DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Vet Center Inspection of North Atlantic District 1 Zone 3 and Selected Vet Centers

VCIP REPORT | REPORT #21-03233-122 | MAY 25, 2023

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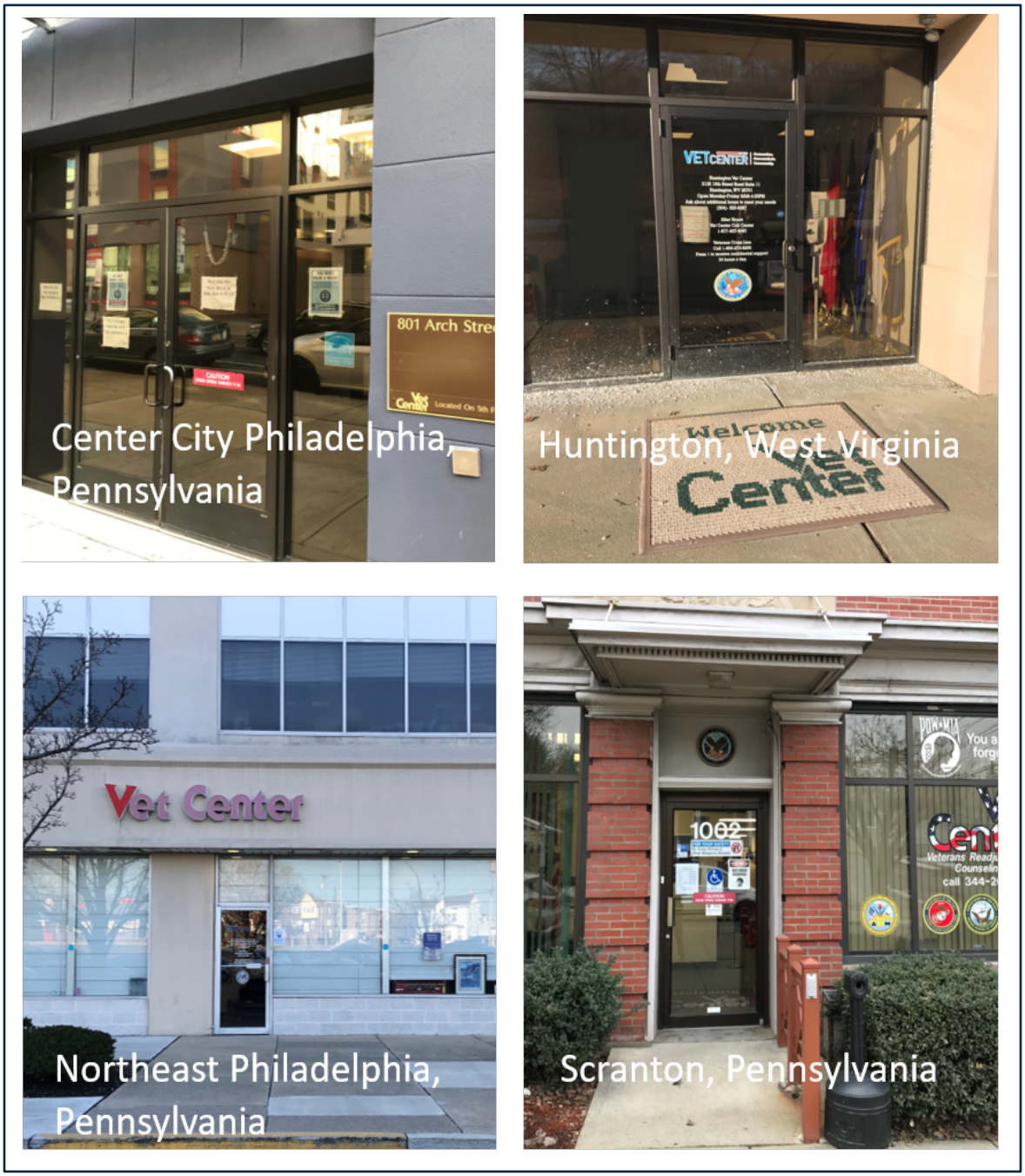

Figure 1. *North Atlantic District 1 Zone 3 Vet Centers inspected: (from top to bottom, left to right) Center City Philadelphia, Pennsylvania; Huntington, West Virginia; Northeast Philadelphia, Pennsylvania; and Scranton, Pennsylvania.*
Source: VA OIG inspection team on-site visit photographs.

