DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Vet Center Inspection of Midwest District 3 Zone 3 and Selected Vet Centers

VCIP REPORT | REPORT #21-03232-37 | JANUARY 12, 2023

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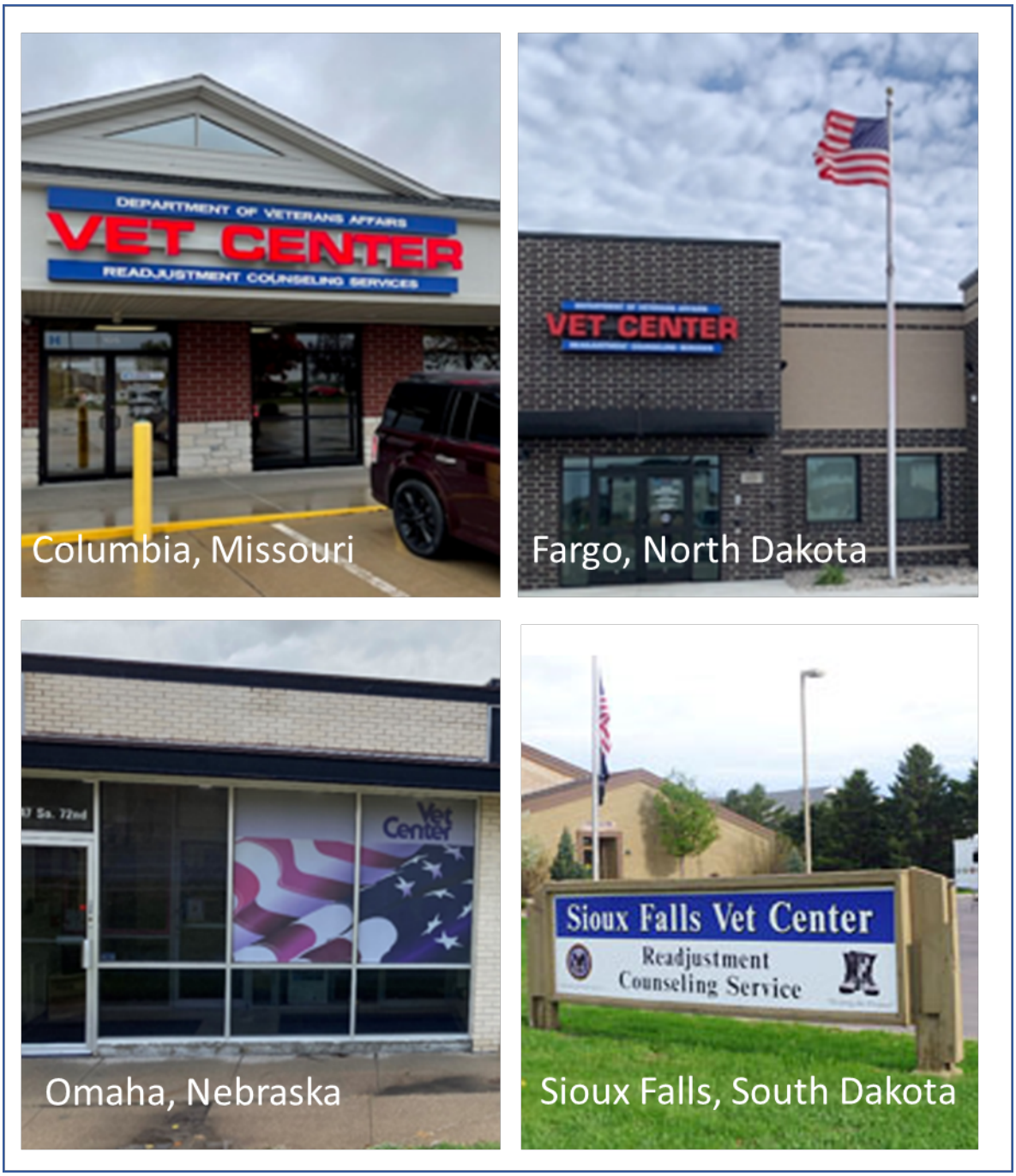

Figure 1. *Midwest District 3 Zone 3 Vet Centers inspected: (from left to right, top to bottom) Columbia, Missouri; Fargo, North Dakota; Omaha, Nebraska; and Sioux Falls, South Dakota.*
Source: VA OIG inspection team virtual visit photographs.

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 VA Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) provides a focused evaluation of aspects of care delivered at vet centers.[1] 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. This inspection focused on Midwest district 3 zone 3 and four selected vet centers: Columbia, Missouri; Fargo, North Dakota; Omaha, Nebraska; and Sioux Falls, South Dakota.[2]

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 related Veterans Health Administration (VHA) services. The inspections cover key aspects of clinical and administrative processes associated with promoting quality care. The OIG selects and evaluates specific areas of focus each fiscal year.[3]

To examine risks or potential risks to clients, the OIG inspection focused on five review areas that influence the quality of client care and service delivery at vet centers:[4]

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

[1] The Vet Center Inspection Program conducts routine and regular inspections of vet centers, whereas hotline inspections focus on fraud, waste, abuse or criminal activity generated from complaints by VA staff and the general public or requested by Congress.

[2] VHA Handbook 1500.01, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010, was in effect during the OIG's inspection period. It was rescinded and replaced by VHA Directive 1500, *Readjustment Counseling Service*, January 26, 2021, then again by VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021, and most recently by VHA Directive 1500(2), *Readjustment Counseling Service*, January 26, 2021, amended December 30, 2021. Unless otherwise specified, the requirements in the 2021 directives contain the same or similar language as the rescinded 2010 documents. 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 per zone.

[3] A fiscal year is a 12-month period from October 1 through September 30.

[4] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010. VHA Directive 1500, VHA Directive 1500(1); VHA Directive 1500(2). 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.

The findings presented in this report are a snapshot of the selected zone and selected vet centers' performance within the identified review areas at the time of the OIG inspection. The OIG findings and recommendations should help vet centers identify areas of vulnerability or conditions that, if addressed, could improve safety and quality of care.

Inspection Results

Leadership and Organizational Risks

The leadership and organizational risks review is specific to the district 3 zone 3 leadership team. The team consists of the district director, deputy district director, associate district director for counseling, and associate district director for administration (see figure 2).[5]

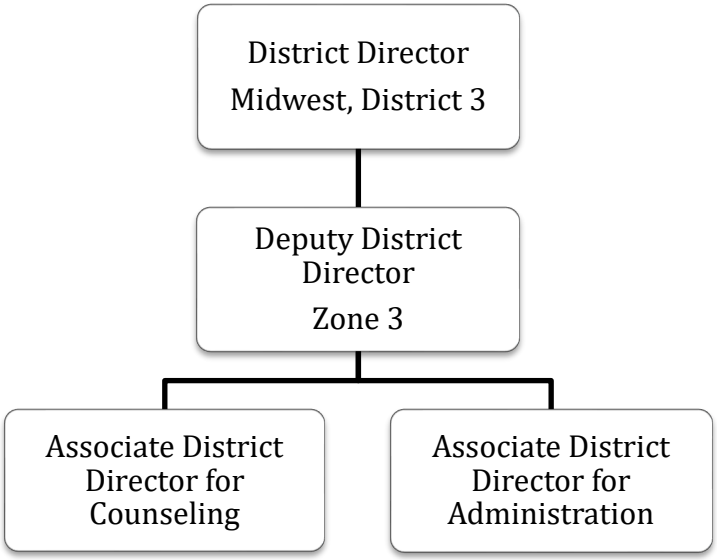

Figure 2. *Midwest district 3 zone 3 leaders.*
Source: VA OIG analysis of district organizational chart.

At the time of the OIG inspection, district leaders had been working together for just over two years.[6] The District Director has been in the role since 2016. There were no vacant district leader positions in the 12 months prior to the inspection.

[5] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center* Administration; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). Readjustment Counseling Service (RCS) is an organizational element within VHA with direct-line authority for community-based vet centers and is responsible for the provision of readjustment counseling.

[6] For the purposes of this report, the term *district leaders* refers to the district director, deputy district director, associate district director for counseling and associate district director for administration.

District leaders were generally knowledgeable about the basic concepts of, and their roles in, quality improvement. District leaders provided examples of what quality improvement meant including collaboration and communication; measuring and assessing systems and processes to ensure compliance; and using feedback to improve safety, processes, programs, efficiency, and performance.

District 3 zone 3 conducted required annual in-service training for vet center counselors; however, trainings were not provided for vet center directors (VCDs), veterans outreach specialists, and office managers.[7]

The VA 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 fiscal year 2020 VA All Employee Survey results.

Readjustment Counseling Services (RCS) requires a follow-up feedback survey for a client once a case is closed or if a client has not been seen in the last 100 days and other select criteria are met. The results from the feedback survey provide district leaders and VCDs with feedback to evaluate the effectiveness of readjustment counseling and services provided. The OIG reviewed district 3 zone 3 Vet Center Service Feedback results for fiscal year 2020, noting all areas were higher than the RCS national average scores.

The OIG found district leaders noncompliant with providing required annual in-service training to vet center directors, veterans outreach specialists, and office managers, and issued one recommendation.

Quality Reviews

The OIG conducted an analysis of the required vet center clinical and administrative annual quality reviews, and morbidity and mortality reviews. Vet centers are required to have annual clinical and administrative quality reviews completed to ensure compliance with policy and procedures. RCS requires morbidity and mortality quality reviews for client safety events including clients with serious suicide or homicide attempts, death by suicide, or homicide.[8]

The OIG found the Associate District Directors of Counseling and Administration were compliant with requirements for completion of clinical and administrative quality reviews, remediation plans, and administrative deficiency resolution; however, they were noncompliant for clinical deficiency resolution. The OIG found the Associate District Director for Counseling noncompliant with completion of morbidity and mortality reviews for serious suicide attempts.

[7] Vet center staff must complete annual training specific to the duty assignments of each position. RCS district directors are responsible for planning and implementing the annual trainings.

[8] 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 morbidity and mortality review.

The OIG issued three recommendations to the District Director for quality reviews and one to the RCS Chief Officer specific to the morbidity and mortality review.

Suicide Prevention

The suicide prevention review included a zone-wide evaluation of electronic client records and a focused review of suicide prevention activities at the four selected vet centers.

The four selected vet centers inspected were compliant with required availability of nontraditional hours for appointments and had critical event plans. The VCDs of the four selected vet centers were compliant with the requirement of attending the support VA medical facility's mental health council meetings.[9]

Two of the four VCDs were noncompliant with the requirement of reviewing the RCS High Risk Suicide Flag SharePoint site monthly.[10] Two of the four vet centers did not have a standardized communication process of collaboration with the support VA medical facility suicide prevention coordinators.[11]

The OIG issued a total of seven recommendations related to suicide prevention. Two recommendations were specific to the suicide prevention zone-wide evaluation of the psychosocial assessment, and suicide risk assessments in the electronic client records. Two recommendations were made regarding consultation and collaboration with VA medical facilities and high risk for suicide clients. Two recommendations were made for completion of safety plans and consultation for clients rated as intermediate or high risk for suicide, with acute, chronic, or both risk levels. One recommendation was specific to the four selected vet centers' suicide prevention and intervention processes.

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[9] Vet center staff are required to participate on all VA medical facility mental health councils and provide non-traditional hours to include evenings or weekends. VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). 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." VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

[10] Microsoft, Definition of SharePoint. "a secure place to store, organize, share, and access information from any device," accessed July 15, 2021. https://support.microsoft.com/en-us/office/what-is-sharepoint-97b915e6-651b-43b2-827d-fb25777f446f.

[11] VHA Deputy Under Secretary for Health for Operations and Management memorandum, "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 did not make recommendations for three suicide prevention deficiencies identified in this report as recommendations on the same matters were directed to the Under Secretary for Health who has authority over both programs in an OIG report, *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021.

Consultation, Supervision, and Training

The consultation, supervision, and training review evaluated the four selected vet centers with results and recommendations specific to those sites. The OIG found the four vet centers had at least one licensed and credentialed VHA-qualified mental health professional on staff, a clinical liaison who was also a mental health professional from the support VA medical facility, and an external clinical consultant who was an independent licensed mental health professional.[12] Three of the four vet centers were noncompliant with the requirement for an external clinical consultant to provide at least four hours of consultation per month.

The VCDs of the four selected vet centers were noncompliant with the requirement to provide regular and ongoing supervision to clinical staff and monthly auditing of electronic client records. Overall, staff at the four vet centers were noncompliant with completing training requirements.

The OIG issued four 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, the OIG found three of the four vet centers were noncompliant with the posting of Architectural Barriers Act Standards tactile (braille) exit signs.[13] One vet center was noncompliant with the requirement of having an updated emergency and crisis plan. The OIG made two recommendations.

Conclusion

The OIG conducted a detailed inspection across five review areas and issued a total of 18 recommendations for improvement to the District Director. The number of recommendations should not be used as a gauge for the overall quality of care provided within the zone. The intent is for district leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues, as well as other less critical findings that, if left unattended, may interfere with the delivery of quality care.

[12] VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. VHA-qualified mental health professionals are mental health practitioners who have met the requirements, including licensure, set forth by the VA to provide mental health services independently. VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). Vet centers are required to maintain a reciprocal relationship with VA medical facilities to ensure clients receive quality care and needed services.

