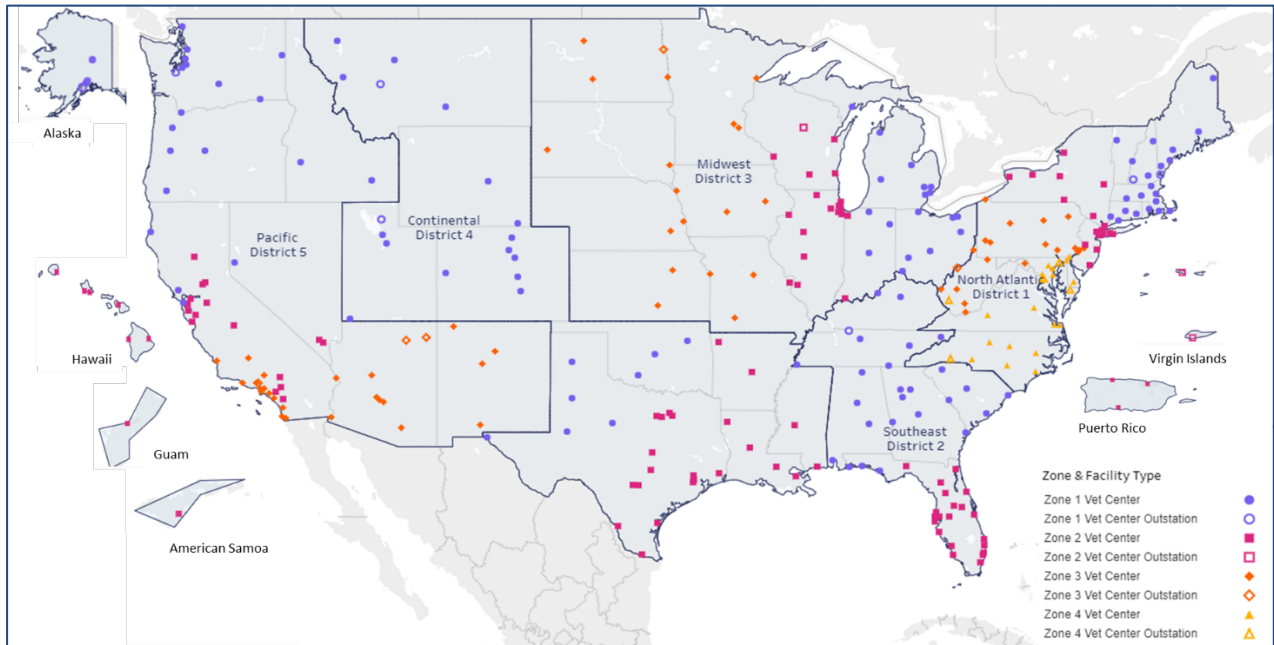


Figure 3. Map of vet centers and vet center outstations. The placement of Alaska, American Samoa, Hawaii, Guam, Puerto Rico and the Virgin Islands is not representative of their actual geographical locations.⁹

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

Vet center services and eligibility continue to expand starting in 1991 with a notable change in 2003 permitting RCS to provide bereavement counseling to surviving parents, spouses, children, and

⁶ VHA Directive 1500(1), 2021. RCS Central Office is the national office responsible for program policy and supervision of RCS district offices, providing direct-line supervision for vet center administrative and clinical functions. Government Accountability Office. *Vietnam Veterans: A Profile of VA’s Readjustment Counseling Program*, Report No. GAO/HRD-87-63, August 1987, and 1995 *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.

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

⁸ 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.

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

siblings of service members who die of any cause while on active duty.¹⁰ Table 1 shows the expansion of vet center eligibility.

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 and/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
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.

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.¹¹ RCS establishes clinical and

¹⁰ “Vet Centers (Readjustment Counseling) – Who We Are,” VA, accessed June 4, 2019, https://www.vetcenter.va.gov/About_US.asp. This includes activated Reserve and National Guard members as noted in table 1.

¹¹ “Vet Centers (Readjustment Counseling),” VA, accessed July 8, 2019, <https://www.vetcenter.va.gov/>. The Vet Center Call Center, reached at 1-877-WAR-VETS or 1-877-927-8387, is a toll-free, 24-hour per day, 7-days per week, confidential call center for veterans and their families to receive support regarding their military experience or any other readjustment issue. VHA Directive 1500, September 8, 2010; VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), 2021.

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

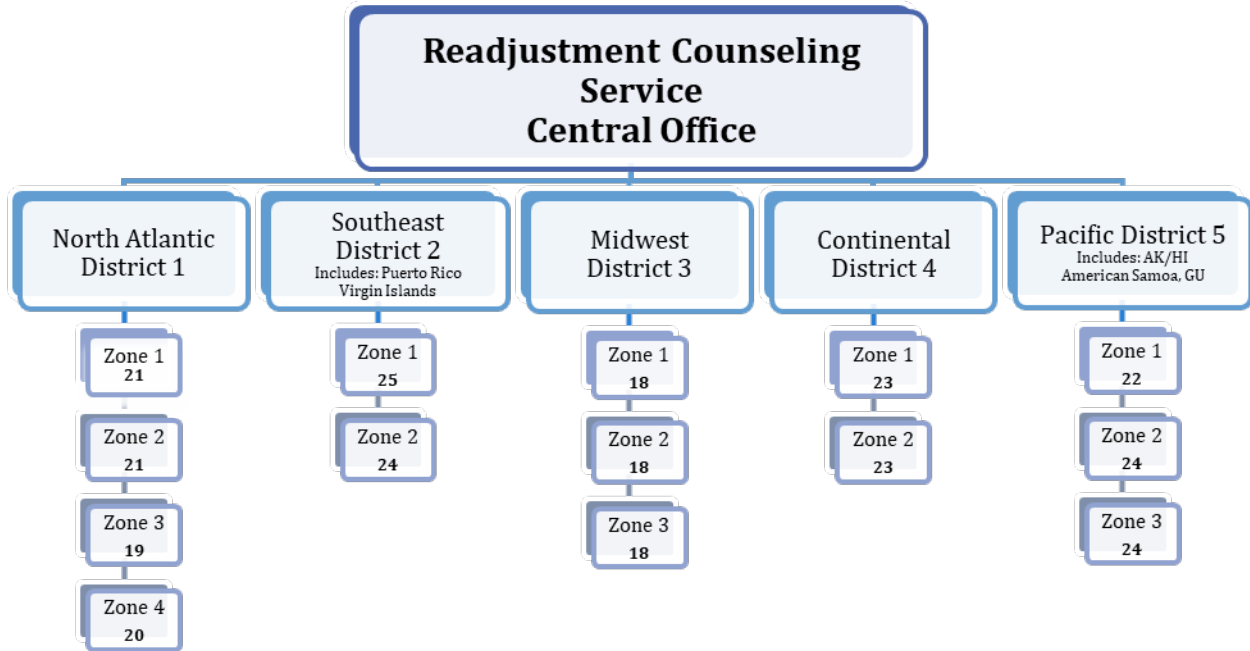


Figure 4. RCS organizational district and zone structure.

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

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

Electronic Client Record

Vet center services are not required to be recorded in the client’s VA electronic health record.¹⁴ 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

¹² VHA Directive 1500, September 8, 2010; VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), 2021.

¹³ VHA Directive 1500, September 8, 2010; VHA Directive 1500(1), 2021.

¹⁴ VHA Directive 1500(1), 2021.

of Defense unless there is a signed release of information.¹⁵ The RCS National Service Support leader reported working with Cerner Corporation and VA's Office of Electronic Health Record Modernization for the development of an RCS-specific electronic client record system.¹⁶

VA Medical Facilities

Guidelines, as outlined in this paragraph, were established by RCS for vet centers to maintain a reciprocal relationship with VA medical facilities to ensure clients receive quality care and needed services.¹⁷ The support VA medical facility director, in coordination with the VCD director, assigns a clinical liaison and an administrative liaison.¹⁸ The VA medical facility clinical liaison coordinates services for complex and shared clients.¹⁹ 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.²⁰ 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.²¹

Purpose and Scope

The purpose of the VA Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) is to conduct routine oversight of vet centers providing readjustment services to clients. The OIG inspection examined operations generally from March 1, 2020, through February 28, 2021. This report evaluates aspects of the quality of care delivered at Pacific district 5 zone 1 (district 5 zone 1) 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.

¹⁵ VHA Handbook 1500.01, September 8, 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.

¹⁶ Per an RCS National Service Support leader, modernization of the RCSnet as the electronic client record system for vet center was being considered and a determination had not been made. VHA Directive 1500, September 8, 2010; 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. "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 and engage healthcare communicates.

¹⁷ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), 2021.

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

¹⁹ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 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 or VHA medical facility.

²⁰ VHA Directive 1500(1), 2021.

²¹ VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), 2021. Vet Centers provide representation on root cause analysis panels when a client completes suicide and is a shared client with the VA medical facility.

The OIG findings are a snapshot of a zone and vet centers' performance within identified focus areas. Although it is difficult to quantify the risk of adverse impact to clients served at vet centers, the OIG recommendations in this report should help vet centers identify areas of vulnerability or conditions that, if addressed, could improve safety and quality of care (see [appendix A](#)).²²

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 response²³
- Suicide prevention
- Consultation, supervision, and training
- Environment of care

Methodology

The OIG announced the inspection to district leaders on May 10, 2021, and conducted virtual site visits from May 10, 2021, through May 26, 2021.²⁴ 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.²⁵

The OIG reviewed RCS policies and practices, validated client RCSnet record findings, examined administrative and performance measure data, explored reasons for noncompliance, and inspected select areas of care within vet centers. The OIG emailed two questionnaires—the first one focused on quality improvement activities and was sent to all VCDs in the zone. The second one focused on vet centers' COVID-19 response and was sent to all staff within the zone. The OIG did not assess responses for accuracy or completeness.

²² 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.

²³ VA, *VHA–Office of Emergency Management, COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan, Version 1.6*, March 23, 2020. “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.” “WHO Director-General’s opening remarks at the media briefing on COVID-19–11 March 2020,” World Health Organization, accessed on August 20, 2020, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>.

²⁴ For the purposes of this report, district leaders refer to the District Director, Deputy District Director, Associate District Director for Counseling and Associate District Director for Administration.

²⁵ “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>.

A new VHA directive was issued in January 2021 (amended May 3, 2021) during the OIG’s inspection period of VCIP operations discussed in this report.²⁶ The new directive rescinded and replaced multiple VHA guidelines and policies addressing RCS operations that were in effect during the inspection period. The OIG compared the rescinded guidelines and policies with the newly issued directive to identify modifications. Unless otherwise specified, requirements in the new directive use the same or similar language as the rescinded RCS-related guidelines and policies under discussion in this report. The OIG findings in this report are based on the RCS-related guidelines and policies that were in effect during the inspection period. Recommendations are consistent with the 2021 directive addressing RCS operations.

District and Zone Selection

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

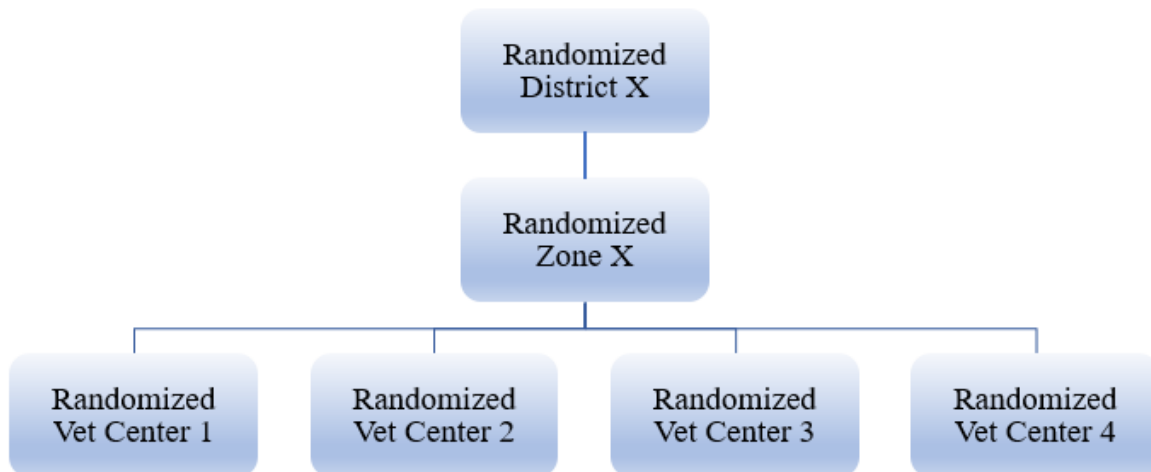


Figure 5. Randomization and selection of inspection sites.