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. 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 North Atlantic district 1 zone 3 and four selected vet centers: Center City Philadelphia, Northeast Philadelphia, and Scranton in Pennsylvania; and Huntington, West Virginia.[1]

VCIP inspections are one element of the OIG's oversight to ensure that the nation's veterans receive high-quality and timely mental health care and 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.[2]

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:[3]

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

[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 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 September 2010 handbook. 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.

[2] A fiscal year is a 12-month period that the federal government uses for accounting purposes running from October 1 through September 30.

[3] *Readjustment Counseling Services (RCS) 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 vet center's 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 1 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).[4]

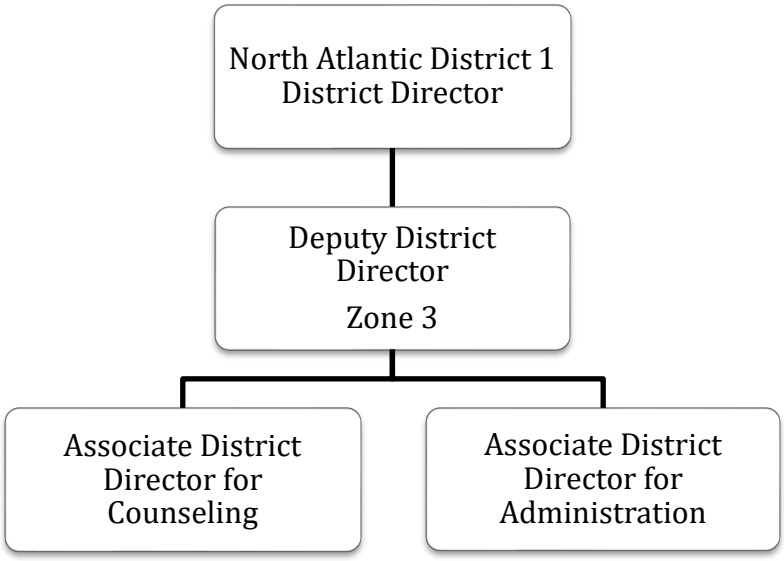

Figure 2. *North Atlantic district 1 zone 3 leaders.*
Source: VA OIG analysis of district organizational chart.

At the time of the OIG inspection, the District Director, Deputy District Director, and Associate District Director for Counseling had been working together for more than two years.[5] The District Director has been in the role since December 2019. There was one vacant district leader position in the 12 months prior to the inspection. The associate district director for administration position was vacant for two months before being filled in October 2021. A district leader

[4] VHA, *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, 2010; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). Readjustment Counseling Service is an organizational element within VHA with direct-line authority for community-based vet centers and is responsible for the provision of readjustment counseling.

[5] For the purposes of this report, *district leaders* refers to the District Director, Deputy District Director, Associate District Director for Counseling, and Associate District Director for Administration.

informed the OIG that the zone 3 Deputy District Director was on leave during the inspection; therefore, coverage was provided by another Deputy District Director.

District leaders were knowledgeable about the basic concepts of, and their roles in, quality improvement principles and practices. District leaders described quality improvement as a systematic and continuous effort to operationalize, evaluate, implement, sustain, and improve processes to support staff and improve client care. Three of four leaders reported not having enough time in a given week to support quality improvement activities.