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

Comments

The RCS Chief Officer and District Director concurred with recommendations 3, 6–13, and 15–18, and concurred in principle with recommendations 1, 2, 4, 5, and 14. An action plan was provided (see responses within the body of the report for full text of RCS comments, and appendixes D and E for the Chief Officer and District memorandums). Based on information provided, the OIG considers recommendation 1 closed. For the remaining open recommendations, the OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Contents

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.[2] Vet center staff assess and manage clients at risk for suicide, substance abuse, and other medical and mental health conditions.[3] Other services include bereavement support for families, referrals to the Veterans Benefits Administration, screening and assessment for employment, outreach, and referral coordination with VA and non-VA providers.[4]

Vet Center History

"RCS [Readjustment Counseling Service] is an autonomous organizational element in VHA [Veterans Health Administration] with direct line authority for administration of all RCS service delivery assets: Vet Centers, MVCs [mobile vet centers], the Vet Center Call Center, and the RCS CFF [Contract for Fee] program; and the provision of all readjustment counseling services."[5] Since opening vet centers in 1979, RCS was one of the first organizations to address

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[1] VHA Handbook 1500.01, Readjustment Counseling Service (RCS) Vet Center Program, September 8, 2010, was in effect during the OIG's inspection period. It was rescinded and replaced by VHA Directive 1500, Readjustment Counseling Service, January 26, 2021, then by VHA Directive 1500(1), Readjustment Counseling Service, January 26, 2021, amended May 3, 2021, and then by VHA Directive 1500(2), Readjustment Counseling Service, January 26, 2021, amended December 30, 2021. Unless otherwise specified, the requirements in the 2021 directives contain the same or similar language as the rescinded 2010 documents. Vet centers provide counseling interventions for psychological and psychosocial readjustment problems related to specific types of military deployment stressors. Readjustment counseling services (RCS) are "designed by law to be provided without a medical diagnosis." Therefore, those receiving readjustment services are not considered patients. To be consistent with RCS policy and terminology, the OIG refers to veterans receiving such services as clients in this report.

[2] 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."

[3] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol", January 25, 2019.

[4] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). VA, "Vet Centers (Readjustment Counseling): Vet Center Eligibility," accessed March 24, 2021, https://www.vetcenter.va.gov/Eligibility.asp.

[5] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010. VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). Readjustment counseling is a counseling service provided by readjustment counselors to assist with combat-related psychological and psychosocial readjustment. The Contract for Fee Program (CFF) provides readjustment counseling to eligible clients and their families who live at a distance from the vet center and provides services through contracted providers.

the psychological and social effects combat has on veterans before the American Psychiatric Association recognized posttraumatic stress disorder as an official diagnosis in 1980.[6]

While vet centers initially focused on Vietnam-era veterans, services are now offered to veterans of any combat theaters, families and active service members.[7] From 1979 through 1985, an estimated 305,000 clients received services at vet centers; an RCS Clinical Program Analyst reported 117,033 clients received care at vet centers in fiscal year 2020 alone.[8] In an attempt to serve the growing veteran population, the number of vet centers expanded from 91 in 1979 to 300 as of December 2021.[9] 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.[10]

[6] VHA Handbook 1500.01.

[7] "Vet Centers (Readjustment Counseling): Who We Are," accessed January 7, 2020, https://www.vetcenter.va.gov/About_US.asp.

[8] Government Accountability Office. Vietnam Veterans: A Profile of VA's Readjustment Counseling Program, Report No. GAO/HRD-87-63, August 1987. Government Accountability Office, 1995 Readjustment Counseling Service: Vet Centers Address Multiple Client Problems, but Improvement Is Needed, Report No. GAO/HEHS-96-113, July 1996. A fiscal year is a 12-month period that the federal government uses for accounting purposes running from October 1 through September 30.

[9] Arthur S. Blank Jr., "Apocalypse Terminable and Interminable: Operation Outreach for Vietnam Veterans." *Hospital and Community Psychiatry,* vol. 33, no. 11, (November 1982): 913-918. VAST Snapshot-Vet Center Listing Fiscal Year 2022 Report, VHA Support Service Center (VSSC).

[10] VHA, *Readjustment Counseling Service Guidelines and Instructions for Administration*, November 23, 2010, VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). RCS outstations promote additional points of access for clients and are aligned under a host vet center. Vet center outstations are distant from established vet centers, and while not having the same staffing requirements, outstations have at least one full-time counselor.

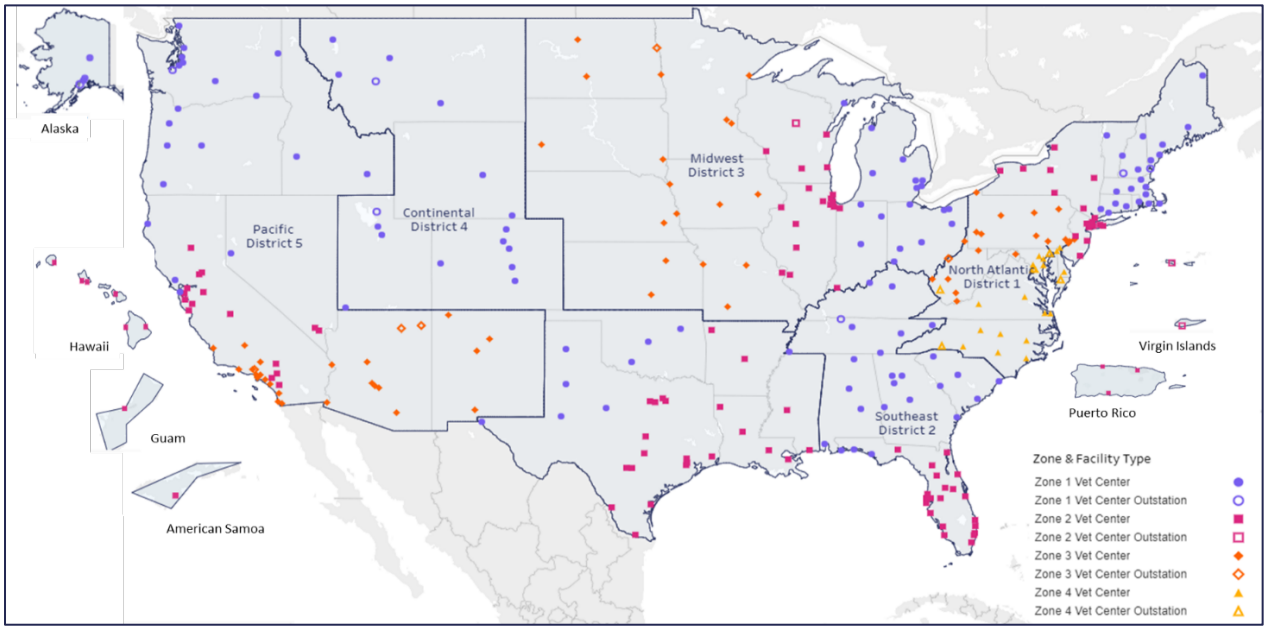

Figure 3. *Map of vet centers and vet center outstations. The placement of Alaska, American Samoa, Hawaii, Guam, Puerto Rico and the Virgin Islands is not representative of their actual geographical locations.*[11]
Source: VA OIG developed using VA Site Tracking (January 19, 2021) and RCS data (as of 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 siblings of service members who die of any cause while on active duty."[12] 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	Women veterans who experienced military sexual trauma
1994	Individuals 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

[11] 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.

[12] "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.

Year	Vet Center Eligibility Expansion
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 Operation Iraqi Freedom or both
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 and care and services to active duty service members reporting sexual assault or harassment without a Tricare referral
2020	Forces who served on active duty in response to a national emergency or major disaster National Guard in response to a disaster or civil disorder Any individual who participated in a drug-related military action as a member of the Coast Guard‡
2022	Reserve members of the Armed Forces with a behavioral health or psychological trauma§

Source: VA OIG analysis of vet center eligibility expansion information. Vet Center Eligibility, accessed January 12, 2022, https://www.vetcenter.va.gov/Eligibility.asp. National Defense Authorization Act for Fiscal Year 2013, Pub. L. No. 112-239 (2013).

**Armed hostile periods were expanded to include additional combat eras. Federal Register, Vol. 77, No. 49, Proposed Rules, March 13, 2012. Vet Centers (Readjustment Counseling) "Who We Are", accessed June 4, 2019, https://www.vetcenter.va.gov/About_US.asp.*

†Vet Center Eligibility, accessed January 12, 2022, https://www.vetcenter.va.gov/Eligibility.asp. National Defense Authorization Act for Fiscal Year 2013, Pub. L. No. 112-239 (2013).

‡Vet Center Eligibility Expansion Act, Pub. L. No. 116-176 (2020).

§VHA Directive 1500(2). The William M. (Mac) Thornberry National Defense Authorization Act, Pub. L. No. 116-283 (2021).

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.[13] The RCS Chief Officer reports directly to the VA Under Secretary for Health and is responsible for strategic planning, coordinating readjustment counseling services with VA services, serving as a policy expert for readjustment counseling, being the direct line authority for all RCS staff, coordinating with RCS Consolidated Human Resources Management Office for hiring, and supervising six RCS national officers. The RCS Operations Officer is responsible for daily operations and providing

[13] "Vet Centers (Readjustment Counseling)," VA, accessed June 15, 2022, https://www.vetcenter.va.gov/. VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). 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.

supervision to the five district directors who oversee the districts. The RCS Operations Officer reports to the RCS Chief Officer. 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 is responsible for all vet center operations.[14]

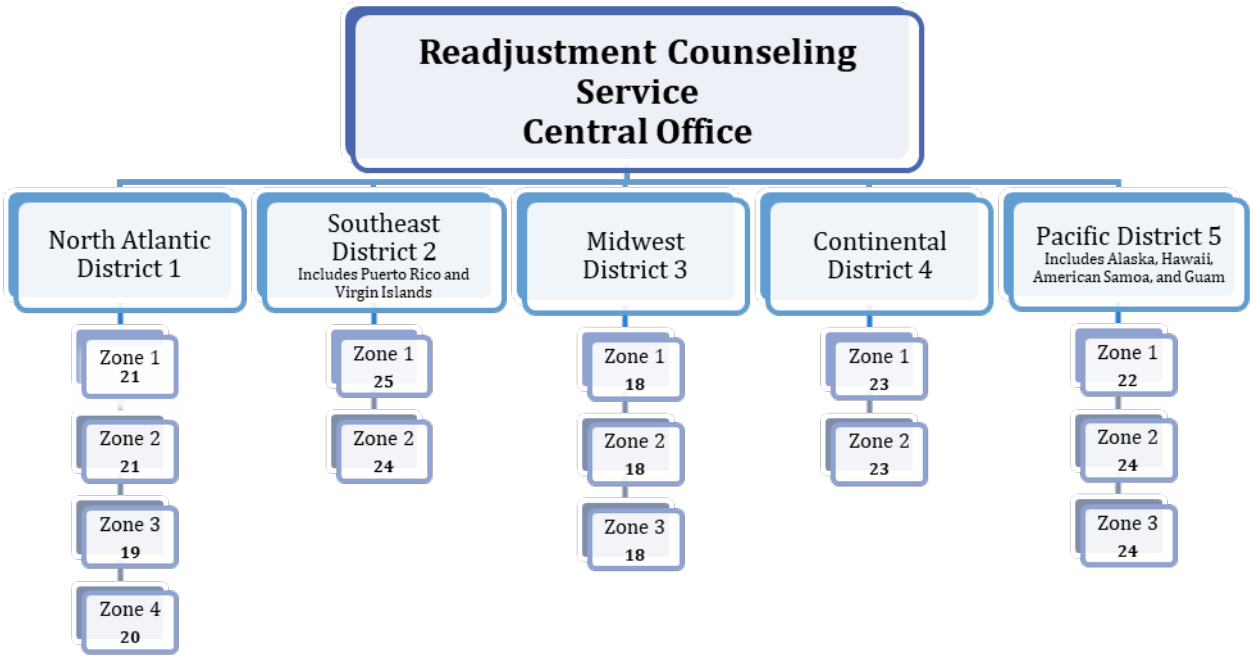

Figure 4. *RCS organizational district and zone structure.*
Source: VA OIG developed using analysis of RCS information.
Note: The number of vet centers in each zone is denoted below the respective zone. The OIG did not assess RCS data for accuracy or completeness.

Electronic Client Record

Vet center services are not required to be recorded in the client's VA electronic health record.[15] 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

[14] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).
[15] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

facilities, VA clinics, or the Department of Defense unless there is a signed release of information.[16]

An RCS leader reported collaborating with Oracle Cerner and Electronic Health Record Modernization Integration Office to explore modernization of RCSNet; however, a determination has not been made.[17]

VA Medical Facilities

Vet centers are required to maintain a reciprocal relationship with VA medical facilities to ensure clients receive quality care and needed services.[18] The support VA medical facility director assigns a clinical liaison and an administrative liaison to aligned vet centers.[19] The VA medical facility clinical liaison coordinates services for shared clients, assists in suicide prevention activities, and supports morbidity and mortality reviews.[20] The VA medical facility administrative liaison provides support for procurement, engineering functions, commuter benefits, and fleet management for U.S. government vehicles.[21] 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.[22]

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.

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[16] VHA Handbook 1500.01, 2010; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); 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.

[17] 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; VHA Directive 1500(1); VHA Directive 1500(2). "Federal Government," Oracle Cerner, accessed June 29, 2021, https://www.cerner.com/solutions/federal-government. Oracle Cerner is a corporation that promotes secure technology to improve healthcare operations of federal health organizations to assist in providing more connected healthcare.

[18] VHA, Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[19] VHA Handbook 1500.01, 2010; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). Support VA medical facilities are facilities that have been identified to assist vet centers with client mental health care.

[20] VHA, *Readjustment Counseling Service Guidelines and Instructions for Administration.* VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). For the purposes of this report, the OIG uses the term VA medical facility instead of VA medical center or VHA medical facility.

[21] VHA, Readjustment Counseling Service Guidelines and Instructions for Administration; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[22] VHA Handbook 1500.01, 2010; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). Vet centers provide representation on root cause analysis panels when a client completes suicide and is a shared client with a VA medical facility.

The OIG inspection examined operations generally from October 1, 2020, through September 30, 2021.[23] This report evaluates the quality of care delivered at vet centers and examines a broad range of key clinical and administrative processes for compliance with RCS policy. The OIG reports its findings to Congress and the Veterans Health Administration (VHA), so informed decisions can be made on improving care.