Source: VA OIG.

The randomly selected entities for this inspection were district 5, zone 1, the Bellingham Vet Center in Washington, Central Oregon in Bend, Tacoma Vet Center in Washington, and Wasilla in Alaska. District 5 zone 1 vet centers are noted in figure 6. For demographic profiles of the zone 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.²⁷

²⁶ VHA Directive 1500(1), 2021.

²⁷ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), 2021. Vet centers are composed of small multidisciplinary teams. The OIG team provided the one-day notice for coordination of client care purposes.

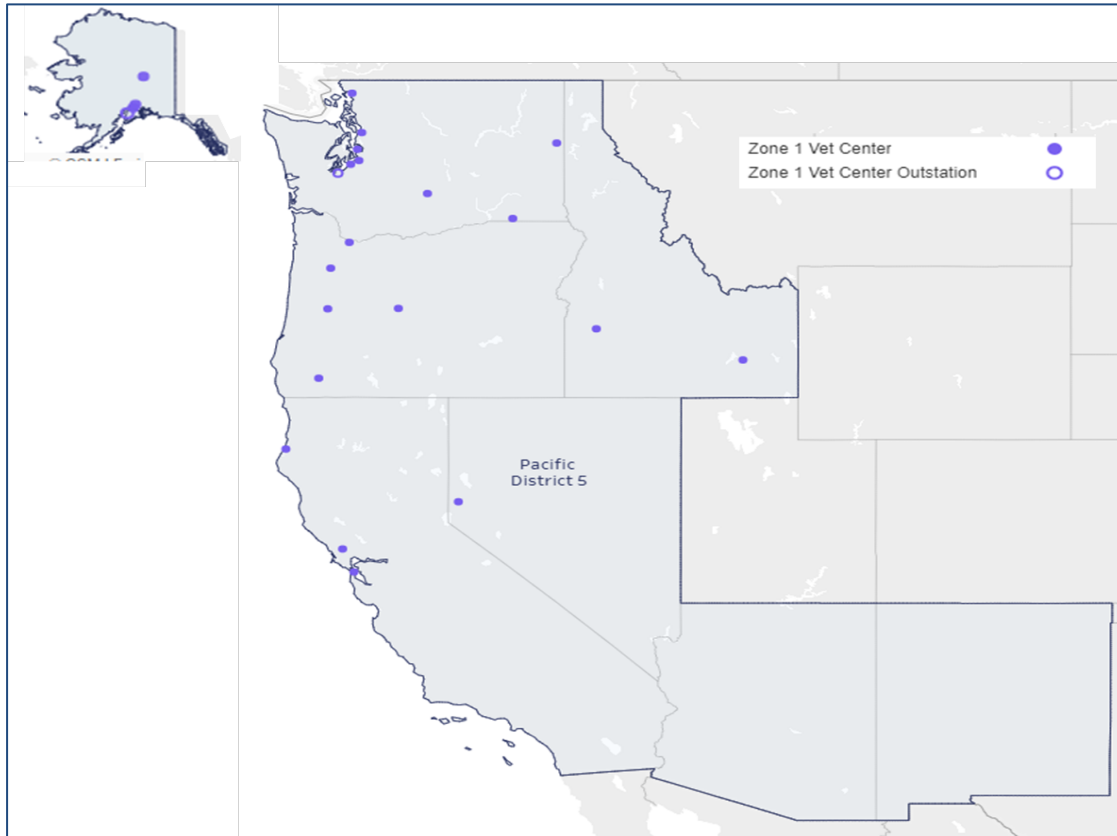


Figure 6. Map of Pacific district 5 zone 1 vet centers.
 Source: Developed by VA OIG using VA Site Tracking.

The leadership and organizational risks review results and recommendations are specific to the district and zone office and included interviews with district leaders and an assessment of

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

The assessment of quality reviews included evaluating the vet center clinical and administrative oversight reviews for the zone as well as 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. This review is designed primarily to gather information from leaders and staff within the zone and to draw general conclusions. Results from the COVID-19 response review generally do not rise to the level of findings.

The suicide prevention review included a zone-wide evaluation of RCSnet electronic client records with results and recommendations specific to the District Director, and a focused review of the four selected vet centers with results and recommendations to the District Director.²⁸

The 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 as amended 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to RCS leadership if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

²⁸ 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. District leaders' 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.²⁹ 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.³⁰

As noted above, the OIG assessed leadership and organizational risks for district 5 zone 1 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 results³¹

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, administrative and fiscal operations,

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

³⁰ 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.

³¹ 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.

outreach events, community relations, hiring staff and clinical programs.³² Figure 7 shows the leadership organizational structure for district 5 zone 1.

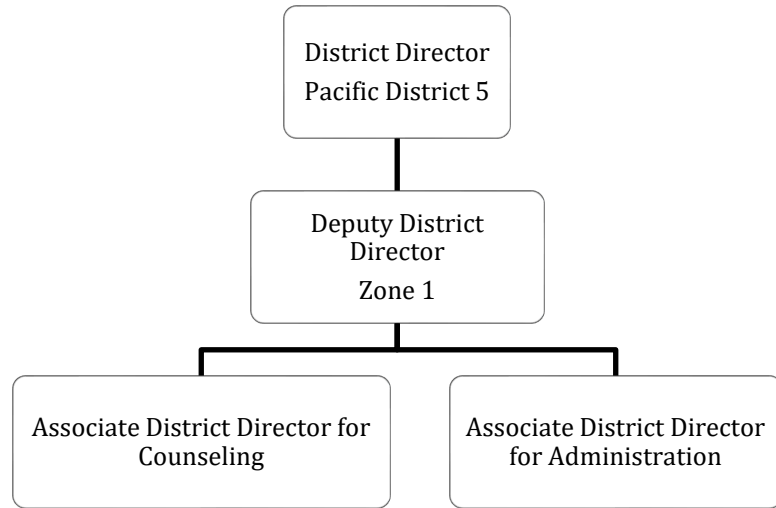


Figure 7. District leaders.
Source: VA OIG analysis of district organizational chart.

At the time of the OIG interviews, district leaders had been working together for about three years. The District Director has been in the role since 2011, with a title change in 2016 from Regional Manager to District Director when RCS restructured the regions to districts.³³ There had been no vacant district leader positions in the 12 months prior to the inspection.

During the twelve months prior to the inspection, one VCD position was vacant for one month and was not in recruitment at the time of inspection. However, the District Director confirmed an acting VCD was assigned for the duration of the vacancy.

Quality Improvement Activities

The OIG interviewed district leaders to assess knowledge about healthcare quality improvement principles and practices. Time spent engaging in quality improvement activities varied across district leadership. One leader reported less than five hours a week, another between five and ten hours per week. District leaders generally reported averaging more than five hours a week. Leaders were knowledgeable about the 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 being receptive to employees and having

³² VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), 2021.

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

open-door communication between staff and leadership.³⁴ Overall, district leaders described how they encouraged a just culture; giving examples of how it promotes an environment to try new ideas, grow, and learn from mistakes. The OIG did not evaluate quality and performance improvement activities.

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.³⁵ Although the OIG recognizes that employee satisfaction survey data are subjective, the information can be (1) a starting point for discussions, (2) indicative of areas for further inquiry, and (3) considered along with other information for leaders' evaluation.

The OIG identified the top three fiscal year 2020 All Employee Survey priorities for the district as growth, workload, and innovation. When interviewed, district leaders discussed actions they initiated to address All Employee Survey results.

To address All Employee Survey results related to growth, district leaders indicated that an all-hands phone meeting was held weekly to not only be open and transparent but to also provide an opportunity for staff to feel connected to one another. The frequency of the phone meetings was increased to twice a week during the COVID-19 pandemic to discuss policy changes, and up-to-date COVID-19 practices.

The Deputy District Director noted that workload had become more stressful during the pandemic but surmised transitioning back to seeing clients in the office would alleviate that stressor. The Deputy District Director also indicated that the district had implemented a zone employee of the quarter award for recognition of staff achievement.

One innovation action cited by a district leader was starting appointments before the top of the hour to avoid bandwidth issues that had been encountered during virtual visits.

³⁴ "Just Culture," Health Quality Council of Alberta, 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."

³⁵ Smith, J. L. and McCarren, H., "Developing servant leaders contributes to VHA's improved organizational health," *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.

Vet Center Service Feedback Survey

A Vet Center Service Feedback survey is required to be available at the vet centers by RCS for a client once a case is closed or a client has not been seen in the last one hundred days and other select criteria are met. Results from the survey provide district leaders and VCDs with feedback to evaluate the effectiveness of readjustment counseling.³⁶ The RCS national database system maintains all client survey feedback and compiles district and national data into summary reports.

The OIG found district 5 zone 1 feedback results were favorable in all areas except appointment scheduling convenience as noted in the table below.³⁷ District 5 zone 1's overall quality of services satisfaction rating for fiscal year 2020 Vet Center Service Feedback score exceeded the national score. Clients reported satisfaction with the overall quality of the vet centers, a welcoming environment, recommendation of services, convenient locations in the community, and feeling better as a result of the services. Table 2 details the results of the Vet Center Service Feedback survey.

**Table 2. District 5 Zone 1 Vet Center Service Feedback Survey Results
October 1, 2019–September 30, 2020**

Feedback Survey Item	District 5 Zone 1 Average Score*	RCS National Average Score*
I was treated in a welcoming and courteous manner by the Vet Center staff.	4.79	4.67
My appointments have been scheduled at a time that was convenient.	4.47	4.59
I would likely recommend the vet center to another Veteran, servicemember, or family member.	4.73	4.55
The Vet Center services were located conveniently in my community.	4.56	4.39
I feel better as a result of the services provided by the Vet Center staff.	4.63	4.39
How satisfied were you with the overall quality of services at the Vet Center?	4.62	4.48

Source: Developed by VA OIG based on RCS National Service Support data provided by the District Director. The OIG did not assess RCS data for accuracy or completeness.

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

District leaders reported actions were taken to positively affect client and family feedback scores. The District Director noted the importance of face-to-face training that would promote a culture to treat

³⁶ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), 2021. The Vet Center Service Feedback survey was formerly known as the Vet Center Client Satisfaction survey. The 2021 directive did not update the survey title and the requirements for administration remained the same.

³⁷ The OIG considered the Vet Center Service Feedback survey results favorable because scores averaged more than four and exceeded RCS national averages in five of six categories.

clients well with an understanding of the impact each vet center staff member has on the service provided. In regard to lower-than-national average feedback scores for appointments scheduled at a time that was convenient, the Deputy District Director noted that younger veterans had schedules and needs that were different from other-era veterans. Extended hours and in-person visits were limited during the pandemic, which negatively affected this population. However, the Deputy District Director felt this issue would be resolved as vet centers return to face-to-face appointments. Staffing shortages were also noted as a barrier to offering more hours for convenience.

Leadership and Organizational Risks Questionnaire

The OIG sent a leadership and organizational risks questionnaire to all district 5 zone 1 VCDs consisting of seven questions to evaluate their perspectives about select quality improvement activities and organizational health. Of the 21 questionnaires distributed, 21 were returned.³⁸ The OIG reviewed and categorized VCD responses to open-ended questions for themes. The OIG did not validate respondent answers for accuracy.³⁹

Overall, district leaders were identified as a resource and support structure for vet center quality improvement activities. VCDs had a good understanding of quality improvement and perceived their role as important to quality improvement. A majority reported spending less than five hours per week engaged in quality related functions. They cited different ways they sought to promote psychological safety in the work place that included staff engagement, open-door policy, individual and staff meetings, and focusing on the needs of the staff. VCDs identified that the All Employee Survey results were used to develop strategies to address issues. The OIG review of responses identified no safety concerns.

Leadership and Organizational Risks Conclusion

Leadership teams appeared stable and cohesive across the district and zone, with sufficient coverage in place for the one VCD position vacancy. District leaders and VCDs had a general understanding of quality improvement and perceived their role as important to driving and overseeing quality improvement activities. The District Director and Deputy District Director had general knowledge of the fiscal year 2020 All Employee Survey results. The Associate District Directors for Administration and Counseling were unable to provide examples of initiatives related to the top three priorities for fiscal year 2020. Questionnaire responses indicated leaders supported quality planning and promoted psychological safety at the vet centers.