The OIG findings are a snapshot of a zone and vet centers' performance within identified focus areas. Although it is difficult to quantify the risk of adverse impact to clients served at vet centers, the OIG recommendations in this report should help vet centers identify areas of vulnerability or conditions that, if addressed, could improve safety and quality of care (see appendix A).[24]

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

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

Methodology

The OIG announced the inspection to district leaders on October 25, 2021, and conducted virtual site visits from October 25, 2021, through November 5, 2021.[25] The OIG interviewed district leaders and four directors at the selected vet centers. Due to travel restrictions during the COVID-19 pandemic, the inspection was conducted virtually.[26]

The OIG reviewed RCS policies and practices to evaluate compliance and identify potential discrepancies, validated client RCSNet record findings, explored reasons for noncompliance, and inspected select areas of care within vet centers. The OIG emailed two questionnaires: the first

[23] The Vet Center Inspection Program conducts routine and regular inspections of vet centers, whereas hotline inspections focus on fraud, waste, abuse or criminal activity generated from complaints by VA staff and the general public or requested by Congress.

[24] The underlined terms are hyperlinks to another section of the report. To return to the point of origin, press "alt" and "left arrow" keys.

[25] 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.

[26] "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. The website has since been updated and has changed to "Domestic Travel During COVID-19".

one focused on leadership and quality improvement activities and was sent to district leaders, the second focused on quality improvement activities sent to all VCDs in the zone.

A VHA directive was issued in January 2021 (amended May 3, 2021 and December 30, 2021) during the OIG's inspection period of VCIP operations discussed in this report.[27] The OIG compared previously used guidelines and policies with the newly issued directive to identify changes. 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).

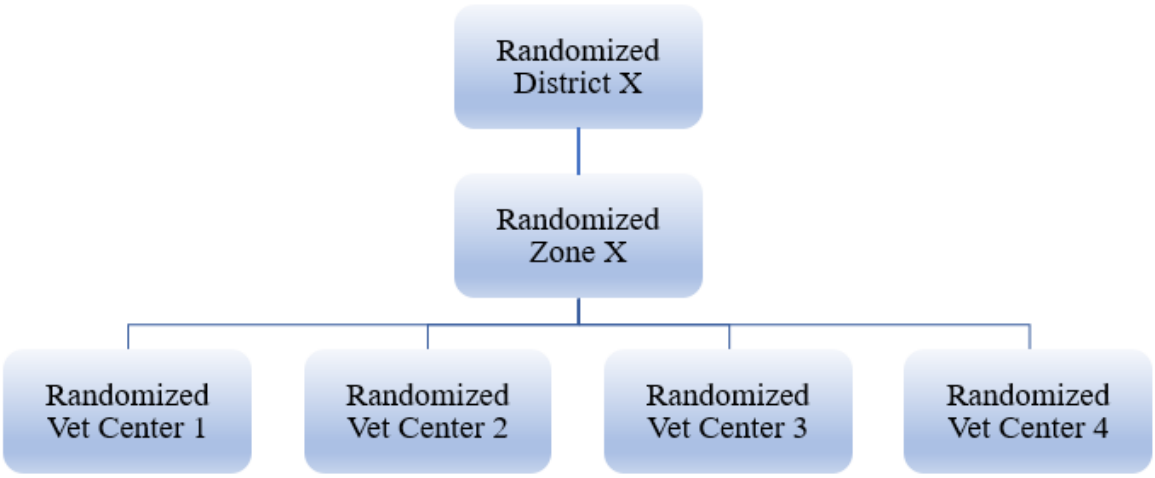

Figure 5. *Randomization and selection of inspection sites.*
Source: VA OIG.

For this inspection, the OIG randomly selected district 3 zone 3. Within zone 3, the OIG randomly selected the Columbia, Missouri; Fargo, North Dakota; Omaha, Nebraska; and Sioux Falls, South Dakota Vet Centers. Zone 3 is noted in figure 6. For demographic profiles of zone 3

[27] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). The OIG inspection period for this report is October 1, 2020, through September 30, 2021.

and the four selected vet centers see appendixes B and C.[28] The OIG provided one-day notice to each vet center prior to formal evaluation.[29]

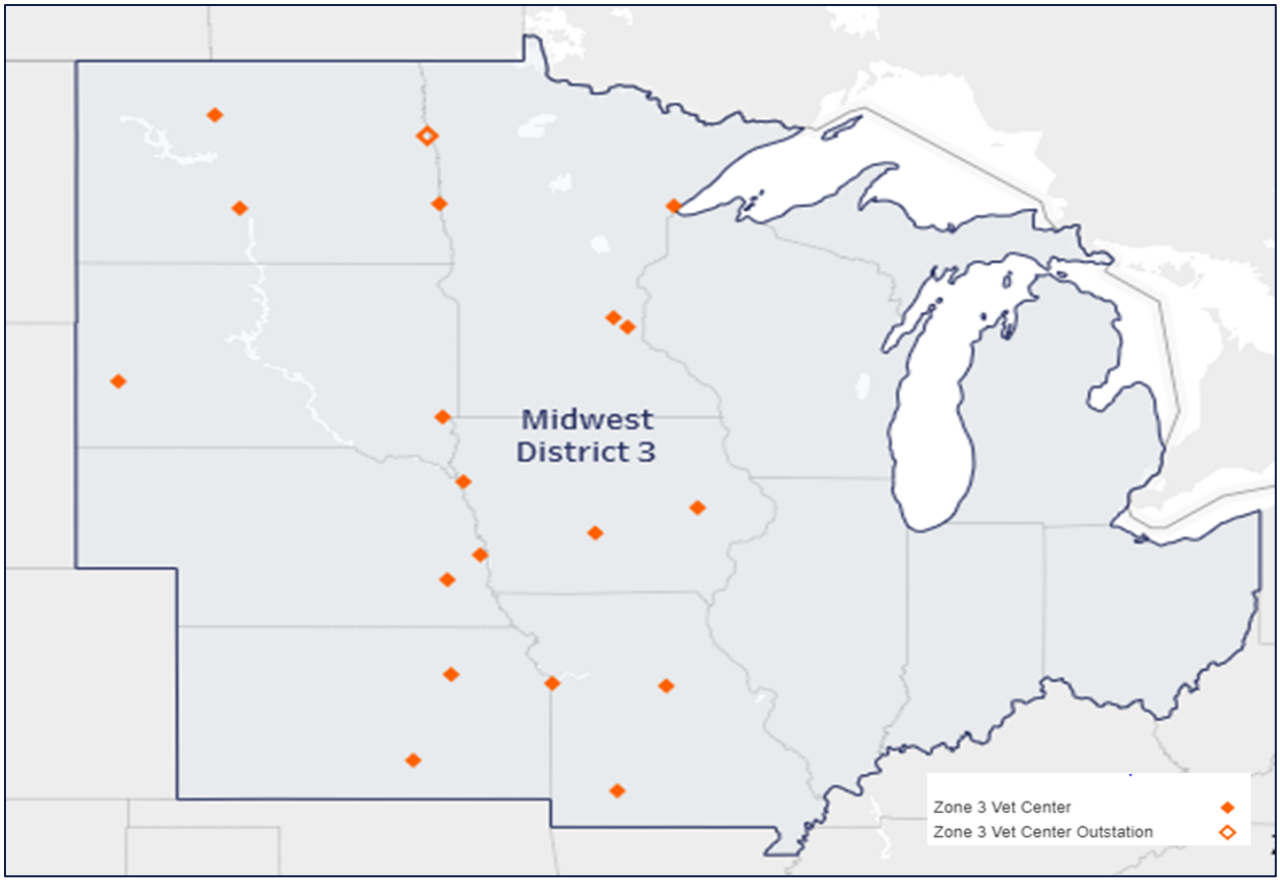

Figure 6. *Map of Midwest district 3 zone 3 vet centers.*
Source: Developed by VA OIG using VA Site Tracking.

The leadership and organizational risks review findings 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,
- district annual in-service training,
- VA All Employee Survey,
- Vet Center Service Feedback survey results, and

[28] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center* Administration; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[29] Vet centers are comprised of small multidisciplinary teams. The OIG team provided the one-day notice for coordination of client care as needed.

- response results obtained through a zone-wide questionnaire sent to all VCDs.

The assessment of quality reviews included interviews with district leaders with findings and recommendations specific to the district and zone office following an evaluation of

- vet center clinical and administrative oversight reviews for the zone,
- evidence of timely resolution of clinical and administrative deficiencies at the four randomly selected vet centers, and
- morbidity and mortality reviews.

The suicide prevention review included three zone-wide evaluations of RCSNet electronic client records with findings 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.[30]

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

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

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

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

[30] The OIG also reviewed VHA electronic health records for vet center clients shared with support VA medical facilities.

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.[31] Leadership is defined as the relationship between individuals who lead, and those who follow. Effective healthcare leadership is essential for achieving quality of care.[32]

As noted, the OIG assessed leadership and organizational risks for district 3 zone 3 by evaluating the following:

- District leadership position stability
- Quality improvement activities
- District annual in-service training
- VA All Employee Survey results (Employee Satisfaction)
- Vet Center Service Feedback survey
- Leadership and organizational risk questionnaire results[33]

District Leadership Position Stability

District directors oversee the deputy district directors who are responsible for an assigned zone (one deputy per zone). Deputy district directors supervise zone associate district directors. Associate district directors for counseling are responsible for providing guidance on all clinical operations, including clinical quality reviews and morbidity and mortality reviews. Associate district directors for administration are 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

[31] Laura Botwinick, Maureen Bisognano, Carol Haraden, *Leadership Guide to Patient Safety*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2006.

[32] Danae F. Sfantou, et al., 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.

[33] 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.

fiscal operations, outreach events, community relations, hiring staff, and clinical programs.[34] Figure 7 shows the leadership organizational structure for district 3 zone 3.

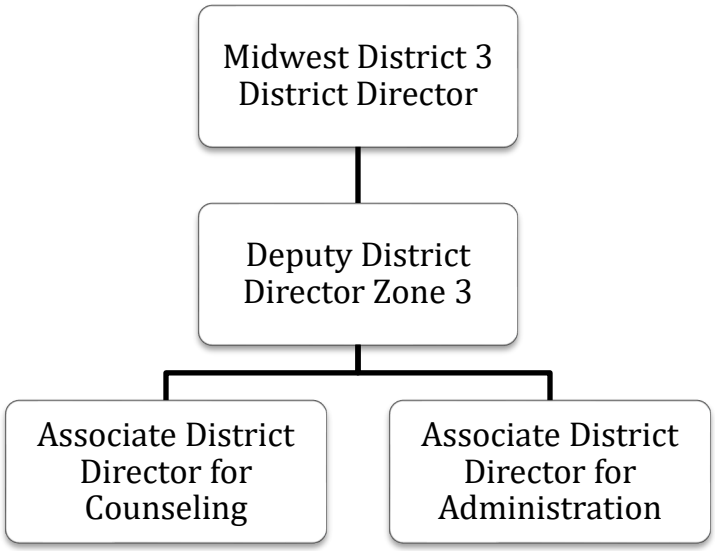

Figure 7. *District leaders.*
Source: VA OIG analysis of district organizational chart.

At the time of the OIG inspection, district leaders had been working together slightly more than two years. The District Director has been in the role since September 2016. There were no vacant district leader positions in the 12 months prior to the inspection. However, during the twelve months prior to the inspection, one VCD position was vacant for two months, the district office confirmed an acting VCD was assigned for the duration of the vacancy. One VCD was on a reassignment; therefore, not in the role at the time of the inspection. However, the district office confirmed an acting VCD was assigned to the vet center during this time.

The District Director stated there was a large degree of oversight responsibilities assigned to the Deputy District Director, including the supervision of VCDs and Associate District Directors for Counseling and Administration, making it challenging to manage 18 geographically dispersed vet centers. Two of three district leaders agreed with this assessment including the effect this has on the ability of the Deputy District Director to provide training and coaching to the staff. In the questionnaire sent to VCDs, 11 of 18 responded that they did not receive training on quality improvement and safety processes.

[34] VHA, Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

Quality Improvement Activities

The OIG sent a questionnaire and interviewed district leaders to assess knowledge about healthcare quality improvement principles and practices. District leaders were generally knowledgeable about the basic concepts of, and their roles in, quality improvement. District leaders shared their perceptions of what quality improvement means including:

- collaboration and communication;
- measuring and assessing systems and processes to ensure compliance; and
- using feedback to improve safety, processes, programs, efficiency and performance.

Three of four leaders did not feel they had enough time in a given week to support quality improvement activities.

District Annual In-service Training

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.[35] Vet center staff must complete annual training specific to the duty assignments of each position. RCS district directors are responsible for planning and implementing the annual trainings, using a wide variety of modalities, including face-to-face trainings or video conferencing.[36]

District 3 zone 3 conducted annual in-service training for the vet center counselors during the inspection period, but did not for other vet center staff. District leaders reported trainings were not provided for VCDs, veterans outreach specialists, and office managers due to the pandemic. VCDs did not receive notification of the training requirements within the OIG's inspection period. District leaders were aware of who assigned the required VHA training to staff in the VA Talent Management System and had a process to ensure required training was assigned and completed.

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 assessment of VA workforce experiences. Since 2001, the instrument has been refined "in response to operational inquiries by

[35] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).
[36] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

VA leadership on organizational health relationships and VA culture."[37] 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 questionnaire to district leaders included questions related to the communication of, and changes implemented from, the All Employee Survey results. The District Director reported the All Employee Survey results were shared on a district wide call, and at the zone level, in addition cohorts of VCDs were created to address specific unique survey results. As a result of the survey, the Deputy District Director noted increased communication and accountability throughout the district and zone, including bi-monthly calls with the Associate District Directors for Counseling and Administration. The Associate District Director for Administration stated that they increased meetings with district office staff and had monthly calls with the VCDs to discuss issues experienced in the field and find out how the district office could assist them.

Vet Center Service Feedback Survey

RCS requires a follow-up feedback survey for a client once a case is closed or a client has not been seen in the last 100 days and other select criteria is met.[38] The results from the feedback survey allows district leaders and VCDs to evaluate the effectiveness of readjustment counseling and services provided.[39] On March 1, 2019, RCS' National Service Support began maintaining all client survey feedback results and compiling the data into quarterly summary reports for RCS and district leaders.[40]

In July 2021, RCS changed the method of collecting client feedback and began using the VA customer service program called Veteran Signals (VSignals).[41] The OIG reviewed the Vet Center

[37] James L. Smith and Heather McCarren, "Developing servant leaders contributes to VHA's improved organizational health," *Organizational Health* 19, (Summer 2013): 1-2. "Healthy organizations are places where employees want to work and customers want to receive services." K. Osatuke, et al., (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.

[38] RCS Chief Officer memorandum, "Readjustment Counseling Service (RCS) Customer Feedback Procedures," February 1, 2019.

[39] VHA, Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[40] Effective January 9, 2017 RCS' National Service Support (NSS) undertook duties of mailing and collecting of RCS client feedback forms

[41] VHA Directive 1003, *VHA Veteran Patient Experience*, April 14, 2020. VHA implemented use of Veteran Signals (VSignals) to solicit feedback from Veteran stakeholders to be used with other tools to improve the patient experience. VSignals includes use of a "Digital Comment Card" that Veteran stakeholders can utilize to provide feedback.

Service Feedback Survey scores from fiscal year 2020 because a full year of feedback results were not available to the OIG for fiscal year 2021.

The OIG questionnaire sent to district leaders included questions regarding receipt of feedback survey results, actions taken as a result of the feedback, and other methods of evaluation of client satisfaction used in fiscal year 2020. In addition to the questionnaire, the OIG interviewed the District Director and Deputy District Director regarding client feedback results.

The OIG found zone 3 Vet Center Feedback scores for veteran clients for fiscal year 2020 were above the national average in almost every category (see table 2).

Table 2. District 3 Zone 3 Vet Center Service Feedback Survey Results October 1, 2019–September 30, 2020

Questions	District 3 Zone 3 Average Score*	RCS National Average Score*
I was treated in a welcoming and courteous manner by the Vet Center staff.	4.79	4.66
My appointments have been scheduled at a time that was convenient.	4.65	4.58
I would likely recommend the vet center to another Veteran, service member, or family member.	4.62	4.60
The Vet Center services were located conveniently in my community.	4.38	4.36
I feel better as a result of the services provided by the Vet Center staff.	4.41	4.40
How satisfied were you with the overall quality of services at the Vet Center?	4.49	4.50

Source: Developed by VA OIG based on RCS National Service Support data provided by the District 3 Director. The OIG did not assess VA's data for accuracy or completeness.
**Scoring 1=very dissatisfied, 2=dissatisfied, 3=neither satisfied nor dissatisfied, 4=satisfied, 5=very satisfied. Vet Center Service Feedback Survey results are divided into three client types: family member, service member, and veteran. The OIG used veteran because it was most representative of the three client types. The OIG used the veteran client type from the vet center service feedback results.*

District leaders' questionnaire responses regarding the frequency feedback results received were varied. The District Director reported receiving feedback weekly, the Deputy District Director reported monthly, and the Associate District Director for Administration stated it was received annually.[42] One district leader stated they hoped the new VSignals program will allow them to have better access to client feedback.

[42] The Associate District Director for Counseling did not respond to this question in the questionnaire.

Leadership and Organizational Risks Questionnaire Results

The OIG distributed a leadership and organizational risks questionnaire to the 18 district 3 zone 3 VCDs to evaluate perceptions about select quality improvement activities and organizational health.. All 18 VCDs questionnaires were returned. The questionnaire consisted of 15 questions and collected both quantitative and qualitative data. The first 14 questions collected the quantitative data in the following areas: quality improvement, psychological safety, just culture and safety, and the VA All Employee Survey. The last question uses qualitative methodology to collect data by allowing VCDs to provide narrative responses related to quality improvement or to further explain any answers in the survey. No immediate safety issues or concerns were identified when OIG reviewed the narrative responses. The OIG did not validate respondent answers for accuracy.

Eighty-eight percent of vet center directors indicated vet center staff speak up, offer ideas, and ask questions. When challenging situations arise, ninety-four percent of respondents felt the vet center team discussed the issues openly to find solutions; however, only fifty percent believed it was easy to ask district leaders for assistance when needed. Seventy-two percent of vet center directors indicated there is a process for vet center staff to report safety issues, errors, and concerns, while sixty-seven percent reported that there was a method to review identified process issues. Sixty-seven percent of respondents believed district leaders communicate goals for quality improvement; however, VCDs indicated there are multiple barriers to implementing quality improvement activities. Some of these barriers include: lack of training, inadequate resources to support quality improvement planning, and lack of quality results to identify areas that needed improvement. Eighty-three percent of VCDs indicated they do not have enough time in a given week to support quality improvement activities.

Leadership and Organizational Risks Findings and Recommendations

The district leadership team appeared stable 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 communicating and overseeing quality improvement activities. District leaders had general knowledge of the VA All Employee Survey and Vet Center Service Feedback results. Questionnaire responses indicated most district leaders and VCDs did not feel they had enough time to support quality improvement activities. Some VCD’s reported experiencing barriers that impeded being able to implement quality improvement activities.

The OIG found the district 3 zone 3 noncompliant with providing required annual in-service trainings for vet directors, veteran outreach program specialists, and office managers.

Recommendation 1

The District Director determines reasons annual in-service training was not provided for vet center directors, veteran outreach program specialists, and office managers, and ensures training is offered for all positions as required.

District Director Concur in Principle.

Annual training was not provided in FY21 due to the COVID 19 Pandemic. Annual training was provided to all roles via virtual sessions during Q4 of FY 2022. Vet Center Director (VCD) and Program Support Assistant (PSA) annual training was completed August 2-4, 2022. Veteran Outreach Program Specialist annual training was completed September 6-8, 2022, and counselor training was completed September 12-15, 2022. Annual Training for all roles is already in the planning stages for FY 2023. FY 2023 PSA training is tentatively scheduled for Q3, VCD training is tentatively scheduled in April 2023, veteran outreach program specialist training is tentatively scheduled in May 2023, and counselor training is tentatively scheduled for 3 separate weeks (cohorts by zone) in July, August, and September of 2023. All FY23 trainings are tentatively planned for in-person sessions. The Veteran Outreach Program Specialist Talent Management System (TMS) Course # is 131004917, Counselor TMS Course # 131004200 and VCD and PSA TMS Course is # 131004435.

Status: Closed

Target date for completion: N/A

OIG Response: The OIG considers this recommendation closed.

Quality Reviews

VHA leaders have articulated the goal to serve as the nation's leader in delivering high-quality, veteran-centered care.[43] 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.[44]

Clinical and Administrative Quality Reviews

RCS requires an annual site visit, for both counseling and administrative services in all vet centers, to ensure compliance with RCS policies and procedures for management and delivery of

[43] VHA, "Blueprint for Excellence–Fact Sheet," September 2014.

[44] VHA, Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration. VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

readjustment counseling.[45] Based on review objectives, the review is conducted by either the associate district director for counseling or the associate district director for administration.

Within 30 days of receiving the site visit report, the VCD, in conjunction with the associate district director for counseling or associate district director for administration, must develop a remediation plan to address all identified deficiencies.

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 feedback[46]

Administrative quality reviews included multiple areas of evaluation:

- Vet center key staff
- Vet center physical site
- Administrative operations
- Privacy and information security management
- Emergency and crisis management Fiscal management[47]

RCS policy requires deputy district directors ensure vet center clinical and administrative quality reviews are conducted each fiscal year and are responsible for approving clinical and administrative quality reviews and remediation plans.[48] Associate district directors for counseling and administration conduct the quality reviews that result in written reports.

[45] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration,* VHA Directive 1500; VHA Directive 1500(1); and VHA Directive 1500(2) require clinical and administrative quality reviews to be completed annually. RCS Chief Officer memorandum, "Revised Clinical Site Visit Protocol" and RCS Chief Officer memorandum, "RCS Annual Oversight Assessments," October 7, 2021, further clarifies that clinical and administrative reviews are completed every fiscal year.

[46] RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

[47] RCS, *Administrative Site Visit (ASV) Protocol*. The OIG requested documentation related to administrative site visit protocol and the template was provided by RCS Central Office on October 7, 2021.

[48] RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

Deficiencies identified in the clinical and administrative quality reviews are included in the site visit reports.[49]

Within 30 days of receiving the clinical or administrative quality review report, the VCD, with the help of the associate district director for counseling or administration, develops a remediation plan with target dates for deficiencies to be corrected.[50] Within 60 days from the date the deputy district director approves the remediation plan, the VCD is responsible for resolving all deficiencies.[51] 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.[52] Figure 8 below depicts the vet center quality review process.

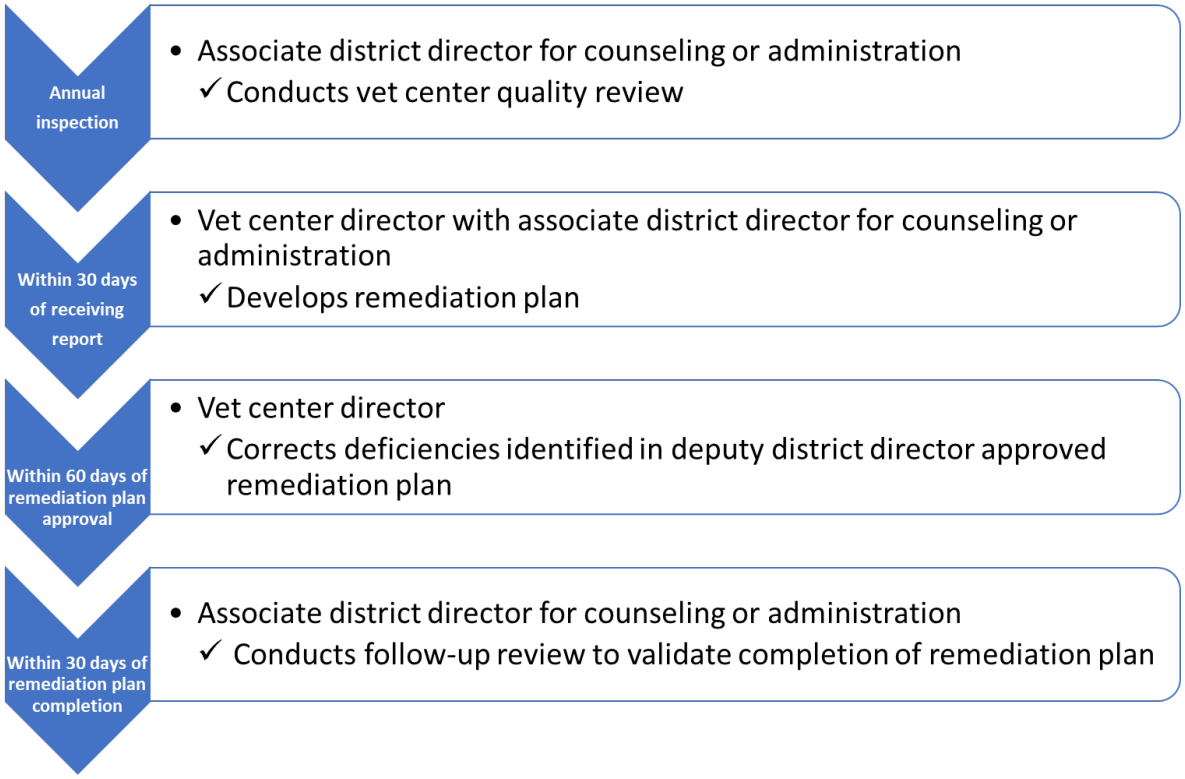

Figure 8. *Vet center clinical and administrative quality review process.*
Source: VA OIG developed using RCS Chief Officer memorandum, "Vet Center Clinical Administrative Site Visits," VHA Directive 1500, VHA Directive 1500(1), and VHA Directive 1500(2).

[49] RCS Chief Officer memorandum, "Vet Center Clinical Administrative Site Visits," November 2, 2018. RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

[50] RCS Chief Officer memorandum, "Vet Center Clinical Administrative Site Visits."

[51] RCS Chief Officer memorandum, "Vet Center Clinical Administrative Site Visits." RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

[52] RCS Chief Officer memorandum, "Vet Center Clinical Administrative Site Visits."

The OIG evaluation of the clinical and administrative review processes for all district 3 zone 3 vet centers included interviewing district leaders and review of

- clinical and administrative site visit reports (zone wide),
- clinical and administrative remediation plans (zone wide),
- clinical and administrative deficiency resolution documentation and timeliness (four selected vet centers), and
- evidence of clinical and administrative deficiency resolution (four selected vet centers).[53]

Clinical and Administrative Quality Review Findings and Recommendations

The Associate District Directors for Counseling and Administration were compliant with the completion of vet center clinical and administrative quality reviews, and remediation plans for identified deficiencies, for all 18 vet centers in district 3 zone 3.

The OIG identified the following findings:

- Clinical quality review remediation plans did not include documentation of deficiency resolution and the time frame for resolution (four selected vet centers)
- Insufficient evidence that clinical quality review identified deficiencies were resolved (four selected vet centers)

Zone-Wide Clinical Quality Reviews and Remediation Plans

Clinical quality reviews were completed for all vet centers. Clinical quality reviews were primarily the responsibility of the Associate District Director for Counseling with the Deputy District Director responsible for the final approval of the quality site visit report.[54] On average, the quality site visit reports were approved within 18 days of the site visit; 3 of the 18 reports exceeded the 30-day time frame. Of the 18 completed quality site visit reports, 16 vet centers had clinical deficiencies identified; all vet centers with identified deficiencies had remediation plans.

Vet Center Specific Clinical Remediation Plans and Deficiency Resolution for Columbia, Fargo, Omaha and Sioux Falls

The OIG examined remediation plans and deficiency resolution for the clinical quality reviews conducted at the Columbia, Fargo, Omaha, and Sioux Falls Vet Centers. RCS requires a

[53] The OIG requested documentation that each deficiency was resolved and evidence to support resolution. Examples of evidence include date and time stamped emails, photos, or invoices.