³⁸ Although there were 22 vet centers in district 5, zone 1, one VCD position was vacant at the time of the inspection (Eureka Vet Center); therefore, only 21 VCDs were available for receipt of the questionnaire.

³⁹ The OIG reviewed and categorized VCD responses for general themes using a manual counting method for frequency of responses. Some responses were analyzed but not included in this review due to infrequency, lack of clarity, or redundancy.

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.⁴⁰ 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.⁴¹

The OIG evaluated quality oversight in district 5 zone 1 in the following areas:

- Clinical and administrative quality reviews
- Critical incident quality reviews

Clinical and Administrative Quality Reviews

RCS requires an annual quality review of all vet centers to ensure compliance with policies and procedures for the administration and provision of readjustment counseling.⁴² Annual quality reviews are composed of separate clinical and administrative reviews. Clinical and administrative quality reviews are similar processes that follow the same timeframes and policy, but are completed independently, produce separate reports, and are documented differently.⁴³

Clinical quality reviews included multiple areas of evaluation:

- Vet center team composition
- Access to vet center services
- Readjustment counseling
- Active client caseloads
- Clinical productivity
- Customer feedback⁴⁴

⁴⁰ VA, *Veterans Health Administration’s Blueprint for Excellence–Fact Sheet*, September 2014.

⁴¹ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), 2021.

⁴² VHA Handbook 1500.01, September 8, 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.

⁴³ RCS-CLI-004, *Implementation of Automated Vet Center Clinical Site Visit (CSV) Operations*, November 4, 2019; VHA Directive 1500(1), 2021.

⁴⁴ RCS-CLI-003.

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 management⁴⁵

RCS policy requires district directors ensure annual vet center clinical and administrative quality reviews are conducted.⁴⁶ Deputy district directors are responsible for approving annual clinical and administrative quality reviews and remediation plans.⁴⁷ Associate district directors for counseling and administration conduct the annual quality reviews that result in written reports. Deficiencies identified in the annual clinical and administrative quality reviews are included in the reports.⁴⁸

Within 30 days of receiving the clinical or administrative annual quality review report, the VCD, with the help of the associate director for counseling or administration, develops a remediation plan with target dates for deficiencies to be corrected.⁴⁹ Within 60 days from the date the deputy district director approves the remediation plan, the VCD is responsible for resolving all deficiencies.⁵⁰ 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.⁵¹ Figure 8 depicts the annual vet center quality review process.

⁴⁵ Readjustment Counseling Service, District 1 Vet Center Administrative Quality Review Template, sections I. to VI., revised October 24, 2016.

⁴⁶ RCS-CLI-001, *Vet Center Clinical and Administrative Site Visits*, November 2, 2018; VHA Directive 1500(1), 2021.

⁴⁷ RCS-CLI-001, November 2, 2018; RCS-CLI-003, January 25, 2019.

⁴⁸ RCS-CLI-001, November 2, 2018; RCS-CLI-003, January 25, 2019.

⁴⁹ RCS-CLI-001, November 2, 2018.

⁵⁰ RCS-CLI-001, November 2, 2018; RCS-CLI-003, January 25, 2019.

⁵¹ RCS-CLI-001, November 2, 2018.

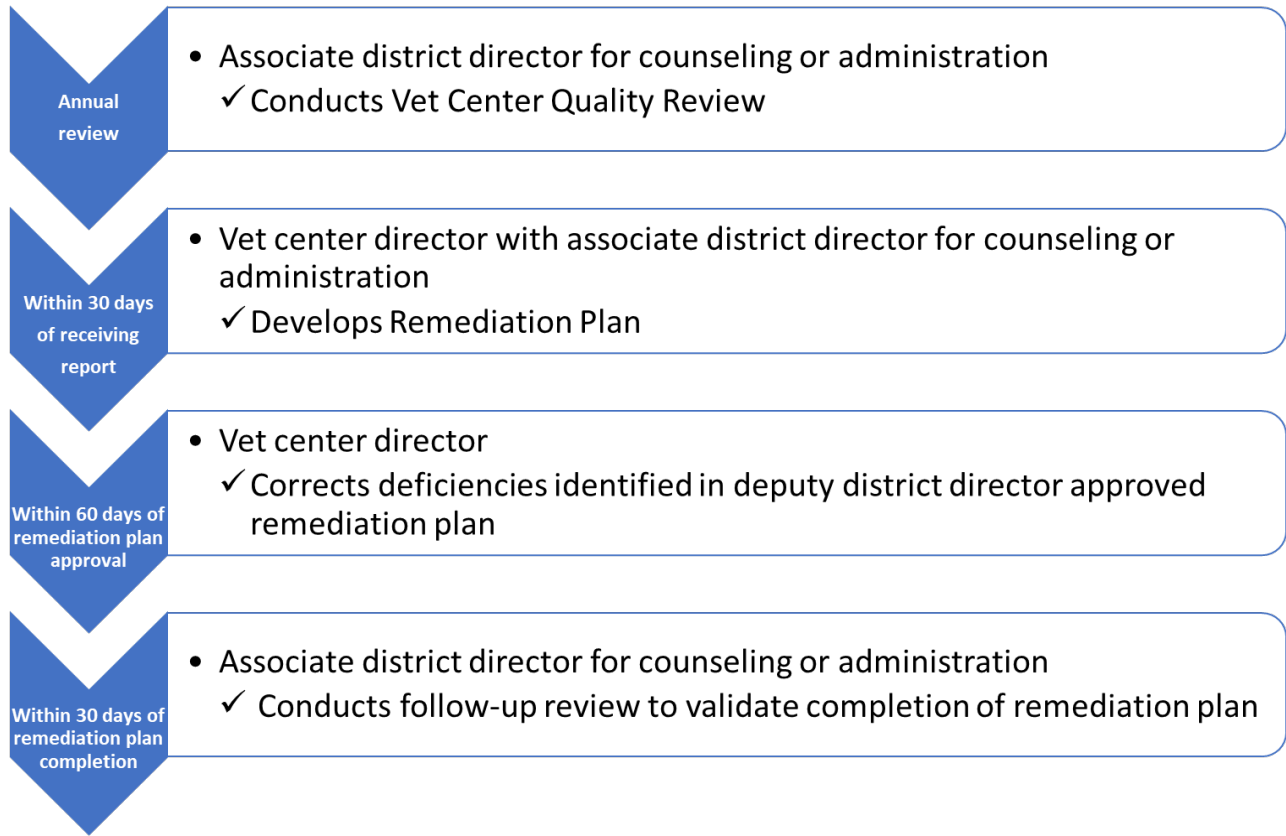


Figure 8. Vet center clinical and administrative quality review process.

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.

The OIG evaluation for the clinical and administrative review processes for all district 5 zone 1 vet centers included interviewing district leaders and review of

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

The Associate District Directors for Counseling and Administration were compliant with the completion of vet center clinical and administrative quality reviews for all 22 vet centers in district 5 zone 1.

Clinical and Administrative Quality Reviews Findings and Recommendations

Clinical Quality Reviews

The OIG found district 5 zone 1 noncompliant with the remediation plans for clinical quality reviews. Clinical quality reviews were primarily the responsibility of the Associate District Director for Counseling with the Deputy District Director responsible for final approval of remediation plans.⁵²

Clinical quality reviews were completed for all vet centers. On average, the clinical site visit reports were approved within 43 days of the site visit; 12 of the 22 reports exceeded the 30-day timeframe. Of the 22 completed clinical quality site visit reports, 21 vet centers had clinical deficiencies identified; 18 of the 21 had remediation plans (see table 3).

The Associate District Director for Counseling was knowledgeable of the clinical oversight process and able to discuss improvements to ensure a robust review through site visit preparation and continued monitoring. One vet center’s quality review was “not met” during the clinical site visit. The vet center was given 90 days to implement a remediation plan to meet a satisfactory status. The Associate District Director for Counseling completed another quality review to ensure issues were resolved and the site passed.

Table 3. District 5 Zone 1 Vet Center Clinical Quality Reviews

Requirement	Expected Reports	Completed Reports
Annual Clinical Quality Reviews	22	22
Clinical Quality Remediation Plans	21	18

Source: VA OIG analysis based on district 5 zone 1 documents.

Note: The OIG request was for the most recent quality reviews completed on or prior to February 28, 2021.

The OIG identified the following findings:

- The Deputy District Director’s 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.⁵³

RCS guidance states 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

⁵² VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), 2021; RCS-CLI-003, January 25, 2019.

⁵³ Although there was a finding for the time period of this review, the OIG determined that updates to the 2021 VHA Directive 1500(1) removed the requirement for deputy district director approval of the remediation plan. The current policy guidelines are congruent with the process steps in the RCSnet system for clinical remediation plans.

activities.⁵⁴ RCS requires deputy district director approval of remediation plans to establish the 60-day timeframe for deficiency resolution. The OIG found that RCSnet does not have a location for remediation plans to record the deputy district director approval signature or date. District leaders explained the clinical quality review process includes deputy district director review of remediation plans, but approval could not be validated because it 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.

Recommendation 1

The District Director determines reasons clinical quality review remediation plans were not completed, ensures completion, and monitors compliance.

District Director response: Concur.

RCS requires that every Vet Center receive a clinical quality review each Fiscal Year (FY). While the clinical quality review has been automated allowing for monitoring compliance, the administrative site visits remain a manual process. 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: April 2022

Administrative Quality Reviews

The district 5 zone 2 Associate District Director for Administration is responsible for administrative quality reviews and the Deputy District Director is responsible for final approval of remediation plans.⁵⁵ The OIG found district 5 zone 1 to be noncompliant with requirements for administrative quality remediation plans.

For each vet center in district 5 zone 1, the Associate District Director for Administration completed an administrative quality site review. On average, the administrative site visit reports were approved within 21 days of the site visit. Of the 22 completed administrative quality site visit reports, 20 vet centers had administrative deficiencies identified; 18 of the 20 vet centers had remediation plans (see table 4). Of the 18 remediation plans, one was not approved by the Deputy District Director. Once a remediation plan is approved and signed by the Deputy District Director, the Associate District

⁵⁴ RCS-CLI-004, November 4, 2019.

⁵⁵ RCS-CLI-001, November 2, 2018.

Director for Administration reported there was no verification of whether actions were resolved for the deficiencies. The OIG was unable to determine if identified administrative deficiencies were resolved within the required remediation timeframe due to the lack of documentation of resolution on the remediation plan.

Table 4. District 5 Zone 1 Vet Center Administrative Quality Reviews

Requirement	Expected Reports	Completed Reports
Annual Administrative Quality Reviews	22	22
Administrative Quality Remediation Plans	20	18

Source: VA OIG analysis based on district 5 zone 1 documents.

Note: The OIG request was for the most recent quality reviews completed on or prior to February 28, 2021.

The OIG identified the following findings:

- District leaders did not provide documentation to demonstrate all deficiencies were corrected.
- Time frame of deficiency resolution could not be determined for all identified administrative deficiencies.

Recommendation 2

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

District Director response: Concur.

RCS requires that every Vet Center receive an administrative quality review each Fiscal Year (FY). The administrative quality review process remains a manual process; the District has implemented a monthly review process to ensure compliance. The District will monitor compliance.

Status: Ongoing

Target date for completion: April 2022

Recommendation 3

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

District Director response: Concur.

The District's manual monitoring of the administrative site visits will include a new review process into the monitoring of administrative site visits to ensure all deficiencies are tracked and resolved as specified in RCS policy as described in response 2 above.

Status: Ongoing

Target date for completion: April 2022

Critical Incident Quality Reviews

VHA's National Patient Safety Improvement Handbook states 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.⁵⁶ RCS requires the VCD to complete a crisis report within 24 hours of a serious suicide or homicide attempt or when a client dies by suicide or homicide, with notification to district and the RCS Central Office leaders within 48 hours.⁵⁷

Additionally, RCS required completion of a critical incident quality review (also known as morbidity and mortality reviews) for client safety events including serious suicide or homicide attempts, death by suicide, or homicide.⁵⁸ Critical incident quality reviews follow RCS psychological autopsy protocol to evaluate actions taken and make recommendations to improve the effectiveness of vet center suicide prevention activities.⁵⁹

To examine the quality oversight process, the OIG evaluated crisis reports and critical incident quality reviews completed for clinical critical events that occurred during the review period and interviewed district leaders.⁶⁰ A total of 17 crisis reports were reviewed. The OIG identified that 10 were completed for a suicide attempt, six for client deaths by suicide, and one for a homicide-related event.