[54] RCS Chief Officer memorandum, "Vet Center Clinical and Administrative Site Visits." RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

remediation plan for all deficiencies identified during quality reviews within 30 days following receipt of the site visit report. Deficiencies are expected to be resolved within 60 days following approval of the remediation plan. [55]

The OIG found clinical remediation plans for the Columbia, Fargo, Omaha, and Sioux Falls Vet Centers addressed all deficiencies identified during the clinical quality reviews. Columbia, Omaha, and Sioux Falls Vet Centers had documentation for deficiency resolution in the remediation plans.[56] The Columbia Vet Center had evidence of resolution of all six deficiencies. [57]

The OIG found the following:

- The Fargo Vet Center did not have documentation of resolution for 10 of the 30 deficiencies identified during the clinical quality site review.
- The Fargo, Omaha, and Sioux Falls Vet Centers had a lack of evidence of resolution for 29 of 38 deficiencies.
- The Fargo, Omaha, and Sioux Falls Vet Centers did not have documentation of timely resolution of deficiencies available for 29 out of 38 deficiencies(see table 3).

Table 3. Vet Center Clinical Remediation Plans and Deficiency Resolution for the Four Selected Vet Centers

	Columbia	Fargo	Omaha	Sioux Falls
Number of Deficiencies Identified by the Associate District Director for Counseling	6	30	4	4
Number of Deficiencies Identified in the Remediation Plan	6	30	4	4
Number of Deficiencies with Documentation of Resolution	6	20	4	4
Number of Deficiencies with Evidence of Resolution	0	0	0	0
Number of Deficiencies with Documentation of Timely Resolution	0	0	0	0

Source: VA OIG analysis based on district 3 zone 3 documents.

[55] RCS Chief Officer memorandum, "Vet Center Clinical and Administrative Site Visits." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[56] Documentation of deficiency resolution is when the deficiency has been documented as resolved in the remediation plan.

[57] Evidence of resolution is requested documents provided to the OIG demonstrating the deficiency has been resolved.

Note: The OIG examined remediation plans and evidence of deficiency resolution that corresponded to Clinical Quality Reviews performed from October 1, 2020, through September 30, 2021.

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 activities.[58] RCS requires deputy district director approval of remediation plans to establish the 60-day time frame for deficiency resolution.[59]

The Deputy District Director explained that remediation plans are monitored by the Associate District Director for Counseling including follow up and monitoring of deficiency resolution. The Associate District Director for Counseling explained completing the documentation requirements set forth in RCSNet for remediation plans and deficiency resolution, and did not keep separate trackers or worksheets. The Associate District Director for Counseling reported an identified deficiency to be resolved when the VCD wrote to the resolution in the action box of the remediation plan. The Associate District Director for Counseling stated that RCSNet had limitations in assistance for oversight including not having the ability to document all the work that occurs between the Associate District Director for Counseling and the VCDs.

Recommendation 2

The District Director determines reasons clinical quality review remediation plans did not include documentation of deficiency resolution and the time frame for resolution for the Fargo, Omaha, and Sioux Falls Vet Centers, takes indicated actions to ensure completion, and monitors compliance.

[58] RCS Chief Officer memorandum, "Implementation of Automated Vet Center Clinical Site Visit (CSV) Operations," November 4, 2019. VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[59] RCS Chief Officer memorandum, "Vet Center Clinical and Administrative Site Visits." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

District Director Concur in Principle.

Clinical Quality Review remediation plans were not completed for FY20 or FY21 for the Fargo, Omaha, or Sioux Falls Vet Centers. Subsequent to this finding, a manual tracking system was developed for all clinical and administrative site visits that is completed and monitored by Associate District Director for Counseling (ADD/C), with oversight from the District Director. Implementation of the Tracker began in October 2021 and has been consistently used since then for tracking Zone 3 clinical quality review remediations. Zone 3 remediation plans and actions will be completed for FY22 and beyond.

Status: Ongoing

Target date for completion: April 2023

Recommendation 3

The District Director determines reasons for lack of evidence that clinical quality review deficiencies were resolved at the Columbia, Fargo, Omaha, and Sioux Falls Vet Centers, takes indicated actions to ensure completion, and monitors compliance.

District Director Concur.

District 3 is implementing a new process for ongoing monitoring of clinical quality review deficiencies across Zone 3. Resolution of the clinical site and remediations will be tracked and monitored in the Power-BI Dashboards and review of records in RCSnet by VCDs in collaboration with the ADDC and DDD, with a goal of deficiency resolution before the next clinical site visit. The District Director will provide oversite to this new process and will ensure discussion with VCDs about all items that are deficient for consecutive clinical quality reviews.

Status: Ongoing

Target date for completion: April 2023

Zone-Wide Administrative Quality Reviews

The associate district director for administration is responsible for administrative quality reviews and the deputy district director is responsible for final approval of remediation plans.[60] The OIG found district 3 zone 3 to be compliant with requirements for administrative quality remediation plans.

[60] RCS Chief Officer memorandum, "Vet Center Clinical and Administrative Site Visits." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

For each vet center in district 3 zone 3, the Associate District Director for Administration completed an administrative quality site review. On average, the administrative site visit reports were approved within 12 days of the site visit. Of the 18 completed administrative quality site visit reports, 12 vet centers had administrative deficiencies identified; all vet centers with identified deficiencies had remediation plans.

Vet Center Specific Administrative Remediation Plans and Deficiency Resolution

The OIG examined remediation plans and deficiency resolution for the administrative quality reviews conducted at the Columbia, Fargo, Omaha, and Sioux Falls Vet Centers. RCS requires a remediation plan for all deficiencies identified during quality reviews within 30 days following receipt of the quality site visit report.[61] Deficiencies are expected to be resolved within 60 days following approval of the remediation plan.[62]

The OIG found that the administrative remediation plans for the Columbia, Fargo, and Omaha Vet Centers addressed all deficiencies identified during the quality reviews. The Sioux Falls Vet Center did not have identified deficiencies during the inspection period's administrative site review; therefore, did not require a remediation plan or deficiency resolution. The OIG found that Columbia, Fargo, Omaha, and Sioux Falls Vet Centers had evidence of resolution for 8 of 12 deficiencies (see table 4).[63]

[61] RCS Chief Officer memorandum, "Vet Center Clinical and Administrative Site Visits." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[62] RCS Chief Officer memorandum, "Vet Center Clinical and Administrative Site Visits." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[63] The Columbia Vet Center administrative site review remediation plan was within the 60-day time frame for deficiency resolution at the time of the OIG's inspection and therefore, was not be considered out of compliance with RCS policy.

Table 4. Vet Center Administrative Remediation Plans and Deficiency Resolution for the Four Selected Vet Centers

	Columbia	Fargo	Omaha	Sioux Falls*
Number of Deficiencies Identified by the Associate District Director for Administration	3	8	1	0
Number of Deficiencies Identified in the Remediation Plan	3	8	1	N/A
Number of Deficiencies with Documentation of Resolution	0	7	1	N/A
Number of Deficiencies with Evidence of Resolution	0	7	1	N/A
Number of Deficiencies with Documentation of Timely Resolution	0	7	1	N/A

Source: VA OIG analysis based on district 3 zone 3 documents.
Note: The OIG examined remediation plans and evidence of deficiency resolution that corresponded to Administrative Quality Reviews performed between October 1, 2020 and September 30, 2021.
**During the OIG inspection period, the Sioux Falls Vet Center did not have identified deficiencies in the administrative site review and, therefore, did not require a remediation plan or deficiency resolution.*

Morbidity and Mortality 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.[64] RCS requires the VCD to complete a crisis report prior to close of business on the day of notification for a serious suicide or homicide attempt or when a client dies by suicide or homicide, with notification to district and RCS Central Office leaders within 48 hours.[65]

Additionally, RCS requires completion of a morbidity and mortality review for client safety events including serious suicide or homicide attempts, and death by suicide or homicide.[66] RCS has established a specific protocol for conducting morbidity and mortality reviews to evaluate

[64] VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, March 4, 2011.

[65] VHA Handbook 1500.01, VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[66] VHA Handbook 1500.01, VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). Prior to the 2021 directive, RCS referred to morbidity and mortality reviews as critical incident quality reviews.

vet center policies and practices regarding client safety and staff actions during the provision of vet center services, and to make recommendations to improve the effectiveness of suicide prevention activities.[67]

To examine the quality oversight process, the OIG evaluated crisis reports and morbidity and mortality reviews completed for serious suicide or homicide attempts, death by suicide or homicide client safety events that occurred during the inspection period, and interviewed district leaders.[68] The OIG reviewed a total of 13 crisis reports: 10 crisis reports were completed for serious suicide attempts, and three for client deaths by suicide.

Morbidity and Mortality Review Findings and Recommendations

The OIG found district 3 zone 3 compliant with requirements for morbidity and mortality reviews related to the three deaths by suicide of active clients. The morbidity and mortality reviews evaluated actions taken and made recommendations for improvement of vet center suicide prevention activities related to deaths by suicide completion.

The OIG found morbidity and mortality reviews were not completed for the seven serious suicide attempts identified. District leaders did not have a process in place to complete morbidity and mortality reviews for serious suicide attempts.

Recommendation 4

The District Director determines reasons why morbidity and mortality reviews for serious suicide attempts were not completed, ensures completion, and monitors compliance.

District Director 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 team 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 2023

[67] VHA, Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[68] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). Crisis reports are used to document "suicide ideation (with inability to maintain safety), suicide attempt, and suicide completion" in RCSNet.

RCS Chief Officer Morbidity and Mortality Review Recommendation

Recommendation 5

The Readjustment Counseling Service Chief Officer defines "serious suicide attempt" and establishes criteria for when a morbidity and mortality review is required as well as a standardized process for completing the review.

Chief Officer Concur in Principle.

Readjustment Counseling Service (RCS) is developing policy that will align RCS more consistently with larger Veterans Health Administration (VHA) to include replacing serious suicide attempt with self-directed violence.

Status: Ongoing

Target date for completion: April 2023

Suicide Prevention

The VA National Veteran Suicide Prevention Annual Report published in the fall of 2021 found that after adjusting for age and sex differences, the suicide rate was 52.3 percent greater in 2019 for veterans than for non-veteran adults.[69] 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." VHA supports a national goal to reduce suicide within the U.S. by 20 percent by the year 2025 through implementation of a public health model.[70] The American Foundation for Suicide Prevention reports that suicide has no single cause, but "most often occurs when stressors exceed current coping abilities of someone suffering from a mental health condition."[71]

In 2017, the VA identified RCS as an important part of the VA's overall suicide prevention strategy.[72] VHA requires a shared responsibility for suicide prevention between RCS, the Office of Mental Health and Suicide Prevention, and VHA suicide prevention coordinators. VHA

[69] VA Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, 2021. The suicide rate included in the report is adjusted for age and gender.

[70] 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.

[71] The American Foundation for Suicide Prevention is a voluntary health organization that supports suicide research and education.

[72] VHA Deputy Under Secretary for Health for Operations and Management memorandum, "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services." November 13, 2017.

recognizes that the unique community-based views of vet centers can help identify opportunities to better identify veterans' risk of suicide and thereby improve clinical outcomes of veterans under VHA care. [73]In 2017, a Memorandum of Understanding between the Office of Mental Health and Suicide Prevention and RCS defined operations for the identification, notification, and treatment of high risk or suicidal veterans and quality reviews related to veteran suicides for active clients. [74]

VHA requires each supporting VA medical facility to establish a high-risk suicide list and develop a process to activate a patient record flag in the client's VA electronic health record.

On May 11, 2020, RCS implemented a SharePoint site for high-risk suicide flag clients organized by zone.[75] In June 2021, RCS informed the OIG that the SharePoint site was expanded to include the REACH VET data.[76] RCS requires vet center directors review the High-Risk Suicide Flag list monthly and document a disposition on the site for all clients seen at the vet center within the previous 12 months.[77] RCS requires the completion of a suicide risk assessment on the first visit during the intake process and subsequent counseling visits as indicated. The vet center counselor is required to develop an individualized safety plan for all risk assessment levels of intermediate or higher.[78]

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 suicide risk assessments *(zone wide)*
- Care coordination and collaboration with VHA–RCS and VA medical facility shared high risk for suicide clients *(zone wide)*
- Safety Plans and Consultation (*zone wide)*
- Access *(four selected vet centers)*

[73] VHA Deputy Under Secretary for Health for Operations and Management memorandum, "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services." November 13, 2017.

[74] VHA Deputy Under Secretary for Health for Operations and Management memorandum, "Memorandum of Understanding between the VHA Office of Mental Health and Suicide Prevention and the VHA Readjustment Counseling Service," August 15, 2017.

[75] Microsoft, Definition of SharePoint. "a secure place to store, organize, share, and access information from any device," accessed July 15, 2021. https://support.microsoft.com/en-us/office/what-is-sharepoint-97b915e6-651b-43b2-827d-fb25777f446f.

[76] Increased predictive risk for suicide was developed by VA's Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) program to determine veterans who have a higher risk for suicide through predictive analytics.

[77] RCS Chief Officer memorandum, "High Risk Suicide Flag Outreach," April 27, 2020.

[78] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

- Care coordination and collaboration with VA medical facilities *(four selected vet centers)*
- High-risk suicide flag client disposition *(four selected vet centers)*
- Critical event plan *(four selected vet centers)*
- Root cause analysis participation and feedback *(four selected vet centers)*

The OIG 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 suicide risk assessments, care coordination and collaboration with VA medical facilities, and safety plans and consultation

Zone-Wide Psychosocial and Suicide Risk Assessment

RCS requires a psychosocial assessment including an intake and military history to be completed by the client's fifth visit unless there is documentation of an extenuating circumstance that would prevent completion of these portions timely.[79] Psychosocial assessments are used to gather information about a client's history including pre-military development, military history, war-related readjustment concerns, and level of functioning to complete a clinical evaluation.[80]

RCS also requires the completion of a suicide risk assessment during the first clinical encounter.[81] The assessment follows VA/Department of Defense Clinical Practice Guidelines by utilizing common terminology used for suicide risk evaluation and consultation practices that are familiar to other clinical providers.[82]

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 suicide risk assessments. The OIG randomly selected two samples of clients new to vet centers from October 12, 2020, through August 31, 2021.[83] The samples included 60 client records with five or more visits, and 40 clients with four

[79] RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[80] *Readjustment Counseling Service Guidelines and Instructions for Vet Center Client Records*, November 23, 2010; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[81] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[82] VA, Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services (RCSNet), September 19, 2020.

[83] The sub-population size was randomly selected and weighted for the two samples. The one-year inspection period was shortened to match the launch date of the new suicide risk assessment.

or less visits.[84] 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. For the suicide risk assessment sample, the OIG reviewed the first clinical progress note for documentation of a completed suicide risk assessment by a clinical staff member. Exclusion criteria for both samples included clients not seen during the inspection period, bereavement cases, family member seeking services during client deployments, administrative visits only, and an "other" category requiring OIG team member concurrence).

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. However, at the time of the inspection, the OIG was unable to determine when intake and military sections were completed; and therefore unable to determine if they were completed by the fifth visit as required.

The OIG reviewed client records to determine timely completion of suicide risk assessments. The OIG was able to determine suicide risk assessment completion through a RCSNet record review. However, despite the OIG having access to the database, dates of completion for suicide risk assessments were unidentifiable. Due to RCSNet limitations, the OIG reviewed the first clinical visit note for documentation that the clinician completed the suicide risk assessment.[85]

Zone-Wide Psychosocial and Suicide Risk Assessment Findings

The OIG determined that district 3 zone 3 vet center clinicians completed 88 percent of military histories and were noncompliant with requirements for completion of intake and suicide risk assessments (see table 5).

[84] RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol." The OIG stratified the population sample given RCS requires completion of the intake and military histories by the fifth visit and suicide risk assessment by the first visit. The sample of 60 client records was reviewed for completion of the intake, military history, and suicide risk assessment. The sample of 40 client records was used to evaluate completion of the suicide risk assessment as this client group had four or less visits and; therefore, completion of the psychosocial assessment was not required.

[85] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); RCS told the OIG that on October 12, 2020, RCS implemented a new risk assessment in the RCSNet individual intake procedural section. The risk assessment was divided into two groups: acute and chronic. Clinical staff determine level of risk as either low, intermediate, or high. For clients seen on or after October 12, 2020, the OIG reviewed electronic health records for completion of the new RCS risk assessment, assessing 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.

Table 5. Estimated Compliance Rate for Psychosocial and Suicide Risk Assessments
October 12, 2020–August 31, 2021

Electronic Client Record Section	Number of Client Records Reviewed	Estimated Compliance (%) Completed Zone Wide	95% Confidence Interval*
Intake	60	15	(7, 25)
Military History	60	88†	(80, 95)
Suicide Risk Assessment	100	51	(41, 61)

Source: VA OIG Analysis.
**Merriam-Webster.com Dictionary, "confidence interval," accessed on January 21, 2021, https://www.merriam-webster.com/dictionary/confidence%20interval. 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."*
†The estimated compliance rate for military history was 88 percent, where the OIG estimated with 95 percent confidence that the true compliance rate is between 80 percent and 95 percent and therefore there is not sufficient information to determine if district 3 zone 3 is above or below the 90 percent benchmark.

The OIG identified the following findings:

- Vet center counselors did not consistently complete the intake portion of the psychosocial assessment.
- Vet center counselors did not consistently complete suicide risk assessments during the first individual clinical visit.

Recommendation 6

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

District Director Concur.

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

Status: Ongoing

Target date for completion: April 2023

Recommendation 7

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

District Director Concur.

The district team provided training to the Vet Center Directors and Readjustment Counselors 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 2023

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 (SPCs), and Readjustment Counseling Service (RCS)."[86] 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.[87] Vet center staff are required to follow confidentiality requirements when coordinating care with the support VA medical facility.[88]

[86] VHA Deputy Under Secretary for Health Operations and Management memorandum, "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service."

[87] VHA Deputy Under Secretary for Health Operations and Management memorandum, "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service.".

[88] 38 C.F.R. § 17.2000–816 (e).

Electronic Client Records

The OIG identified 50 RCS clients who were flagged as high risk for suicide by the support VA medical facility and who were seen at district 3 zone 3 vet centers from September 1, 2020, through August 31, 2021, following the placement of the high-risk flag.[89]

The OIG evaluated each client record for the following:

- Consultation and coordination of services with a shared support VA medical facility within 60 days from placement of the high risk for suicide flag
    - Adherence to confidentiality requirements if consultation and coordination occurred within 60 days.[90]
- Timely notification to the support VA medical facility suicide prevention coordinator if client posed a significant safety risk[91]
    - Adherence to confidentiality requirements if notification occurred.

Zone-Wide Care Coordination and Collaboration with VA Medical Facilities Findings

The OIG found vet centers in district 3 zone 3 were not compliant with requirements for shared clients with the support VA medical facility related to suicide prevention and intervention. The OIG excluded 13 of 50 client records. Exclusions included clients with closed cases and two clients who were not seen at a vet center during the inspection period.

The OIG found that of the 37 records reviewed, 27 had documented coordinated care with support VA medical facilities as required. Of the 27, only 10 followed confidentiality

[89] There was a total of 37 clients at high-risk for suicide during this time period in zone 3. The OIG extracted all high risk for suicide (newly activated and reactivated) clients from all district 3 zone 3 vet centers associated with support VA medical facilities and cross referenced the clients with RCSNet database to identify shared clients. The data extraction period was adjusted (shortened by two months from inspection period) to allow time for RCS clinical staff to complete required care coordination following high-risk flag placement, suicide risk status changes, and crisis events. If a client had more than one significant safety risk during the review period, the team evaluated a randomly selected significant safety risk for the client.

[90] "The Vet Center supports prompt and open communication of readjustment counseling information with VA medical facility and other community providers by obtaining a voluntary written Release of Information (ROI) form from the eligible individual as required for client confidentiality." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[91] RCS policy does not define a significant safety risk; in the absence of an RCS definition of a significant safety risk, the OIG used suicidal ideation with intent and plan, preparatory suicidal behaviors, self-injurious or potentially self-injurious behaviors and suicide attempts. For the purposes of this report, timely is defined as notification that should occur on the same day that the significant safety risk is identified.

requirements. Overall, 27 percent of records reviewed followed requirements for care coordination while maintaining confidentiality.[92]

The OIG identified the following findings:

- Vet center clinical staff did not consistently consult or coordinate with support VA medical facilities on shared clients who were deemed high risk for suicide.
- For clients where coordination occurred with VA medical facilities, vet center clinical staff did not consistently follow confidentiality requirements.

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 Concur.

The district team provided training to Vet Center Directors and Readjustment Counselors regarding the importance of collaborating and coordinating care with VAMC providers on all shared clients, especially those with increased risk. Compliance is monitored during monthly chart audits conducted by the VCD's and ADD/C.

Status: Ongoing

Target date for completion: April 2023

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.

[92] The OIG estimated that 95 percent of the time, the true compliance rate for consultation and coordination and following confidentiality requirements was between 13 and 42 percent.

District Director Concur.

The district team provided training to Vet Center Directors and Readjustment Counselors on the importance of communicating the benefits of consultation and coordination of care with VA Medical Center (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 monthly chart audits conducted by the VCD's and the monthly RCSNet report provided to the ADD/C for oversight.

Status: Ongoing

Target date for completion: April 2023

Zone-Wide Safety Plans and Consultation

RCS provides guidance to vet centers for assessment and management of individuals who are considered at risk for suicide.[93] Suicide risk assessments are divided into two interrelated categories, acute and chronic. Counselors determine a self-harm level of low, intermediate or high for both categories. Vet center counselors are required to complete a suicide risk assessment at the initial counseling visit and as professionally indicated following the initial session.[94] Counselors are also required to complete a safety plan and seek consultation for any client who is assessed at intermediate to high risk for suicide, in either acute, chronic or both categories. [95]

Safety plans must be individualized and developed in conjunction with the client and vet center counselor. Completed safety plans are entered into the electronic client record, and provided to the client.[96] Safety plans identify coping strategies and support resources a client can utilize to lower risk of suicidal behavior. Over time, individuals can experience fluctuating levels of suicidality and a safety plan is designed to break the cycle early, providing the client with tools to avoid re-entering a suicidal state.[97]

[93] VA, Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services [RCSnet], updated October 5, 2020. VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[94] VA, Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services [RCSnet], updated October 5, 2020; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[95] VA, Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services [RCSnet], updated October 5, 2020; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[96] VA, Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services [RCSnet]; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[97] VA, Suicide Prevention Program Guide, November 1, 2020.

Consultation is required with the VCD, Associate District Director for Counseling, external clinical consultant, or other support VA medical facility mental health professionals, including the suicide prevention coordinator within 30 days "for individuals assessed to be at intermediate to high risk either acute, chronic or both."[98]

Electronic Client Records

The OIG randomly sampled 50 RCS clients who were assessed at intermediate to high risk for suicide, in either acute, chronic, or both categories, and were seen at district 3 zone 3 vet centers from October 12, 2020, through August 31, 2021.[99]

The OIG evaluated each client record for

- completion of a safety plan or documentation of client declining a safety plan, and
- documentation of consultation within 30 days.

Zone-Wide Safety Plans and Consultation Findings

The OIG found vet centers in district 3 zone 3 were not compliant with requirements for completion of safety plans and consultation with a VCD, associate district director for counseling, external clinical consultant, or support VA medical facility mental health professional for clients assessed at intermediate or high, or acute or chronic risk levels (see table 6).

In district 3 zone 3, the OIG found that 50 percent of records reviewed followed RCS requirements for completion of a safety plan and 40 percent of records reviewed followed RCS requirements for consultation and coordination for shared clients with support VA medical facilities (noted in table 6).

Table 6. Estimated Compliance Rate for Safety Plans and Consultation October 12, 2020–August 31, 2021

Electronic Client Record Review Area	Number of Client Records Reviewed	Estimated Compliance (%) Completed Zone Wide	95% Confidence Interval
Safety Plans	50	50	(26, 64)
Consultation	50	40	(26, 54)

Source: VA OIG Analysis.

[98] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). The OIG utilized 30 days as the time frame within which consultation should occur.

[99] A sample of 50 clients, assessed at intermediate or high, acute or chronic, risk level during the inspection period, was used for the evaluation. For clients with multiple risk assessments during the inspection period, the OIG evaluated one randomly selected risk assessment assessed at intermediate or high, acute or chronic risk level.

Recommendation 10

The District Director ensures clinical staff complete safety plans for clients that are assessed at intermediate or high, acute or chronic, risk level as required and monitors compliance across all zone vet centers.

District Director Concur.

The district team provided training to Vet Center Directors and Readjustment Counselors on the importance of completing a safety plan when a client is assessed at intermediate or high, acute or chronic, risk level. The Vet Center Director and District leadership will monitor compliance.

Status: Ongoing

Target date for completion: April 2023

Recommendation 11

The District Director ensures clinical staff consult with the vet center director, external clinical consultant, associate district director for counseling, or support VA medical facility mental health provider to include the suicide prevention coordinator following a client's suicide risk assessment as required, and monitors compliance across all zone vet centers.

District Director Concur.

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

Status: Ongoing

Target date for completion: April 2023

Vet Center Specific Suicide Prevention

The remainder of the report provides inspection findings at the following randomly selected vet centers in district 3 zone 3:

- Columbia Vet Center, Missouri
- Fargo Vet Center, North Dakota
- Omaha Vet Center, Nebraska

- Sioux Falls Vet Center, South Dakota

Access

In the 2017 Memorandum of Understanding, RCS core values include providing veterans with appointments outside of regular business hours and consists of appointment availability in the mornings, evenings, and weekends at all vet centers.[100] To assess for compliance, the OIG interviewed VCDs and reviewed documents provided regarding 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.[101] The 2017 Memorandum of Understanding outlines the following responsibilities:

- Standardization of a communication process between RCS and VA medical facility 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 coordinators[102]
- 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 veterans who were receiving RCS counseling services
- RCS qualified clinician on all root cause analysis procedures involving shared clients[103]

The OIG interviewed VCDs and requested the following:

[100] VHA Deputy Under Secretary for Health Operations and Management memorandum, "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service."

[101] VHA, *Readjustment Counseling Service Guidelines and Instructions for Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); VHA Handbook 1160.01. Mental health councils at "Each VA medical center must establish and maintain a Mental Health Executive Council that includes representation from core mental health professional disciplines and specialty VA mental health programs with administrative support from the medical center."

[102] RCS policy does not define timely notification. In the absence of a definition of timeliness, the OIG considered notification on the same day of a significant safety risk as timely.

[103] VHA Deputy Under Secretary for Health Operations and Management memorandum, "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service."

- Evidence of the VCD's or designee's participation in VA medical facility mental health council meetings
- Evidence of client disposition from the four selected vet centers in the RCS High Risk Suicide Flag SharePoint site
- Evidence of vet center critical event plan with desktop reference
- 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 at high risk for suicide.[104] RCS staff created a SharePoint site that is populated monthly with names of VA medical facility identified high-risk suicide flag clients who currently receive or have received vet center services within the past 12 months. 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. In June 2021, RCS Clinical Program and Training Analyst reported that the SharePoint site was expanded to include clients with an increased predictive risk for suicide.

The OIG requested documentation of clients identified on the High Risk Suicide Flag SharePoint site from the district office and any documented disposition from October 1, 2020, through September 30, 2021, to evaluate compliance with RCS requirements for high risk clients.

Critical Event Plan

Vet centers are required to have a critical event plan. Critical event plans are coordinated with the community and include a desktop reference sheet, for vet center staff, outlining how to respond when a client presents as suicidal or homicidal either on the phone or in person.[105]

Root Cause Analysis Participation and Feedback

Root cause analysis is a review of systems and processes that surround an adverse event or a close call.[106] The review consists of an interdisciplinary team of individuals familiar with the event and staff with varying educational backgrounds and experience. The team works together to understand the "what" and "why" of the events and identify changes that could be made to

[104] RCS Chief Officer memorandum, "High Risk Flag Suicide Outreach."