⁵⁶ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

⁵⁷ VHA Handbook 1500.01, September 8, 2010; *RCS Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), 2021.

⁵⁸ VHA Handbook 1500.01, September 8, 2010; *RCS Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), 2021. The term critical incident quality review is not used in the 2021 directive; the 2021 directive refers to all such reviews as morbidity and mortality reviews.

⁵⁹ Isometsä, ET, Psychological autopsy studies—a review, *Eur Psychiatry*, November 2001 16(7): 379-85, accessed December 9, 2020, <https://pubmed.ncbi.nlm.nih.gov/11728849/>. "A psychological autopsy synthesizes the information from multiple informants and records." VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010. VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), 2021.

⁶⁰ VHA Directive 1500(1), 2021. Crisis reports are used to document clinical critical events in RCSnet.

Critical Incident Quality Reviews Findings and Recommendations

Crisis reports were completed for suicide attempts, some with notations from the counselor that the case was discussed with leaders and documented in the electronic record.

The OIG found district 5 zone 1 compliant with requirements for critical incident quality reviews related to the six deaths by suicide. The OIG confirmed that RCS followed the 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 no process in place to complete a critical incident quality review for serious suicide attempts.

The OIG found 7 of 10 reported suicide attempts resulted in the client being transported to a hospital for further evaluation and treatment.⁶¹ A critical quality incident review was not completed for any of the 10 serious suicide attempts, as required.

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.

⁶¹ RCS policy does not define a serious suicide attempt; in the absence of an RCS definition of a serious suicide attempt, the OIG considered the client being transferred to the hospital an indicator of a serious suicide attempt that would have met the criteria for completion of a critical incident quality review.

District 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: April 2022

COVID-19 Response

On March 11, 2020, because of the spread of COVID-19 globally, the World Health Organization declared a pandemic.⁶² On March 16, 2020, in an effort to ensure continuity of services and to reduce the risk of uninfected clients and staff acquiring COVID-19, RCS began to require vet centers to screen all visitors for COVID-19, document screening results, and refer clients with positive screens to the appropriate level of care. RCS also 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.⁶³
- Work with local VA medical facility and community health partners to determine appropriate referrals for visitors with positive screens.

On March 20, 2020, RCS issued a COVID-19 operational assessment guide focused on client needs and local environment for its operational decisions.⁶⁴ RCS also 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.⁶⁵

⁶² VA, *VHA's Office of Emergency Management COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan, Version 1.6*, March 23, 2020. "WHO Director-General's opening remarks at the media briefing on COVID-19—11 March 2020," World Health Organization, accessed on August 20, 2020, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>. Merriam Webster, *Definition of pandemic*. A pandemic is an outbreak of a disease that occurs over a wide geographic area and affects an exceptionally high proportion of the population, accessed June 23, 2021, <https://www.merriam-webster.com/dictionary/pandemic>.

⁶³ RCS-OPS-001, *Vet Center Novel Coronavirus Screening (COVID-19)*, March 16, 2020.

⁶⁴ RCS-OPS-004-COVID-19, *Readjustment Counseling Service (RCS) Operational Level Assessment*, March 20, 2020.

⁶⁵ VA, VHA Office of Emergency Management, March 23, 2020; RCS-OPS-004.

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:

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.⁶⁶

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.⁶⁷ 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.⁶⁸ An RCS memorandum issued on March 31, 2020, stated “As the population risk of COVID-19 exposure increases, so will our need to leverage telework and telehealth to meet the needs of those we serve.”⁶⁹ In addition to using VA Video Connect, RCS permitted the use of a VANTS teleconferencing for group therapy sessions.⁷⁰

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

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

⁶⁶ VA, VHA Office of Emergency Management, March 23, 2020.

⁶⁷ RCS-ADM-005, *COVID-19 Readjustment Counseling Service (RCS) Guidance for Telework and Duty Location*, March 23, 2020.

⁶⁸ RCS defines telework-ready as an employee who is eligible to telework, has an approved written telework agreement and has taken required training.

⁶⁹ RCS-OPS-005, March 31, 2020.

⁷⁰ VA Video Connect (VVC) is a VHA-online platform used for the provision of video telehealth, including mental health services. VVC uses computer webcams, smart phones, and tablets to administer telehealth-based therapy to veterans. VANTs was the Veterans Affairs National Telecommunications System used for conference calls (VANTS is no longer operational).

Emergency Planning

District leaders were as prepared as possible considering the circumstances of the pandemic but realized the importance of identifying what needed to be done. There was a level of fear involved. Although the district leaders were not ready, they were able to handle it and discussed their process for setting up virtual care as one example. A district emergency operation plan was not in place prior to the pandemic on March 11, 2020.

Communication and Field Guidance

The District Director, Deputy District Director, and Assistant District Director for Administration felt RCS Central Office field guidance related to COVID-19 was timely. The flow of information and communication was good across the district and zone with the Deputy District Director communicating to the Associate District Directors for Counseling and Administration and VCDs. Information was relayed to staff at all-hands calls held twice a week. District leaders were constantly engaging in conversation regarding the vet centers.

Supplies and Infrastructure

Sanitation supplies were adequate including face masks for staff; clients and staff maintained social distancing guidelines. When asked about plans in place to determine what needed to be cleaned and disinfected, one of the four leaders did not think plans were in place at vet centers. Although there was nothing specific in writing, district leaders reported the VCDs understood what needed to be cleaned. There were janitorial service contracts for the vet centers.

Access and Client Care—Telework and Telehealth

All staff were authorized and had the capability 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.

Client Screening and Referral

Clients were called by vet center staff 24 hours prior to scheduled appointments for screening of COVID-19 symptoms. The Associate District Director for Administration explained that instead of the Veteran Outreach Program Specialist doing outreach, the specialist contacted clients and screened them by phone. When clients screened positive for COVID-19 symptoms, referral pathways were followed.⁷¹

⁷¹ 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. The information provided in this report section is based on those interviews or the OIG’s virtual inspection.

Emergency Planning

Three of the four vet centers were adequately prepared to respond to the pandemic. The Bellingham Vet Center was not prepared initially but was shortly after the onset of the pandemic. Each vet center had an emergency plan in place at the beginning of the pandemic. Three of the four vet centers evaluated the plan’s effectiveness. The Bellingham Vet Center’s emergency plan evaluation was ongoing.

Two vet centers, Bellingham, and Tacoma, received useful pandemic-related information from state and county officials. The Central Oregon Vet Center had all its client information available on laptops, allowing for seamless care. The Wasilla Vet Center did not have adequate data. The Wasilla VCD suggested having information in the future regarding local bed availability in intensive care units in order to gauge a response.

The Central Oregon and Wasilla Vet Centers established referral mechanisms with local VA medical facilities and community health partners for clients with positive screens for COVID-19, while Bellingham and Tacoma Vet Centers referred clients to appropriate levels of care, but did not have an established a referral process with community partners. Two of four VCDs worked with community health partners and VA medical facilities.

Supplies and Infrastructure

The COVID-19 Response Plan noted routine cleaning and disinfection for frequently touched surfaces.⁷² The RCS 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.⁷³ Cleaning supplies at all four vet centers were adequate at the onset of the pandemic and a plan was in place to determine what needed to be cleaned and disinfected. Steps were taken to encourage social distancing and all four vet centers inspected had soap and water stations for hand washing.

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. Consistent with the COVID-19 Response Plan, all four vet centers were

⁷² VA, VHA Office of Emergency Management, March 23, 2020.

⁷³ RCS, *RCS Moving Forward Plan, Balancing Readjustment Counseling Services in the COVID-19 Era*, July 11, 2020.

able to provide telehealth services following the onset of the pandemic. Necessary equipment and training were available at each vet center. Clients who were unable to be seen in-person were offered alternative services such as telehealth, teleconferencing, or counseling by phone.⁷⁴

Client Screening Including Referral

Three of the four vet centers called and screened clients for COVID-19 symptoms 24 hours prior to scheduled appointments. Tacoma Vet Center staff attempted to make pre-appointment screening calls but such calls were not always possible because of staffing shortages and client care needs. Visitors and unscheduled walk-in clients at all four vet centers were screened for COVID-19 symptoms upon arrival. Clients with positive screens were referred to local VA medical facilities or community partners.

District 5 Zone 1 Staff Responses to COVID-19 Questionnaire

The OIG sent a COVID-19 voluntary questionnaire to all zone vet center staff. Of the 136 questionnaires sent, 114 (84 percent) were returned with responses. The questionnaire had a series of 14 questions about personal and patient safety, leadership communication, personal protective equipment, work assignments, telework, and employee assistance. The questionnaire included open-ended questions that asked what the vet center did well, what needed improvement, and lessons learned during the pandemic. Information in this section is based on the questionnaire responses. The OIG did not validate respondent answers for accuracy.

District leaders provided routine communication and guidance that helped with employee and client safety. The OIG determined 42 (37 percent) respondents were given new work assignments during the pandemic (for example, telehealth or other). Most were offered telework, completed telework agreements, and teleworked during the pandemic. Of 112 respondents, employee assistance or other types of assistance were available for 86 (77 percent).⁷⁵ Qualitative responses to “what went well” included enactment of COVID-19 safety procedures, transition to telework, and implementation of telehealth mechanisms to continue to provide care to clients.

Respondents’ lessons learned included the effectiveness of telehealth services including preference of receiving services through telehealth platforms, the importance of remaining flexible/adaptable to a changing situation and the importance of effective leadership during a pandemic situation.

COVID-19 Response Review Conclusion

In general, district leaders reported supplies and infrastructure were adequate and continued to be monitored at the time of the OIG inspection. Precautionary measures were implemented with COVID-19 screenings for vet center visitors. Visitors with positive screenings were referred to local

⁷⁴ VA, VHA Office of Emergency Management, March 23, 2020.

⁷⁵ Two of 114 COVID-19 questionnaires that were returned did not include a reply to the question “Was Employee Assistance and/or other assistance services made available to you during the pandemic?”

care pathways. Telework expanded and vet centers increased their 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. Safe social distancing was observed 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. Most employees indicated that the implementation of telehealth and telework was a positive action for flexibility with alternative modes of care.

Suicide Prevention

The VA *National Suicide Data Report* published in the fall of 2018 found that in 2016, the suicide rate was 1.5 times greater for veterans than for non-veteran adults.⁷⁶ 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.”⁷⁷ 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.”⁷⁸

RCS was identified as an important part of VA’s overall suicide prevention strategy.⁷⁹ 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. 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.⁸⁰

The support VA medical center is responsible for identifying high risk individuals and activating a flag in the veteran’s VA electronic health record, which is visible to RCS counselors. Per VHA,

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

⁷⁶ 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.

⁷⁷ 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.

⁷⁸ VA Office of Mental Health and Suicide Prevention, “National Strategy for Preventing Veteran Suicide 2018–2028.”

⁷⁹ 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.

⁸⁰ Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017.

determined to be at high risk for suicide are provided with follow up for all missed mental health and substance abuse appointments.⁸¹

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—RCS shared high risk for suicide clients (*zone-wide*)
- Access (*four selected vet centers*)
- Care coordination and collaboration with VA medical facilities (*four selected vet centers*)
- High risk suicide flag client disposition (*four selected vet centers*)
- Crisis plans (*four selected vet centers*)
- Root cause analysis participation and feedback (*four selected vet centers*)⁸²

Psychosocial Assessment and Lethality Risk Assessments (Zone-Wide)

RCS states, “the client record is one of the most important components of clinical practice. Properly maintained, the clinical record reflects the quality of treatment.”⁸³ 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.⁸⁴ Psychosocial assessments are used to gather information about the client “presenting issues and level of functioning” to complete a clinical evaluation.⁸⁵

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.”⁸⁶ An RCS Central Office leader reported that effective October 2020, RCS replaced the lethality risk assessment within the psychosocial assessment with a “Comprehensive Suicide Risk Assessment and Safety Plan.” The new

⁸¹ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, amended November 16, 2015.

⁸² None of the four selected vet centers had clients requiring root cause analysis; therefore, this topic is not reviewed in this report.

⁸³ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Client Records*, November 23, 2010.

⁸⁴ RCS-CLI-003; VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Client Records*, November 23, 2010; VHA Directive 1500(1), 2021.

⁸⁵ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Client Records*, November 23, 2010; VHA Directive 1500(1), 2021.