[105] RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

[106] VHA Handbook 1050.01. Adverse events are defined as "untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical facility, outpatient clinic, or other VHA facility." A close call is "an event or situation that could have resulted in an adverse event, but did not, either by chance or through timely intervention. Such events have also been referred to as "near miss" incidents."

reduce the likelihood of reoccurrence.[107] If a death by suicide occurs with a shared client and a root cause analysis is conducted, vet center staff should be included in the root cause analysis investigation and receive feedback from the support VA medical facility root cause analysis team when cases are reviewed.[108]

The OIG reviewed all clients who died by suicide from Veterans Integrated Service Network (VISN) 15, 16, and 23 offices.[109] The list was cross referenced with RCS clients to determine shared clients between VA medical facilities and the four selected vet centers.

Vet Center Specific Suicide Prevention Findings and Recommendations

The OIG found all four vet centers compliant with nontraditional hours allowing clients easier access to services. All four vet centers had critical event plans that included a desktop reference sheet. All four vet centers participated in their respective VA medical facility mental health council meetings. None of the four vet centers had shared clients, with support VA medical facilities, who died by suicide during the OIG inspection period; therefore, vet center staff did not participate in root cause analysis investigations.

The OIG found issues related to

- monthly review of the High Risk Suicide Flag SharePoint site, and
- standardized communication process between vet centers and suicide prevention coordinators at support VA medical facilities.

RCS High Risk Suicide Flag SharePoint

RCS requires VCDs to review a national SharePoint site monthly that lists clients designated as high risk for suicide by VHA facilities and clients at increased predictive risk for suicide who were active at vet centers within the previous 12 months. Once reviewed, VCDs were responsible for determining a plan of action for clients on the list and documenting a disposition on the SharePoint site. The Columbia VCD reported reviewing the SharePoint site every month and the Fargo VCD reported receiving a monthly email alert from the Associate District Director for Counseling to review the SharePoint and staff clients if they were on the list; however, there were incomplete dispositions for clients on the report provided by district staff for both vet centers.

[107] VHA Handbook 1050.01.

[108] VHA, Readjustment Counseling Service Guidelines and Instructions for Administration; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[109] The support VA medical facilities for District 3 Zone 3 are located within VISNs 15, 16, and 23.

Recommendation 12

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 Columbia and Fargo Vet Centers, takes action to ensure requirements are met, and monitors compliance.

District Director Concur.

Training has been completed for Vet Center Directors and Readjustment Counselors 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 monthly.

Status: Ongoing

Target date for completion: April 2023

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 (OMHSP), suicide prevention coordinators, and RCS.[110]

The OIG found the Omaha and Sioux Falls Vet Centers had a standardized communication process with the support VA medical facility suicide prevention coordinator, with a local Memorandum of Understanding or standard operating procedure outlining the process. The Columbia and Fargo Vet Centers met with the suicide prevention coordinators at the support VA medical facility; however, did not have a formal written process in place.

In its VCIP report, *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 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

[110] VHA Deputy Under Secretary for Health Operations and Management memorandum, "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Service."

Office of Mental Health and Suicide Prevention and Readjustment Counseling Service Memorandum of Understanding, and initiates action as necessary.

Therefore, the OIG did not make a recommendation related to standardized communication and collaboration processes between suicide prevention coordinators and vet centers in this report.[111]

Consultation, Supervision, and Training

Each vet center is assigned a clinical liaison and an external clinical consultant from the support VA medical facility.[112] Clinical liaisons help coordinate care for clients with the support VA medical facility, whereas external clinical consultants provide guidance on clinically complex cases.[113]

Vet centers are comprised of small multidisciplinary teams, are community-based, and traditionally located outside of VA medical facilities. Vet center teams are at least four staff consisting minimally of a VCD, an office manager, a counselor, and an outreach program specialist.[114] Vet centers are required to have at least one VHA-qualified licensed mental health professional on staff.[115]

VCDs provide staff supervision, maintain VA and community partnerships, and 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 or caregivers
- Counseling for conditions related to military sexual trauma[116]

In February 2016, the VHA Under Secretary for Health stated the need for continued review and certification of suicide prevention training annually for VHA clinicians. Following the initial mandated training, staff were required to complete the corresponding refresher courses for their

[111] VA OIG, *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers, Report No. 20-02014-270*, September 30, 2021. RCS leaders informed the OIG that the 2017 Memorandum of Understanding was discontinued on March 22, 2022.

[112] VHA, Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[113] RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[114] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[115] VHA, Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[116] *VHA Handbook 1500.01;* VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). The VCD is responsible for vet center operations including staff supervision, administration, and clinical programs.

positions.[117] On October 15, 2020, VHA updated the suicide prevention training course and refresher requirements for all staff.[118]

RCS requires annual training specifically focused on all background knowledge and skill sets for vet center staff to perform administrative and counseling duties specific to each vet center staff position.[119]

Military sexual trauma is reported to VA providers at a rate of about one in three for women and one in 50 for men. RCS clinical staff are required to complete military sexual trauma training.[120]

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

- Clinical liaison
- External clinical consultation
- VHA-qualified mental health professional on staff
- Supervision
- Staff training

Consultation

Clinical Liaison

The clinical liaison is a mental health professional, appointed from the support VA medical facility.[121]

External Clinical Consultation

External clinical consultants are assigned from the support VA medical facility to provide a minimum of four hours per month of consultation. The external clinical consultants must be VHA-qualified mental health professionals who are licensed and credentialed through the support VA medical facility. If the VA medical facility is unable to provide an external consultant, the vet center is authorized to seek services from the private sector. External clinical

[117] 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.

[118] VA Secretary memorandum, "Agency-Wide Required Suicide Prevention Training (VIEWS 3346983)," October 15, 2020.

[119] VHA Handbook 1500.01, 2010; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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

[121] VHA Handbook 1500.01, 2010; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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 provide consultation to vet center clinicians in the treatment of complex veteran cases.[122]

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

- Vet center staffing spreadsheets[123]
- Documentation demonstrating external clinical consultation of four hours a month

VHA-Qualified Mental Health Professional

Each vet center is required to maintain one licensed and credentialed VHA-qualified mental health professional.[124] 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 October 1, 2020, through September 30, 2021.
2. If the vet center had more than one VHA-qualified mental health professional on staff,
    a. the OIG randomly selected one individual, and
    b. requested credentialing documentation of that individual from RCS's Consolidated Human Resource Management Office.

Supervision

VCDs are to provide individual supervision to all vet center staff on an ongoing basis.[125] If the VCD is not a VHA-qualified mental health professional, a licensed clinical designee will assist with the supervision of clinical staff.[126] VCDs must also complete a monthly chart audit of 10 percent of every full-time counselor's active client caseload.[127]

The OIG evaluated supervision through interviews with the four VCDs and reviewed documentation of weekly supervision from July 1, 2021, through September 30, 2021, and

[122] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*;VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

[123] A staffing spreadsheet was requested from each vet center to provide information on appointed liaisons, consultants, and their associated service lines.

[124] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[125] VHA Handbook 1500.01, 2010; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

[126] VHA Handbook 1500.01, 2010; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

[127] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

monthly chart audits from October 1, 2020, through September 30, 2021, for all counselors on staff.[128]

Staff Training

In December 2017, VHA clinical staff (including RCS clinical staff) were mandated to complete Suicide Risk Management Training for Clinicians within 90 days of entering their position and annually thereafter. Additionally, non-clinical staff were required to complete the S.A.V.E. training withing 90 days of entering their positions, or as an annual refresher.[129] In October 2020, the Department of Veterans Affairs 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.[130]

All VA medical facilities and vet centers provide military sexual trauma services. Vet Center clinical staff are required to complete VHA military sexual trauma training within 90 days of entering their position.[131] All vet center staff, regardless of position, are required to complete in-service training annually.[132]

To determine compliance the OIG requested training records and proof of attendance for required training completed for all staff employed from October 1, 2020, through September 30, 2021.

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, a clinical liaison who is also a mental health professional from the support VA medical facility, and an external clinical consultant, who is an independent licensed mental health professional.

The OIG found deficiencies in other areas:

- External clinical consultation
- Supervision
- Monthly chart audits

[128] District leaders informed the OIG the expectation in zone 3 is to conduct weekly individual clinical supervision.

[129] VHA Directive 1071. S.A.V.E. refers to "Signs," Ask," "Validate," "Encourage" and "Expedite," and is a training video collaboration with VA and PyschArmor Institute.

[130] VA Secretary memorandum, "Agency-Wide Required Suicide Prevention Training (VIEWS 3346983)."

[131] VHA Directive 1115.01.

[132] VHA Handbook 1500.01, 2010; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

- Staff training

External Clinical Consultation

RCS requires four hours of external clinical consultation monthly.[133] The OIG found all four VCDs documented consultation hours. However, only Sioux Falls Vet Center met the required four hours of external clinical consultation per month. The Columbia Vet Center provided evidence of external clinical consultation occurring all months of the inspection period but did not meet the four-hour requirement for ten months. The VCD stated that meetings took place weekly; however, documentation was not kept for all meetings. The Fargo Vet Center provided evidence of external clinical consultation occurring all months of the inspection period but did not meet the four-hour requirement for four months. The acting VCD reported meeting every other week; however, if the external clinical consultant was unavailable, the meetings were not held or rescheduled. The Omaha VCD reported having consultation for four hours a month; however, three meetings were missed during the inspection period. If the external clinical consultant was unavailable or there was a holiday, it was not rescheduled and the hours were not made up.

Recommendation 13

The District Director determines reasons for noncompliance with processes for completing and tracking four hours of external clinical consultation per month at the Columbia, Fargo and Omaha Vet Centers, ensures vet center directors implement processes, and monitors compliance.

District Director Concur.

The district team provided training to the VCD's on the importance of external consultation. VCD's and ADD/C monitor and track the frequency and length of time of all external consultation meetings through RCSNet Oversight Tracker. Compliance is monitored monthly by the VCD's and the ADD/C.

Status: Ongoing

Target date for completion: April 2023

[133] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol."

Supervision

RCS policy requires ongoing supervision to help with staff cohesion, problem solving, client case coordination, and the coordination of services with VA partners. RCS does not specify how supervision is tracked to ensure completion.[134] District leaders stated an expectation of weekly supervision with the Associate District Director for Counseling reporting that VCD's are aware of the expectation.

The OIG found all four vet centers did complete supervision, but were noncompliant with the provision of weekly individual staff supervision . The Columbia VCD provided documentation of staff supervision; however, the VCD reported meeting with staff twice a month despite having weekly time reserved on their calendars. The acting Fargo VCD reported that regularly scheduled meetings for supervision were stopped in August due to staffing concerns and increased caseload responsibilities, but the VCD was available for staff to contact when there were specific case issues. The Omaha VCD provided evidence of group supervision; however, the Associate District Director for Counseling reported an expectation of weekly individual supervision. The Sioux Falls VCD provided individual supervision weekly, but did not reschedule supervision when staff were on leave.

Recommendation 14

The District Director determines reasons for noncompliance with staff supervision provided by vet center directors at the Columbia, Fargo, Omaha, and Sioux Falls Vet Centers, ensures staff supervision occurs as required, and monitors compliance.

District Director Concur in Principle.

The VHA Directive 1500(1) which was published on January 26, 2021, indicates that the VCD is responsible for "providing individual supervision to all Vet Center staff, counselors, outreach workers, and office managers on an ongoing basis."

Status: Ongoing

Target date for completion: April 2023

Monthly Chart Audits

Oversight is one of the main responsibilities of a VCD to ensure quality clinical services. A methodology used to complete oversight is chart audits. RCS policy requires VCDs to complete

[134] RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

a monthly 10 percent audit of each full-time counselor's active client caseload. [135] The OIG found that all four VCDs were noncompliant in conducting case audits.

The Columbia VCD provided the RCSNet audit reports but did not meet the 10 percent audit for active client caseload for staff, which they attributed to rounding down number of cases reviewed compared to actual caseload. The VCD reported concerns of accuracy of RCSNet audit reports and errors in the caseload numbers. The acting Fargo VCD provided chart audits for staff, but was missing complete chart audit records for three counselors. Of the two counselors at the Omaha vet center, the VCD completed monthly chart audits for 11 of the 12 months for one of the staff. The VCD was unable to pull previous caseload information from RCSNet for the other counselor who retired and was removed from the system. Therefore, the OIG was unable to determine if 10 percent of the caseload was reviewed. The Sioux Falls VCD documented monthly chart audits for each counselor throughout the inspection period; however, the VCD did not review 10 percent of active client caseloads and therefore was noncompliant.

Recommendation 15

The District Director verifies and determines reasons for noncompliance with monthly RCSNet chart audits at the Columbia, Fargo, Omaha, and Sioux Falls Vet Centers, ensures chart audits are completed as required, and monitors compliance.

District Director Concur. Recent updates to RCSNet have made tracking this requirement easier and Vet Center Directors have been trained on the requirements and the importance of conducting monthly Chart audits. The district team will monitor compliance. Status: Ongoing Target date for completion: April 2023

Staff Training

RCS requires completion of mandatory trainings for both clinical and non-clinical staff.[136] The OIG found all four vet center non-clinical staff were compliant with completion of annual suicide prevention and refresher training but Columbia and Sioux Falls Vet Center clinical staff were noncompliant. The Columbia VCD reported awareness of incorrect training assignments; however, staff completed the incorrectly assigned trainings despite the error in assignment. The Sioux Falls VCD believed VA Talent Management System trainings assigned were correct but

[135] RCS Chief Officer memorandum, "Revised Clinical Site Visit (CSV) Protocol." VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[136] RCS, Administrative Site Visit (ASV) Protocol.

this was not the case for two staff members. Both the Columbia and Sioux Falls VCDs thought VA Talent Management System training assignments were completed by the district office.