⁸⁶ RCS-CLI-003.

assessment follows VA/DoD Clinical Practice Guidelines by utilizing common terminology used for suicide risk evaluation and consultation practices that are familiar to other clinical providers.⁸⁷

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 March 1, 2020, through February 28, 2021.⁸⁸ The samples included 60 client records with five or more visits, and 40 clients with four or less visits.⁸⁹ The OIG reviewed the 60 client records with five or more visits and assessed clients only if there were five or more individual counseling visits (excluding clients not seen during the review period, bereavement cases, family member seeking services, client deployments, and administrative visits only). Client records 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. The OIG reviewed 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.⁹⁰ The OIG team used a 90 percent benchmark to evaluate electronic client records for compliance with selected RCS requirements for psychosocial assessments (including intake and military histories) and lethality risk assessments.

The OIG was able to determine intake and military history completion through a RCSnet record review. However, the OIG was unable to determine when intake and military sections were

⁸⁷ *Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services (RCSnet)*, September 19, 2020.

⁸⁸ The sub-population size was randomly selected and weighted for the two samples.

⁸⁹ RCS-CLI-003. 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 was reviewed for completion of the intake, military history, and lethality risk assessment. The sample of 40 client records was used to evaluate completion of the lethality risk assessment as this client group had less than five visits and; therefore, completion of the psychosocial assessment was not required.

⁹⁰ On October 11, 2020, RCS implemented a new risk assessment in the RCSnet individual intake procedural section. The risk assessment was subdivided into two interrelated categories: acute and chronic. Clinical staff determine level of risk as either low, intermediate, or high. For clients seen 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 on or after October 12, 2020, the OIG reviewed clinical rationales for inclusion of narrative sections from the new RCS risk assessment that assessed for suicidal ideation, suicidal history, risk and protective factors, and warning signs. Timely completion refers to completion of the note or assessment within two business days of client contact.

completed. The OIG was unable to evaluate if intake and military histories were completed by the fifth visit as required.

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

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

- A full lethality assessment
- The lethality portion of the intake assessment
- The new risk assessment⁹¹

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

Overall, the OIG found district 5 zone 1 vet centers noncompliant with requirements for completion of intake and lethality assessments (see table 5).⁹²

⁹¹ The lethality portion of the intake assessment and the new risk assessment includes creation dates but does not have completion dates in RCSnet or the database.

⁹² Based on statistical analysis, the OIG determined there was not a finding for military history.

**Table 5. District 5 Zone 1 Vet Centers RCSnet Client Record Review
March 1, 2020–February 28, 2021**

Electronic Client Record Section	Number of Client Records Reviewed	Estimated Compliance (%) Completed Zone-Wide	95% Confidence Interval*
Intake	56	37.5	(25.0, 50.0)
Military History	56	80.4	(69.6, 89.8)
Lethality Risk Assessment	99	18.7	(11.3, 26.5)

Source: VA OIG district 5 zone 1, RCSnet electronic 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 vet center counselors did not consistently complete following:

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

Recommendation 5

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

District Director response: Concur.

The District provided training to the field on the steps necessary to ensure the proper completion and electronic monitoring of intake assessments within RCSNet in FY 2021. The Vet Center Director and District leadership will monitor compliance.

Status: Ongoing

Target date for completion: April 2022

Recommendation 6

The District Director ensures lethality risk assessments are completed on the first clinical visit and monitors compliance across all zone vet centers.

District Director response: Concur.

The District provided training to the field on electronic monitoring of risk assessment completed in FY 2021. The Vet Center Director and District leadership will monitor compliance.

Status: Ongoing

Target date for completion: April 2022

Recommendation 7

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 has provided training in FY 2021 to the field regarding the requirements for, and completion of, intake assessments, military histories, and lethality risk assessments. The Vet Center Director and District leadership will monitor compliance.

Status: Ongoing

Target date for completion: April 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 Memorandum of Understanding, there is a “shared responsibility for suicide prevention among the Office of Mental Health and Suicide Prevention (OMHSP), Suicide Prevention Coordinators (SPC), and Readjustment Counseling Service (RCS).”⁹³ Further, RCS clinical staff are required 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.⁹⁴ 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

⁹³ Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017.

⁹⁴ Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017.

support VA medical facility suicide prevention coordinator for all clients with lethality assessment changes.⁹⁵

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 39 RCS clients who were flagged as high risk for suicide by the support VA medical facility and who were seen at district 5 zone 1 vet centers from March 1, 2020, through December 31, 2020, following the placement of the high risk flag.⁹⁶ 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:

- 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
 - Adherence to confidentiality requirements if consultation and coordination occurred.⁹⁷
- Timely notification to the support VA medical facility suicide prevention coordinator if client posed a significant safety risk⁹⁸
 - Adherence to confidentiality requirements if notification occurred.

⁹⁵ RCS-CLI-003. "Vet Center counselors seek consultation from the Vet Center Director, the External Clinical Consultant (assigned by the nearest VAMC), the VHA Suicide Prevention Coordinator, or any combination thereof, for all clients who are assessed as at mild-risk or greater, consistent with the most recent publication of VHA Directive 1500." Effective October 12, 2020, RCS issued requirements for completion of the risk assessment in accordance with the publication of VHA Directive 1500 (1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021, which states "For individuals assessed to be at Intermediate to High-Risk either acute, chronic, or both: (a) The Vet Center counselor will seek consultation on the case through the Vet Center Director, ADD/C, VA assigned External Clinical Consultant, and/or other VHA mental health professionals to include the Suicide Prevention Coordinator at the support VA medical facility." The OIG evaluated both the old lethality assessment and the new risk assessment.

⁹⁶ There was a total of 39 clients at high risk for suicide during this time period in zone 1; the whole population was reviewed. The OIG extracted all high risk for suicide (newly activated and reactivated) clients from all district 5 zone 1 vet centers associated with support VA medical facilities and cross referenced the clients with RCSnet database to identify shared clients. Data extraction period was adjusted (shortened by two months from review period) to allow time for RCS clinical staff to complete required care coordination following high risk flag placement, lethality status changes, and crisis events.

⁹⁷ 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."

⁹⁸ 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.

- Consultation with the VCD, external clinical consultant, or suicide prevention coordinator within 30 days of lethality assessment change⁹⁹
- All progress notes within the review period in the electronic client record documenting suicide or homicide completions, attempts, gestures, or interventions exist, and whether each identified progress note had a corresponding crisis report¹⁰⁰

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

The OIG found vet centers in district 5 zone 1 were not compliant with requirements of coordination of shared clients for suicide prevention and intervention. The OIG excluded 4 of 39 client records. Exclusions included clients with closed cases and one client who was not seen at a vet center during the review period.

The OIG found that 23 of 35 records reviewed in district 5 zone 1 (66 percent) were compliant with RCS requirements for consultation and communication for shared clients with support VA medical facilities as noted in table 6 below.

⁹⁹ The OIG utilized 30 days as the timeframe within which consultation should occur. As noted above, the OIG evaluated both the pre-October 12, 2020 and post-October 12, 2020 lethality assessments.

¹⁰⁰ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), 2021.

**Table 6. District 5 Zone 1 Vet Centers RCSnet Client Record Review
Suicide Prevention and Intervention—March 1, 2020–February 28, 2021**

Review Area	Number of Electronic Records Reviewed	Percent Compliant (%)
Vet Center staff consulted with and coordinated services with the shared VA medical facility for care of high risk clients.	35	66
Vet Center staff consulted with and coordinated services with the shared VA medical facility following confidentiality requirements.	35	29
The client posed a significant safety risk, and the counselor provided timely notification to the suicide prevention coordinator at the support VA medical facility.	20	65
A counselor assigned or documented a lethality change of mild or greater, and the counselor consulted with the VCD, external clinical consultant, or VHA suicide prevention coordinator at the support VA medical facility.	31	32
Progress notes documenting suicide or homicide completions, attempts, gestures, or interventions exist, and each progress note has a corresponding crisis report.	22	41

Source: VA OIG district 5 zone 1, RCSnet electronic record reviews.

For the clients reviewed, the OIG identified the following findings:

- Vet centers did not consistently consult or coordinate with VA medical facilities on shared clients who were deemed high risk for suicide.
- For clients where coordination occurred with VA medical facilities, vet centers did not consistently follow confidentiality requirements.
- For clients who posed a significant safety risk, the counselor did not consistently provide timely notification to the suicide prevention coordinator at the VA medical facility.
- For clients with a documented lethality change of mild or greater, vet centers did not consistently consult with a VCD, external clinical consultant, or VA medical facility suicide prevention coordinator.
- Vet centers did not consistently complete a crisis report for clients when progress notes indicated a death by suicide or homicide, attempt, gesture, or intervention existed.

Recommendation 8

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.

District Director response: Concur.

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. It is important to note that unless there is a psychiatric emergency or imminent concern for safety, RCS privacies require authorization by the client for coordination. The reconciliation of these lists will be monitored by the District Associate District Director Clinical (ADDC) to ensure compliance.

Status: Ongoing

Target date for completion: April 2022

Recommendation 9

The District Director verifies clinical staff follow confidentiality requirements when consulting and coordinating care with the support VA medical facility for shared clients at 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 as appropriate. Compliance is monitored through the VCD's monthly RCSNet report provided to the ADD/C for oversight.

Status: Ongoing

Target date for completion: April 2022

Recommendation 10

The District Director confirms clinical staff make timely notification to the suicide prevention coordinator at the support Veterans Affairs medical facility for clients with significant safety risks and monitors compliance across all zone vet centers.

District Director response: Concur.

RCS has published VHA Directive 1500(1) dated January 26, 2021. The Directive sets in policy Vet Center coordination for suicide prevention to include the VA Medical Center clinical liaison to coordinate suicide prevention activities. The Directive also requires the Vet Center to coordinate with the Suicide Prevention Coordinator when referring clients that are at high-risk and referred to the VA Medical Center to support the referral and coordinate services.

Status: Complete

Target date for completion: N/A

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

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 Office established a Post-Crisis Working Group to establish appropriate steps vet center staff should take following a crisis or lethality change. The Group developed a 'Quick Reference Guide' which spells out the expectations for consultation. This new Guide, along with other new expectations have been presented to clinical staff in the District. As a follow-on to the Group's work, clinical staff are assigned, on a rotating basis, to review charts to ensure compliance with these expectations.

Status: Ongoing

Target date for completion: November 2021

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. Crisis reports are logged for suicide attempts or completions in the District. Coordination with District ADD/C’s occur shortly after the log a crisis is completed and the District monitors compliance through the completion of a case review, or a determination is made and documented in RCSNet. The District will continue to monitor compliance.

Status: Ongoing

Target date for completion: April 2022

Vet Center-Specific Suicide Prevention

The remainder of the report provides inspection findings at the following randomly selected vet centers in district 5 zone 1:

- Bellingham Vet Center, Washington
- Central Oregon Vet Center, Bend
- Tacoma Vet Center, Washington
- Wasilla Vet Center, Alaska

Access

In the Memorandum of Understanding, RCS indicates that the provision of veterans outside of regular business hour to include appointment availability in the mornings, evenings, and weekends at all vet centers is a core value.¹⁰¹ 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 councils.¹⁰² The Memorandum of Understanding outlines the following responsibilities:

¹⁰¹ Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017.

¹⁰² VHA Directive 1500(1), 2021; VHA Handbook 1160.01. Mental health councils at “Each VA medical center 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.”

- Standardization of a communication process between RCS and suicide prevention coordinators
- Sharing lists of veterans at high risk for suicide between VA medical facilities and RCS
- Timely notification of clients with significant safety risks to suicide prevention coordinators¹⁰³
- 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 of suicide
- Identification of those who were receiving RCS counseling services¹⁰⁴

The OIG interviewed VCDs and requested the following:

- Evidence of the VCD's or designee's participation on VA medical facility mental health council meetings
- Office of Mental Health and Suicide Prevention lists received
- VA medical facility high risk for suicide flag lists received
- Documents supporting a standardized communication process with the support VA medical facility suicide prevention coordinator

High Risk Suicide Flag Client Disposition

Isolation and social disconnectedness may leave some clients more vulnerable to self-harm, particularly those who are identified as being high risk for suicide.¹⁰⁵ 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.¹⁰⁶ As of May 11, 2020, VCDs are required to review the site monthly for clients seen at their vet center, determine if outreach is needed, and document a disposition.

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 February 28, 2021, to evaluate compliance with RCS requirements for high risk clients.

¹⁰³ Timely was defined by the OIG as notification that occurs as soon as pertinent information that would promote safety is available.

¹⁰⁴ Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017.

¹⁰⁵ RCS-CLI-006, *High Risk Flag Suicide Outreach*, April 27, 2019.

¹⁰⁶ 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>. RCS-CLI-006, April 27, 2019.

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.¹⁰⁷

RCS requires several preparatory actions to reduce the occurrence of a crisis event and minimize the severity should one occur. One requirement is for vet centers to have a written plan addressing how staff responds to crisis situations (crisis plan).¹⁰⁸ The OIG requested and reviewed crisis plans to assess for compliance.

Vet Center-Specific Suicide Prevention Findings and Recommendations

The OIG found the vet centers complied with nontraditional hours allowing clients easier access to services. None of the four vet centers had shared clients with support VA medical facilities who died by suicide during the OIG review period; therefore, vet center staff did not participate in root cause analysis panels. The OIG found issues related to

- vet center participation in mental health council meetings,
- receipt of the Office of Mental Health and Suicide Prevention list identifying veterans at increased predictive risk for suicide,¹⁰⁹
- receipt of the VA medical facility high risk suicide flag list,
- monthly review of the High Risk Suicide Flag SharePoint site,
- standardized communication process between vet centers and suicide prevention coordinators at support VA medical facilities, and
- crisis plans.

¹⁰⁷ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; RCS-CLI-003.

¹⁰⁸ *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; RCS-CLI-003.

¹⁰⁹ Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH-VET) identifies veterans who have a higher risk for suicide through predictive analytics.

Mental Health Council

VA medical facility mental health council meetings comprise essential mental health disciplines and specialty programs. VA medical facilities “are encouraged to include representation from Readjustment Counseling Centers (Vet Centers) in this Council.”¹¹⁰ The mental health councils are responsible for

- proposing program improvement and innovation,
- coordinating communication, and
- evaluating mental health policy impact.¹¹¹

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.”¹¹² Although RCS requires participation, the OIG did not find a policy or guidance specifying how attendance is tracked and requested evidence of attendance.

The Central Oregon VCD reported attending all meetings during the review period but was unable to provide evidence demonstrating participation on the VA medical facility Mental Health Council. Wasilla staff attended the meetings and provided evidence supporting attendance. Bellingham and Tacoma Vet Centers provided documentation from the support VA medical facility that mental health council meetings were discontinued around 2015-2016.

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 the mental health council for the Central Oregon Vet Center and takes actions as indicated to ensure compliance with Readjustment Counseling Service requirements.

¹¹⁰ VHA Handbook 1160.01.

¹¹¹ VHA Handbook 1160.01.

¹¹² VHA Handbook 1500.01, September 8, 2010; *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; RCS-CLI-003; VHA Directive 1500(1), 2021.

District Director response: Concur.

The Deputy District Director is working with VISN 20 staff to ensure all VHA support facilities understand the requirement to have Vet Center representation on the mental health council as members. District will continue to monitor this situation to ensure compliance.

Status: Ongoing

Target date for completion: April 2022

Office of Mental Health and Suicide Prevention List

The Office of Mental Health and Suicide Prevention is responsible for sharing with RCS a monthly list of veterans who have an increased predictive risk for suicide, so vet centers can identify clients on the list who are receiving counseling services and better coordinate care with medical centers.¹¹³ The OIG found three of the four vet centers were noncompliant with receiving the monthly list of veterans who had an increased predictive risk for suicide from the Office of Mental Health and Suicide Prevention.

The Wasilla VCD reported sitting in on weekly mental health calls with the support VA medical facility and was updated on clients that were high risk during the calls. The VCD began receiving a list in August 2020 after working with the suicide prevention coordinator to meet requirements outlined in the Memorandum of Understanding, but none of the vet centers received the list from the Office of Mental Health and Suicide Prevention as required.¹¹⁴

In its inaugural Vet Center Inspection Program 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.

Therefore, the OIG does not make a recommendation on the matter in this report.¹¹⁵

¹¹³ 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. Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017.

¹¹⁴ Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017.

¹¹⁵ VA OIG, *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021.

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 that may include initiating services at vet centers and vet center referrals to VA medical facilities when appropriate.¹¹⁶

The OIG found the four vet centers were not receiving the flagged high risk for suicide list from the Office of Mental Health and Suicide Prevention as required.¹¹⁷ The Tacoma VCD reported receiving the list from the support VA medical facility suicide prevention coordinator, not the Office of Mental Health and Suicide Prevention, in November and December 2019; however, the vet center was removed from the mailing list and did not begin receiving the client list again until March 2021.

The Wasilla VCD began receiving a list in August 2020 after working with the support VA medical facility suicide prevention coordinator but did not receive it from the Office of Mental Health and Suicide Prevention as outlined in the Memorandum of Understanding.¹¹⁸

In its inaugural Vet Center Inspection Program 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 with the Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding.

Therefore, the OIG does not make a recommendation on the matter in this report.¹¹⁹

RCS High Risk Suicide Flag SharePoint

On May 11, 2020, RCS required VCDs to review a national SharePoint site that lists client designated as high risk for suicide by VHA facilities who were active at vet centers within the past 12 months. Once reviewed, VCDs were responsible for determining a plan of action for clients on the list with staff and documenting a disposition on the SharePoint site. The Bellingham VCD reported only reviewing the SharePoint site every couple of months and not being aware of the requirements to

¹¹⁶ Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017.

¹¹⁷ Two of the four vet centers received the list but not from the Office of Mental Health and Suicide Prevention as required.

¹¹⁸ Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017.

¹¹⁹ VA OIG, *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021.

review monthly nor receiving training. The remaining three VCDs were in compliance with the requirement.

Recommendation 14

The District Director determines reasons for noncompliance with High Risk Suicide Flag SharePoint site requirements and the tracking of continuity of care for clients with a high risk suicide flag at the Bellingham Vet Center, takes action to ensure requirements are met, and monitors compliance.

District Director response: Concur.

Training has been completed for VCD's and clinical staff on the requirements associated with the High Risk Suicide Flag (HRSF) lists which come out each month. Since June 2021, Vet Center Directors have been responding to the monthly HRSF list. District staff are monitoring completion of these lists on a monthly basis.

Status: Ongoing

Target date for completion: April 2022

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 the relationship with the Office of Mental Health and Suicide Prevention, suicide prevention coordinators, and RCS.¹²⁰

The OIG found while each of the vet centers inspected did have informal contact with the suicide prevention coordinators at the support VA medical facility, none of the four vet centers had a standardized communication process with the support VA medical facility suicide prevention coordinator whether that was with a local Memorandum of Understanding or standard operating procedure outlining the process. The Bellingham VCD stated staff communicated with the suicide prevention coordination when needed, but typically did not have high risk cases. The Central Oregon VCD reported having a process for communication with the suicide prevention coordinator; however, did not have a formal written process. The Tacoma and Wasilla VCDs reported having ongoing communication with the suicide prevention coordinator; however, did not have a formal written process in place.

¹²⁰ Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service, 2017.

In its inaugural Vet Center Inspection Program 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.

Therefore, the OIG does not make a recommendation on the matter in this report.¹²¹

Crisis Plan

The Central Oregon, Tacoma, and Wasilla Vet Centers had a written crisis plan detailing staff response in crisis situations. At the time of the inspection, the Bellingham VCD reported being knowledgeable of how to respond in crisis situations and not having a written plan because one had not been needed yet.

Recommendation 15

The District Director determines reasons the Bellingham Vet Center did not have a written crisis plan, ensures requirements related to crisis plans are met and monitors compliance.

District Director response: Concur.

The Vet Center crisis action plan at the Bellingham Vet Center is under revision.

Status: Ongoing

Target date for completion: November 2021

Consultation, Supervision, and Training

Each vet center is assigned a clinical liaison and an external clinical consultant from the support VA medical facility.¹²² Clinical liaisons help coordinate care for shared clients with the support VA medical facility whereas external clinical consultants provide guidance on complex and shared cases.¹²³

Vet centers are composed of small multidisciplinary teams, are community-based, and traditionally located outside of VA medical facilities. Vet center teams consist minimally of a VCD, an office

¹²¹ VA OIG, *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021.

¹²² VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), 2021.

¹²³ *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; RCS-CLI-003.

manager, and two or more counselors.¹²⁴ Vet centers are required to have at least one VHA-qualified licensed mental health professional on staff (see table 7).¹²⁵

VCDs are accountable for the clinical and administrative oversight of readjustment counseling services that include specific therapies:

- Individual and group counseling
- Family counseling for military-related issues
- Bereavement counseling for family members
- Counseling for conditions related to military sexual trauma¹²⁶

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 that 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.¹²⁷ On October 15, 2020, VHA updated the suicide prevention training course and refresher requirements for clinicians.¹²⁸

Military sexual trauma is reported to VA medical facility 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.¹²⁹

RCS requires vet center staff to have a basic level of cross training to promote its mission of assisting veterans' post-war social and psychological readjustment, and to enhance small team functionality. Vet center staff are required to complete annual in-service training that includes cross training in 16

¹²⁴ 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."

¹²⁵ *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), 2021.

¹²⁶ VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), 2021. The team leader is responsible for vet center operations including staff supervision, administrative duties, and clinical programs. The OIG learned in December 2019 during communications with vet center and district office leaders that the team leader position was referred to as a director.

¹²⁷ VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017. VA Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*. An average of 18 veterans died by suicide daily in 2018. Of those 18 veterans, seven had recently used a VA medical facility in the year of, or the year prior to their death.

¹²⁸ VHA Memorandum, *Agency-Wide Required Suicide Prevention Training (VIEWS 3346983)*, October 15, 2020.

¹²⁹ VHA Directive 1115.01, *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017.

core curriculum topics.¹³⁰ 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 (see table 7).¹³¹

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

- Clinical liaison consultation
- External clinical consultation
- VHA-qualified mental health professional on staff
- 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, if unavailable, the private sector, to provide a minimum of four hours per month of consultation. The external clinical consultants are required to be licensed and a VHA-qualified mental health professional 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 case reviews and assist vet center clinicians in the treatment of complex and emergent veteran cases.¹³²

¹³⁰ 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.

¹³¹ RCS, *Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), 2021.

¹³² *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; RCS-CLI-003.

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

- Vet center staffing spreadsheets
- Vet center oversight trackers
- Documentation demonstrating external clinical consultation of four hours a month¹³³

Internal Licensed Independent Practitioners

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 March 1, 2020, through February 28, 2021.
2. If the vet center had more than one VHA-qualified mental health provider on staff,
 - a. the OIG randomly selected one individual, and
 - b. requested credentialing documentation of that individual from RCS's Centralized Human Resource Management Organization.

Supervision

RCS requires VCDs use supervision and staff meetings to accomplish objectives related to staff cohesion, problem solving, case coordination, and collaboration with VHA. On a weekly basis, the VCD is required to complete one hour supervision with clinical staff and conduct staff meetings composed of vet center staff to accomplish the objectives.¹³⁴ If the VCD is not a VHA-qualified mental health professional, a clinical designee who is licensed will provide individual supervision to clinical staff.¹³⁵ VCDs must also complete a monthly chart audit of 10 percent of every counselor's active client records.

The OIG evaluated supervision through interviews with the four VCDs and reviewed documentation of:

¹³³ A staffing spreadsheet was requested from each vet center to provide information on appointed liaisons, consultants, and their associated service lines. The OIG also retrieved the oversight tracker from RCSnet populated by each vet center documenting current VA medical facility support staff.

¹³⁴ RCS-CLI-003, 2019; VHA Directive 1500(1), 2021. The 2021 directive requires "Providing individual supervision to all Vet Center staff, counselors, outreach workers, and office managers on an ongoing basis."

¹³⁵ *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; RCS-CLI-003.

- Weekly supervision for all counselors on staff from December 1, 2020, through February 28, 2021 (13 weeks per counselor), and
- Monthly chart audits of 10 percent of each counselor’s caseload from March 1, 2020, through February 28, 2021 (12 months per counselor).