Additionally, clinical staff at all four vet centers were noncompliant with completing military sexual trauma training. The Columbia, Fargo, and Sioux Falls VCDs reported thinking that the trainings were correct because they were assigned by the district office. The Omaha VCD did not know military sexual trauma training was required and believed if a staff member was employed by VHA previously, the training was already completed. All four vet centers were noncompliant with completing annual in-service training in fiscal year 2021 for VCD's, veterans outreach specialists, and office managers. VCD's told the OIG that annual in-service training for fiscal year 2021 was provided for clinical staff only.

Recommendation 16

The District Director determines reasons staff at the Columbia, Fargo, Omaha, and Sioux Falls Vet Centers did not complete required trainings, ensures all mandatory trainings are complete, and monitors compliance.

District Director Concur.

A new process is in development to establish guidelines for the assignment, tracking and follow-up of mandatory trainings. The district team will work with the RCS national training manager to identify the required trainings and ensure electronic assignment are established and monitored for compliance.

Status:

Target date for completion: April 2023

Environment of Care

VHA defines environment of care as "the built environment, including how it is arranged and the special features that protect patients, visitors, and staff; equipment and systems used to support patient care or to safely operate the building or space; and people, including those who work within the hospital, patients, and anyone else who enters the environment, all of whom have a role in minimizing risks by ensuring that these environments support all Veterans' dignity, privacy, safety, and security."[137] RCS requires that the office space promotes interaction amongst eligible clients and their families and facilitates access to readjustment counseling services.[138]

[137] VHA Directive 1608, Comprehensive Environment of Care (CEOC) Program, June 21, 2021.

[138] RCS, *Administrative Site Visit (ASV)* Protocol; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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

Physical Environment

To assess compliance with environmental cleanliness, the OIG virtually inspected the exterior to assess if it appeared clean, neat, and presentable, and interior furnishings to determine if they were clean and in good repair. The OIG also assessed each vet center for a welcoming or non-institutional environment decorated with military appreciation items, including an informal space for clients and families to interact. [139]

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.[140] Facilities subject to the Architectural Barriers Act must comply with the Architectural Barriers Act Accessibility Standards.[141] The OIG evaluated if vet centers were compliant with Architectural Barriers Act Accessibility Standards related to people with disabilities including entrances, parking spaces, and exit signs.[142]

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/building emergency plan, site/facility/building temporary relocation plan, management of disruptive behavior plan, violence in the workplace (including active shooter plan), and handling of suspicious mail and bomb threats."[143] 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 eligible clients to talk about military and traumatic experiences in an environment that is less stigmatizing than traditional medical settings.[144] Any documents or items displaying confidential or sensitive 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

[139] RCS, *Administrative Site Visit (ASV)* Protocol; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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

[141] 41 C.F.R. § 102–76.65(a).

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

[143] RCS, Administrative Site Visit (ASV) Protocol.

[144] VHA Handbook 1500.01, 2010; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

is double-locked and complies with VHA security requirements; the directive dated January 26, 2021, does not address file storage specifications.[145] The OIG virtually assessed each vet center's offices, group counseling rooms, and storage rooms to determine compliance with privacy requirements.

Environment of Care Findings and Recommendations

The OIG virtually inspected 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. The vet centers had furnishings that were clean and in good repair. All four vet centers had sound-proofed, 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 Accessibility Standards for an accessible entrance and designated parking spaces for people with disabilities.

The OIG found deficiencies in the following:

- Architectural Barriers Act compliant exit signage
- Current emergency and crisis plans

Architectural Barriers Act Accessibility Standards

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."[146] The OIG found Columbia, Fargo, and Omaha Vet Centers did not have a tactile (braille) sign posted near the exit discharge. At the time of inspection, the acting Fargo VCD reported working with the district office to obtain signage. The Omaha Vet Center staff were able to provide the OIG documentation that the tactile signs were ordered.

[145] VHA Handbook 0730/4, *Security and Law Enforcement*, March 29, 2013. Security must be floor-to-ceiling.
[146] 36 C.F.R. § Pt. 1191, App. D.

Recommendation 17

The District Director evaluates and determines reasons for noncompliance with tactile (braille) signage at the Columbia, Fargo, and Omaha Vet Centers and ensures all exit doors are compliant with Architectural Barriers Act requirements.

District Director Concur.

The district team will work with the RCS leasing point of contact to have the braille signage added to the identified Vet Centers.

Status: Ongoing

Target date for completion: April 2023

Emergency Plan

RCS requires each vet center to have a current emergency and crisis plan that addresses "contingencies for phone and computer disruptions, weather/national disaster emergency plan, site/facility/building emergency plan, site/facility/building temporary relocation plan, management of disruptive behavior plan, violence in the workplace plan (including Active Shooter Plan), [and] handling of suspicious mail and bomb threats." The OIG found all four vet centers had emergency and crisis management plans; however, the Fargo Vet Center plans were not dated; therefore, the OIG was unable to determine if it was current.

Recommendation 18

The District Director reviews reasons for noncompliance of a missing date on the emergency and crisis plan at the Fargo Vet Center and ensures compliance.

District Director Concur.

The Fargo Vet Center Director completed and submitted an emergency and crisis plan containing all required components. This plan is under review by the district team for compliance.

Status: Ongoing

Target date for completion: January 2023

Appendix A: Summary of Vet Center Inspection Program Recommendations

The intent of the recommendations is for VCDs to use them as a road map to help improve operations and clinical care. The 18 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. Summary of Vet Center Inspection Program Recommendations

Leadership and Organizational Risk	Requirement	Recommendation
District Training	Annual in-service training	1. The District Director determines reasons annual in-service training was not provided for vet center directors, veteran outreach program specialists, and office managers and ensures training is offered for all positions as required.
Quality Reviews	**Requirement**	**Recommendation**
Clinical and Administrative Quality Reviews	Clinical quality review remediation plans	2. The District Director determines reasons clinical quality review remediation plans did not include documentation of deficiency resolution and the time frame for resolution for the Fargo, Omaha, and Sioux Falls Vet Centers, takes indicated actions to ensure completion, and monitors compliance.
		3. The District Director determines reasons for lack of evidence that clinical quality review deficiencies were resolved at the Columbia, Fargo, Omaha, and Sioux Falls Vet Centers, takes indicated actions to ensure completion, and monitors compliance.
Morbidity and Mortality Reviews	Completion of morbidity and mortality reviews for all serious suicide attempts of active clients	4. The District Director determines reasons why morbidity and mortality reviews for serious suicide attempts were not completed, ensures completion, and monitors compliance.
		5. The Readjustment Counseling Service Chief Officer defines “serious suicide attempt” and establishes criteria for when a morbidity and mortality review is required as well as a standardized process for completing the review.

Suicide Prevention (Zone Wide Electronic Record Review)	Requirement	Recommendation
Intake Assessment	Completion of psychosocial assessments within five visits	6. The District Director ensures the intake portion of the psychosocial assessment is completed and monitors compliance across all zone vet centers.
Suicide Risk Assessment	Completion of risk assessments during the first clinical encounter	7. The District Director ensures suicide risk assessments are completed on the first clinical visit and monitors compliance across all zone vet centers.
Confidentiality and Coordination	Confidentiality and coordination with VA medical facilities	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.
		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.
Safety Plans and Consultation	Safety Plans	10. The District Director ensures clinical staff complete safety plans for clients that are assessed at intermediate or high, acute or chronic, risk level as required and monitors compliance across all zone vet centers.
	Consultation following suicide risk level changes	11. The District Director ensures clinical staff consult with the vet center director, external clinical consultant, associate district director for counseling, or support VA medical facility mental health provider to include the suicide prevention coordinator following a client's suicide risk assessment as required, and monitors compliance across all zone vet centers.
Suicide Prevention (Vet Center)	**Requirement**	**Recommendation**
Suicide Prevention and Intervention (Vet Center)	Monthly review and documentation in RCS High Risk Suicide Flag SharePoint Site	12. 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 Columbia and Fargo Vet Centers, takes action to ensure requirements are met, and monitors compliance.

Consultation, Supervision and Training	Requirement	Recommendation
External Clinical Consultation	Documentation of four hours of external clinical consultation per month	13. The District Director determines reasons for noncompliance with processes for completing and tracking four hours of external clinical consultation per month at the Columbia, Fargo and Omaha Vet Centers, ensures vet center directors implement processes, and monitors compliance.
Supervision	Supervision with clinical staff members	14. The District Director determines reasons for noncompliance with staff supervision provided by vet center directors at the Columbia, Fargo, Omaha, and Sioux Falls Vet Centers, ensures staff supervision occurs as required, and monitors compliance.
Monthly Audit	Monthly 10 percent client record audit for each counselor	15. The District Director verifies and determines reasons for noncompliance with monthly RCSNet chart audits at the Columbia, Fargo, Omaha, and Sioux Falls Vet Centers, ensures chart audits are completed as required, and monitors compliance.
Training	Completion of all mandatory trainings	16. The District Director determines reasons staff at the Columbia, Fargo, Omaha, and Sioux Falls Vet Centers did not complete required trainings, ensures all mandatory trainings are complete, and monitors compliance.
Environment of Care	**Requirement**	**Recommendation**
General Safety	All exit signage Architectural Barriers Act standards compliant	17. The District Director evaluates and determines reasons for noncompliance with tactile (braille) signage at the Columbia, Fargo, and Omaha Vet Centers and ensures all exit doors are compliant with Architectural Barriers Act requirements.
	Emergency, crisis plan or both are current	18. The District Director reviews reasons for noncompliance of a missing date on the emergency and crisis plan at the Fargo Vet Center and ensures compliance.

Appendix B: District 3 Zone 3 Profile

Table B.1. Zone 3 Profile
(October 1, 2020–September 30, 2021)

Profile Element	District 3 Zone 3	
Total Budget Dollars		$2,561,704.10
Unique Clients*		4,413
New Clients		1,420
Active Duty Clients		131
Spouse/Family Clients		2,472
Bereavement Clients		186
Position	**Authorized**	**Filled**
Total Full-time †	114	102
District Director and District Administrative Staff	3	3
Zone Leaders (Deputy District Director, Associate District Directors for Administration/Counseling) and Zone Administrative Staff	4	4
Vet Center Director	18	18
Clinical Staff	54	46
Veterans Outreach Program Specialist‡	20	17
Vet Center Office Staff	18	17
Contract Providers	N/A	

Source: VA OIG analysis of information from district 3 zone 3.
**Unique clients are the number of clients seen at the vet center during the inspection period and could include bereavement, active duty or spouse/family clients.*
†Total full-time includes the zone specific staff only and does not include the district leaders.
‡Veteran Outreach Program Specialist are responsible for vet center outreach services. Veteran Outreach Program Specialists conduct outreach in order to educate, engage, and encourage eligible individuals to obtain needed services at the vet center.

Profile Summary: From October 1, 2020, through September 30, 2021, district 3 zone 3 operated on a total budget of $2,561,704.10 and served 4,413 unique clients, 1,420 new clients, 131 active duty, 2,472 spouses and family members, and 186 bereavement clients. There was a total of 114 authorized full-time positions, with 12 vacancies throughout the zone as of October 27, 2021.

Appendix C: Selected Vet Center Profiles

The table below provides general background information for the four selected zone 3 vet centers.

Table C.1. Fiscal Year 20221 Vet Center Profiles

Profile	Columbia Vet Center	Fargo Vet Center	Omaha Vet Center	Sioux Falls Vet Center
• Total Budget Dollars	$119,768	$282,637	$107,681	$140,111
• Unique Clients	157	276	415	213
• Bereavement Clients	12	11	20	16
• Active Duty Clients	2	9	10	1
• Spouse/Family Clients	143	62	113	131
• New Clients	53	58	221	63
Total Number of Positions	**Columbia Vet Center**	**Fargo Vet Center**	**Omaha Vet Center**	**Sioux Falls Vet Center**
• Total Authorized Full-time Positions	6	8	6	6
• Total Filled Positions	6	8	4	6
• Total Vacancies	0	0	2	0
• Total Part-time Positions	0	0	0	0

Source: VA OIG analysis of information provided by district 3 zone 3.

Appendix D: RCS Chief Readjustment Counseling Officer Memorandum

Department of Veterans Affairs Memorandum

Date: November 1, 2022

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

Subj: Vet Center Inspection of Midwest District 3 Zone 3

To: Office of the Under Secretary for Health (10N)
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 Program-District 3 Zone 3*. I have reviewed the recommendations and submit action plans to address all findings in the report.
2. Comments regarding the contents of this memorandum may be directed to the Readjustment Counseling Service action group at VHA10RCSAction@va.gov.

(Original signed by:)

Michael Fisher
Chief Officer, Readjustment Counseling Service

Appendix E: RCS Midwest District 3 Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 25, 2022

From: Joseph Dudley, Acting District Director, District 3

Subj: OIG Draft Report, Vet Center Inspection Program-District 3 Zone 3

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 Centers Inspection Program-District 3 Zone 3.
2. I have reviewed the draft report and request closure of recommendation one since annual trainings were completed for all disciplines in Fiscal Year 2022. I concur with the other recommendations and comments and action plans are provided in the attachment.
3. Please express my thanks to the team for their professionalism and assistance to us in our continuing efforts to improve the care we provide to our Veterans.

(Original signed by:)

Joseph J Dudley
Acting District Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Jill Murray, LCSW, Director Matthew Baker, LCSW Mahshid Lee, LCSW Sarah Levis, LCSW Laura Savatgy, MPA
Other Contributors	Josephine Andrion, MHA, RN Leakie Bell-Wilson, MSN, RN Jennifer Christensen, DPM Limin Clegg, PhD Shelevia Dawson, MSN, RN Dawn Dudek, LCSW Reynelda Garoutte, MHA, BSN Lindsay Gold, LCSW Christopher Hoffman, LCSW, MBA Adam Hummel, MPPA Brandon Leflore-Nemeth Ryan Mairs, MSW, LICSW Christine Micek, MSN, RN Bina Patel, PhD, LCSW Nitin Patel, BS, MPH Natalie Sadow, MBA Harold Stanek, MS Robyn Stober, JD, MBA April Terenzi, BA, BS Rashiya Washington, JD Sonia Whig, MS, RDN Dawn M. Woltemath, MSN, RN

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