Training

In December 2017, VHA clinical staff (including RCS staff) were mandated to annually complete Suicide Risk Management Training for Clinicians and non-clinical staff were required to complete the S.A.V.E. training through the VHA Employee Education System.¹³⁶ Non-clinical staff were required to complete S.A.V.E. or S.A.V.E. refresher training, and clinical staff were required to complete Suicide prevention for Clinicians training within 90 days of entering their position and annually thereafter.¹³⁷ In October 2020, VHA updated requirements for all clinicians implementing Skills Training for Evaluation and Management of Suicide to be completed within 90 days of hire or as an annual refresher training.¹³⁸

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 position.¹³⁹ All vet center staff, regardless of position, are required to complete in-service training annually.¹⁴⁰

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 March 1, 2020, through February 28, 2021.¹⁴¹

Consultation, Supervision and Training Findings and Recommendations

The OIG found all four vet centers had at least one licensed and credentialed VHA-qualified mental health professional on staff. The OIG found deficiencies in other areas (see table 7):

- Clinical liaison assignment
- External clinical consultant assignment
- External clinical consultation hours

¹³⁶ S.A.V.E. refers to “Signs,” Ask,” “Validate,” “Encourage” and “Expedite,” and is a training video collaboration with VA and PsychArmor Institute.

¹³⁷ VHA Directive 1071.

¹³⁸ VHA Memorandum, *Agency-Wide Required Suicide Prevention Training (VIEWS 3346983)*, October 15, 2020.

¹³⁹ VHA Directive 1115.01.

¹⁴⁰ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), 2021.

¹⁴¹ Talent Management System is a computer program used by VA staff for education and other services.

- Supervision requirements
- Required monthly 10 percent audits of records
- Staff training completion

Table 7. District 5 Zone 1 Consultation, Supervision, and Training

Elements Reviewed	Findings*			
	Bellingham Vet Center	Central Oregon Vet Center	Tacoma Vet Center	Wasilla Vet Center
VHA Clinical Liaison				
Assigned	Noncompliant	Compliant	Noncompliant	Compliant
Social Work or Mental Health Service Department	N/A	Compliant	N/A	Compliant
External Clinical Consultant				
Assigned	Noncompliant	Compliant	Compliant	Compliant
Licensed	N/A	Compliant	Compliant	Compliant
Four Hours a Month of External Clinical Consultation	N/A	Noncompliant	Noncompliant	Noncompliant
VHA-Qualified Mental Health Provider				
On Staff	Compliant	Compliant	Compliant	Compliant
Licensed	Compliant	Compliant	Compliant	Compliant
Credentialed	Compliant	Compliant	Compliant	Compliant
Supervision				
Monthly Audit (10%) of each Counselor's Caseload March 1, 2020 – February 28, 2021	Noncompliant	Noncompliant	Noncompliant	Noncompliant
Clinical Supervision (one hour a week) December 1, 2020 – February 28, 2021	Noncompliant	Noncompliant	Noncompliant	Noncompliant
Staff Training[†]				
Annual Suicide Prevention for Clinical Staff	Compliant	Noncompliant	Noncompliant	Noncompliant
Annual Suicide Prevention for Non-Clinical Staff	Compliant	Noncompliant	Noncompliant	Noncompliant
Military Sexual Trauma Training	Noncompliant	Noncompliant	Noncompliant	Compliant
Annual In-service Training	Noncompliant	Noncompliant	Noncompliant	Noncompliant

Source: VA OIG analysis of district 5 zone 1 documents received and interview results.

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

[†] District 5 held virtual annual training for vet center directors, office managers, and veteran outreach program specialists only during fiscal year 2021. Counselors completed training in the community.

The Bellingham Vet Center did not have a clinical liaison nor external clinical consultant appointed from its support VA medical facility for the review period. The Bellingham VCD reported being aware of these requirements and in the past, hiring an external clinical consultant from the community. The VCD stated being directed by district office to stop using the community provider for budget reasons approximately four years prior to the inspection. Two VCDs were assigned to provide monthly external clinical consultation. The Associate District Director for Counseling confirmed not hiring community external clinical consultants for financial reasons and allowing vet centers to use other VCDs as consultants in the absence of one from the support VA medical facility. The OIG was informed that it was not a practice for the district office to periodically check for availability of a VA medical facility consultant if one was not appointed.

As of April 2021, the Bellingham Vet Center was assigned a clinical liaison and external clinical consultant from the support VA medical facility; therefore, the OIG does not make a recommendation on this matter.

Clinical Liaison

The Tacoma Vet Center did not have a clinical liaison appointed. The VCD reported not being aware of the requirement and only aware of needing an external clinical consultant.

Recommendation 16

The District Director determines reasons for noncompliance with the appointment of a clinical liaison at the Tacoma Vet Center, ensures assignment of a liaison, and monitors compliance.

District Director response: Concur in principle.

With the recent publishing of VHA Directive 1500(1) the District Office has been coordinating with our VA medical support facilities to validate the names of the administrative and clinical liaisons, as well as, clinical consultant. Since the OIG visit it has been confirmed by VA Puget Sound that the assigned clinical consultant is also the clinical liaison at the Tacoma Vet Center.

Status: Complete

Target date for completion: N/A

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

External Clinical Consultant

RCS requires four hours of external clinical consultation monthly.¹⁴² The OIG found all four VCDs documented consultation hours. However, none of the vet centers met the required four hours of

¹⁴² VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010. RCS-CLI-003.

external clinical consultation per month. The Bellingham VCD reported having consultation for four hours a month; however, it was not correctly documented. The Central Oregon VCD documented consultation meetings in fiscal year 2020, but did not keep attendance and the OIG was unable to validate consultation hours. The Tacoma VCD stated that there were times when the external clinical consultant did not attend meetings, but these hours were not made up, instead they called the consultant as needed. The Wasilla VCD did not make up hours when consultants were on leave and did not have a coverage plan at the time of the inspection.

Recommendation 17

The District Director determines reasons a process for completing and tracking four hours of external clinical consultation per month did not occur at the Bellingham, Central Oregon, Tacoma, and Wasilla 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: April 2022

Supervision

RCS policy requires regularly scheduled weekly supervision to help with staff cohesion, problem solving, client case coordination, and the coordination of care with VA medical facilities. 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.¹⁴³

The OIG found that all four vet centers were noncompliant with the provision of weekly staff supervision. The Bellingham VCD was conducting group supervision but did not document the group participants. The Associate District Director for Counseling reported that the district expectation for supervision was that it be conducted individually and for one hour a week. Group supervision would be considered a clinical team meeting and would not meet this requirement. The Central Oregon VCD had 31 of 39 weeks of documented weekly supervision. The VCD stated supervision was scheduled weekly; however, meetings were not rescheduled if missed. The Tacoma VCD had 60 of 91 weeks of documented weekly supervision. The VCD stated supervision was not completed when client care superseded the requirement or when staff was on leave. The supervision was not rescheduled in such instances. The Wasilla VCD had 15 of 26 weeks of documented weekly

¹⁴³ RCS-CLI-003.

supervision.¹⁴⁴ The VCD reported having scheduled weekly supervision but did not reschedule supervision when missed. The VCD also stated that an open-door policy allowed for regular daily contact and informal supervision which resulted in at least one hour per week.

Recommendation 18

The District Director determines reasons for noncompliance with staff supervision provided by vet center directors at the Bellingham, Central Oregon, Tacoma, and Wasilla Vet Centers, ensures staff supervision occurs as required, and monitors compliance.

District Director response: Concur in principle.

With the publication of the new VA Director 1500(1) in January 2021 the requirement for one hour of supervision weekly has been removed.

Status: Complete

Target date for completion: N/A

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

Monthly Audit

Oversight is one of the main responsibilities of a VCD to ensure quality clinical services. A methodology used 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.¹⁴⁵ The OIG found that the Bellingham, Central Oregon, Tacoma, and Wasilla VCDs were noncompliant in conducting case audits.

Bellingham, Tacoma, and Wasilla VCDs completed audits for most months in the review period; however, the number of active client caseloads was missing from the audit forms. The Tacoma VCD stated there was no way to determine prior caseload numbers in RCSnet, another noted that caseload numbers could not be determined from RCSnet. Absent the total number of active clients per counselor, the OIG was unable to determine if 10 percent of caseloads was reviewed.

The Bellingham VCD provided the RCSnet audit report as supplemental evidence; however, stated the RCSnet audit report did not accurately reflect caseload numbers. The Tacoma VCD reported being aware of missing two months of audits and indicated not documenting some of the audits completed. The Wasilla VCD documented monthly chart audits throughout the review period for each counselor. The VCD reported examining the master client list to determine the number of

¹⁴⁴ 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.

¹⁴⁵ RCS-CLI-003.

caseload reviews needed to meet the 10 percent but did not document this number. The Central Oregon VCD completed audits but missed two months in the review period due to unspecified scheduling conflicts. The VCD documented caseload numbers, however, rounded down to determine the number of charts to be audited and therefore did not meet the 10 percent requirement for many months.

Recommendation 19

The District Director verifies and determines reasons for noncompliance with monthly RCSnet chart audits at the Bellingham, Central Oregon, Tacoma, and Wasilla Vet Centers, ensures chart audits are completed as required, and monitors compliance.

District Director response: Concur.

Recent updates to RCSNet have made tracking this requirement easier and Vet Center Directors have been trained on the requirements associated with Chart audits. The District will monitor compliance.

Status: Ongoing

Target date for completion: April 2022

Staff Training

RCS requires completion of mandatory trainings for both clinical and non-clinical staff. The OIG found clinical and non-clinical staff at the Central Oregon, Tacoma, and Wasilla Vet Centers were noncompliant with completion of annual suicide prevention and refresher trainings. Additionally, clinical staff at the Bellingham, Central Oregon, and Tacoma Vet Centers were noncompliant with completing military sexual trauma training. Staff at all four vet centers were noncompliant with completing annual in-service training in fiscal year 2020.¹⁴⁶ All four VCDs had the capability to review assigned trainings, but had no knowledge of which trainings were required.

The District Director told the OIG that annual in-service training for fiscal year 2020 was only provided to VCDs, office managers, and veteran outreach program specialists. Counseling staff were not offered in-service training and were given the option to attend community trainings. The OIG requested written guidance from district leaders verifying annual in-service changes, but no documentation was provided. All four VCDs reported annual in-service training for counselors and veteran outreach program specialists was not offered or required through the district for fiscal year 2020.

¹⁴⁶ All face-to-face training conferences were canceled in FY20 due to COVID-19; virtual annual in-service trainings were conducted for Vet Center Directors, office managers, and veteran outreach program specialists.

Recommendation 20

The District Director determines reasons employees at the Bellingham, Central Oregon, Tacoma, and Wasilla Vet Centers did not complete required trainings, 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: April 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.”¹⁴⁷ 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.¹⁴⁸

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 the environment, general safety, and 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, 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.¹⁴⁹

¹⁴⁷ VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.

¹⁴⁸ VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), 2021.

¹⁴⁹ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), 2021.

General Safety

The Architectural Barriers Act of 1968 applies to buildings or facility spaces leased in whole or in part by the United States after August 12, 1968.¹⁵⁰ Facilities subject to the Architectural Barriers Act must comply with the Architectural Barriers Act Accessibility Standard.¹⁵¹ The OIG evaluated if vet centers were compliant with Architectural Barriers Act standards related to people with disabilities including entrances, parking spaces, and exit signs.¹⁵²

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.”¹⁵³ Vet Center staff must identify and minimize objects that could be potentially used as weapons within their environment.¹⁵⁴ The OIG reviewed and assessed if crisis and emergency management plans were comprehensive and current.

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.”¹⁵⁵ Vet centers are required to have an office space for the VCD and each counselor, as well as a group counseling room that is soundproof and appropriate for confidential counseling. The office manager is required to have a separate space that affords privacy for sensitive duties, while being able to access the waiting area to receive clients.¹⁵⁶ Any documents or items displaying protected health information must be secured. According to RCS *Guidelines and Instructions for Vet Center Administration* (rescinded January 26, 2021), confidential records must be stored in a room that is double locked and complies with VHA security requirements; the January 26, 2021 directive does not address file storage specifications.¹⁵⁷ The OIG virtually assessed each vet center’s offices, group counseling rooms, and storage rooms to determine compliance with privacy requirements (see table 8).

¹⁵⁰ Architectural Barriers Act of 1968 (codified as amended at 42 U.S.C. § 4151- 4156).

¹⁵¹ 41 C.F.R. § 102–76.65(a).

¹⁵² Architectural Barriers Act Accessibility Standards (codified at Appendices C and D to 36 C.F.R. part 1191).

¹⁵³ Readjustment Counseling Service, District 1 Vet Center Administrative Quality Review Template; VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), 2021.

¹⁵⁴ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), 2021.

¹⁵⁵ VHA Handbook 1500.01, September 8, 2010; VHA Directive 1500(1), 2021.

¹⁵⁶ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010; VHA Directive 1500(1), 2021.

¹⁵⁷ VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010.

Table 8. District 5 Zone 1 Environment of Care

Reviewed Elements	Findings			
	Bellingham Vet Center	Central Oregon Vet Center	Tacoma Vet Center	Wasilla Vet Center
Physical Environment				
Clean Exterior	Compliant	Compliant	Compliant	Compliant
Neat Exterior	Compliant	Compliant	Compliant	Compliant
Presentable Exterior	Compliant	Compliant	Compliant	Noncompliant
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
General Safety				
Accessible Entrance	Compliant	Compliant	Compliant	Compliant
Designated Accessible Parking	Compliant	Compliant	Compliant	Compliant
Exit Signs Compliant with Architectural Barriers Act	Noncompliant	Noncompliant	Noncompliant	Noncompliant
Crisis Management Plan	Compliant	Compliant	Compliant	Compliant
Objects Potentially used as Weapons Minimal	Compliant	Compliant	Compliant	Compliant
Privacy				
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	Compliant	Compliant	Compliant
Secure Double Locked Room for Client Records	Noncompliant	Compliant	Noncompliant	Compliant

Source: VA OIG analysis of Environment of Care inspections conducted from May 10, 2021 through May 26, 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 the interior design being welcoming and non-institutional. Waiting areas were large and comfortable, with furnishings that were clean, in good repair, and serviceable. All four vet centers had soundproofed private office spaces for the director and counselors and at least one group counseling room. All four vet centers complied with the Architectural Barriers Act standards for an accessible entrance and designated accessible parking spaces.

The OIG found deficiencies in the following:

- Presentable exterior
- Architectural Barriers Act-compliant exit signage
- Secure double locked storage room for client records

Exterior

The OIG found exterior front entrance steps in disrepair and an unclearly marked as a designated parking space for people with disabilities in the rear parking lot at the Wasilla Vet Center. The VCD reported the steps had been damaged for approximately one to one and half months and reported contacting the landlord and the district office.

Recommendation 21

The District Director evaluates and determines reasons for noncompliance with a presentable exterior at the Wasilla Vet Center and ensures all exterior grounds are in good repair.

District Director response: Concur.

Vet Centers operate in leased space. The current building lessor is refusing to make repairs. The District is working with VISN 20 Contracting to relocate the Wasilla Vet Center.

Status: Ongoing

Target date for completion: June 2022

Architectural Barriers Act

The OIG found all four vet centers noncompliant in one element of general safety. RCS requires that each vet center follow the 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).¹⁵⁸ The OIG found the four vet centers did not have a tactile sign posted near any of their doors at exit discharge.

Recommendation 22

The District Director evaluates and determines reasons for noncompliance with tactile (braille) signage at the Bellingham, Central Oregon, Tacoma, and Wasilla Vet Centers and ensures all exit doors are compliant with Architectural Barriers Act requirements.

District Director response: Concur.

The District will work with the RCS Central Office and RCS leasing POC [point of contact] to have the braille signage added to the identified Vet Centers.

Status: Ongoing

Target date for completion: December 2021

Privacy

RCS requires that “Confidential/sensitive information is secured.”¹⁵⁹ The OIG found Bellingham and Tacoma did not securely store protected health information. The Bellingham Vet Center had a storage room that had one lock with locked file cabinets inside, but files were stored in cardboard boxes on top of the locked file cabinets. The Tacoma VCD indicated that there were no more paper client records being kept and if there were client records they would store them in the office manager’s room; however, that door remained open during business hours and the file cabinet in the office was not locked during the time of inspection.

Recommendation 23

The District Director reviews reasons for noncompliance with securing confidential and sensitive information at the Bellingham and Tacoma Vet Centers and ensures all vet center employees safely and securely store protected health information.

¹⁵⁸ 36 C.F.R. § Pt. 1191, App. D.

¹⁵⁹ Readjustment Counseling Service, District 1 Vet Center Administrative Quality Review Template, section IV.b., revised October 24, 2016.

District Director response: Concur.

The Bellingham Vet Center misunderstood the requirement for having two locked doors. They had boxes of files that were recently returned from their Contract-for-Fee provider which were not locked in a cabinet in the room. The situation has been resolved as all files are now inside a locked cabinet and all staff have been retrained on information security and privacy. The Tacoma Vet Center is in the processing of ordering new lockable filing cabinets to ensure they can properly secure documents.

Status: In process

Target date for completion: January 2022

Appendix A: Summary of Vet Center Inspection Recommendations

The intent of the recommendations is for VCDs to use them as a road map to help improve operations and clinical care. The 23 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
Clinical and Administrative Quality Reviews	Clinical quality review remediation plans.	1. The District Director determines reasons clinical quality review remediation plans were not completed, ensures completion, and monitors compliance.
	Administrative quality review remediation plans.	2. The District Director determines reasons administrative quality review remediation plans were not completed, ensures completion, and monitors compliance. 3. The District Director evaluates the process for resolution of administrative quality review deficiencies and initiates action steps as necessary.
Critical Incident Quality Reviews	Completion of 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) for serious suicide attempts were not completed, ensures completion, and monitors compliance.
Suicide Prevention	Requirement	Recommendation
Intake Assessment	Completion of psychosocial assessments within five visits	5. 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	6. The District Director ensures lethality risk assessments are completed on the first clinical visit and monitors compliance across all zone vet centers.

<p>Intake Assessment, Military History, and Lethality Assessment</p>	<p>Completion of psychosocial assessments within five visits</p>	<p>7. 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.</p>
<p>Suicide Prevention and Intervention: Care Coordination and Collaboration with VA Medical Facilities</p>	<p>High risk shared client list</p>	<p>8. 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.</p>
	<p>Confidentiality and coordination with VA medical facilities</p>	<p>9. The District Director verifies clinical staff follow confidentiality requirements when consulting and coordinating care with the support VA medical facility for shared clients at high risk for suicide and monitors compliance across all zone vet centers.</p>
	<p>Following confidentiality requirements when coordinating care with VA medical facilities and timely notification to the suicide prevention coordinator</p>	<p>10. The District Director confirms clinical staff make timely notification to the suicide prevention coordinator at the support VA medical facility for clients with significant safety risks and monitors compliance across all zone vet centers.</p>
	<p>Consultation following lethality status changes</p>	<p>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.</p>
	<p>Crisis Reports</p>	<p>12. The District Director ensures clinical staff complete crisis reports as required and monitors compliance across all zone vet centers.</p>

Suicide Prevention and Intervention (Vet Center-Specific)	Mental Health Council participation with VA medical facilities	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 the mental health council at the Central Oregon Vet Center and takes action as indicated to ensure compliance with Readjustment Counseling Service requirements.
	Monthly review and documentation in RCS High Risk Suicide Flag SharePoint Site	14. The District Director determines reasons for noncompliance with High Risk Suicide Flag SharePoint site requirements and the tracking of continuity of care for clients with a high risk suicide flag at the Bellingham Vet Center, takes action to ensure requirements are met, and monitors compliance.
	Crisis Plans	15. The District Director determines reasons the Bellingham Vet Center did not have a written crisis plan, ensures requirements related to crisis plans are met, and monitors compliance.
Consultation, Supervision and Training	Requirement	Recommendation
Clinical Liaison	Assigned clinical liaison	16. The District Director determines reasons for noncompliance with the appointment of a clinical liaison at the Tacoma Vet Center, ensures assignment of a liaison, and monitors compliance.
External Clinical Consultation	Documentation of four hours of external clinical consultation per month	17. The District Director determines reasons a process for completing and tracking four hours of external clinical consultation per month did not occur at the Bellingham, Central Oregon, Tacoma, and Wasilla Vet Centers, ensures vet center directors implement processes, and monitors compliance.
Supervision	One hour weekly supervision with clinical staff members	18. The District Director determines reasons for noncompliance with staff supervision provided by Vet Center Directors at the Bellingham, Central Oregon, Tacoma, and Wasilla Vet Centers, ensures staff supervision occurs as required, and monitors compliance.

Monthly Audit	Monthly 10 percent client record audit for each counselor	19. The District Director verifies and determines reasons for noncompliance with monthly RCSnet chart audits at the Bellingham, Central Oregon, Tacoma, and Wasilla Vet Centers, ensures chart audits are completed as required, and monitors compliance.
Training	Completion of all mandatory trainings	20. The District Director determines reasons employees at the Bellingham, Central Oregon, Tacoma, and Wasilla Vet Centers did not complete required trainings, ensures all staff complete assigned mandatory trainings, and monitors compliance.
Environment of Care	Requirement	Recommendation
Physical Environment	Exterior	21. The District Director evaluates and determines reasons for noncompliance with a presentable exterior at the Wasilla Vet Center and ensures all exterior grounds are in good repair.
General Safety	All exit signage Architectural Barriers Act-compliant	22. The District Director evaluates and determines reasons for noncompliance with tactile (braille) signage at the Bellingham, Central Oregon, Tacoma, and Wasilla Vet Centers and ensures all exit doors are compliant with Architectural Barriers Act requirements.
Privacy	Confidential/sensitive information secured	23. The District Director reviews reasons for noncompliance with securing confidential and sensitive information at the Bellingham and Tacoma Vet Centers and ensures all vet center employees safely and securely store protected health information.

Source: VA OIG recommendations.

Appendix B: Zone Profile

**Table B.1. District 5 Zone 1 Profile
October 1, 2019–September 30, 2020**

Profile Element	District 5 Zone 1	
Total Budget Dollars	\$14,901,030.73	
Unique Clients	8,651	
New Clients	2,129	
Active Duty Clients	348	
Spouse/Family Clients	1,241	
Bereavement Clients	57	
Position	Authorized	Filled
Total Full-time	154	138
District Leaders	4	4
District and Zone Staff [†]	3	3
Vet Center Director	22	22
Clinical Staff	77	65
Veterans Outreach Program Specialist [‡]	26	24
Vet Center Office Staff	22	20
Contract Providers	N/A	3

Source: VA OIG analysis of information from district 5 zone 1 leaders.

* At the time of inspection, district 5 zone 1 reported 22 vet centers. District provided zone profile reports on the fiscal year, not the review period for inspection.

[†] District and Zone staff includes the district administrative officer, district executive assistant, and the district 5 zone 1 program support assistant.

[‡] 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.

[§] Contract providers are not included in the authorized or filled totals.

Profile Summary: From October 1, 2019, through September 30, 2020, district 5 zone 1 operated on a total budget of \$14,901,031 and served 8,651 unique clients; 2,129 new clients; 348 active duty service members; 1,241 spouses and family members; and 57 bereavement clients. There was a total of 154 positions, with 16 vacancies throughout the zone as of May 12, 2021.

Appendix C: Vet Center Profiles

The table below provides general background information for the four selected district 5 zone 1 vet centers.

Table C.1. FY20 Vet Center Profiles

Profile Element	Bellingham Vet Center	Central Oregon Vet Center	Tacoma Vet Center	Wasilla Vet Center
• Unique Clients	308	397	922	226
• Bereavement Clients	4	2	7	1
• Active Duty Clients	3	5	77	16
• Spouse/Family Clients	44	57	96	32
• New Clients	73	100	287	41
Total Number of Positions (as of May 11, 2021)	Bellingham Vet Center	Central Oregon Vet Center	Tacoma Vet Center	Wasilla Vet Center
• Total Authorized Full-time positions	6	6	9	5
• Total Part-time positions	0	0	0	0
• Vet Center Director	1	1	1	1
• Clinical Staff	3	3	7	1
• Veterans Outreach Specialist	1	1	1	1
• Office Staff	1	1 (vacant)	2	1
• Other	N/A	1 (MSW intern)	3 (work study)	N/A

Source: VA OIG analysis of information provided by district 5 zone 1.

Note: 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 14, 2021

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

Subj: Vet Center Inspection of Pacific District 5 Zone 1 and Selected Vet Centers

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

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, *Vet Centers Inspection of Pacific District 5 Zone 1 and Selected Vet Centers*. Readjustment Counseling Service (RCS) has reviewed the report and either concurs or concurs in principle with recommendations 1-23 and are submitting 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.

(Original signed by:)

Michael Fisher

Appendix E: Pacific District 5 District Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 13, 2021

From: District Director, Pacific District 5 (RCS5)

Subj: Vet Center Inspection of Pacific District 5 Zone 1 and Selected Vet Centers

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, *Vet Center Inspection of Pacific District 5 Zone 1 and Selected Vet Centers*.
2. In reviewing the draft report, the District has addressed all identified recommendations and has either resolved or developed a plan to resolve all remaining items.

(Original signed by:)

Steven R. Reeves
District Director

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

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