Vet center staff must complete annual training specific to the duty assignments of each position. Readjustment Counseling Service (RCS) district leaders are responsible for planning and implementing the annual trainings, using a wide variety of modalities, including face-to-face trainings or video conferencing. District 1 zone 3 conducted annual in-service trainings during the inspection period and developed training agendas for vet center staff positions.[6]

The VA All Employee Survey is an annual survey of VA workforce experiences. District leaders reported sharing the All Employee Survey results through zone calls, town hall meetings, and emails. Based on All Employee Survey results, district leaders streamlined communication, provided training, and encouraged sharing of resources and team building to reduce burnout.

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 are met.[7] The results from the feedback survey provide district leaders and vet center directors (VCDs) an opportunity to evaluate the effectiveness of readjustment counseling and services provided.

The OIG reviewed Vet Center Service Feedback Survey results for fiscal year 2020, and found district 1 zone 3 client feedback results were higher than the national average in all areas except convenience of appointment scheduling and vet center location. The District Director surmised the higher than national average Vet Center Service Feedback scores were a result of client's favorable view of vet centers.

Quality Reviews

The OIG conducted an analysis of 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.

[6] The OIG inspection period for this report was January 1, 2021, through December 31, 2021.

[7] Policy Memorandum, RCS-NSS-001, "Readjustment Counseling Service (RCS) Customer Feedback Procedures," February 1, 2019. The Vet Center Service Feedback Survey includes feedback from veterans, active duty service members, and family.

RCS requires morbidity and mortality reviews for client safety events including clients with serious suicide or homicide attempts, and death by suicide or homicide.[8]

The OIG found the Associate District Director for Counseling was compliant with requirements for completion of clinical quality reviews and remediation plans. The Associate District Director for Administration was compliant with requirements for completion of administrative quality reviews; however, was deficient in remediation plan completion for two vet centers. The Associate District Directors for Counseling and Administration were noncompliant for clinical and administrative deficiency resolution. The OIG found the Associate District Director for Counseling noncompliant with completion of morbidity and mortality reviews for two serious suicide attempts and one homicide completion. The OIG issued seven recommendations.[9]

Suicide Prevention

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

The four selected vet centers inspected were compliant with required availability of nontraditional hours for appointments. All four VCDs were compliant with the requirement of reviewing and dispositioning RCS High Risk Suicide Flag SharePoint clients. All four VCDs were noncompliant with the requirement of attending the support VA medical facility's mental health council meetings.[10] None of the four vet centers had a standardized communication process for collaboration with the support VA medical facility suicide prevention coordinators.[11]

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[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.

[9] The OIG did not make recommendations for deficiencies identified in this report related to morbidity and mortality reviews for serious suicide attempts as recommendations on the deficiencies were directed to the RCS Chief Officer, who has authority over all districts, in the OIG report *Vet Center Inspection of Midwest District 3 Zone 1 and Selected Vet Centers*, Report No. 21-03231-38, January 19, 2023.

[10] Vet center staff are required to participate on all support 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.

[11] Deputy Under Secretary for Health for Operations and Management (10N), "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services," November 13, 2017, outlines responsibilities shared between RCS and the Office of Mental Health and Suicide Prevention. RCS leaders informed the OIG that the 2017 Memorandum of Understanding was discontinued on March 22, 2022. 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 the OIG report, *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021.

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

Consultation, Supervision, and Training

The consultation, supervision, and training review evaluated the four selected vet centers with findings and recommendations specific to those sites. One of the four vet centers inspected was not compliant with requirements to have a clinical liaison who is a mental health professional appointed from the VA medical facility. All four vet centers were compliant with having an independent licensed mental health professional as an external clinical consultant. All four vet centers were compliant with having a licensed and credentialed VHA-qualified mental health professional on staff.[12]

Three of four VCDs were noncompliant with completion of four hours of external clinical consultation per month. All four VCDs were noncompliant with providing ongoing and reoccurring supervision to clinical staff. All four VCDs were not compliant with auditing 10 percent of each counselor's electronic client records. Staff at all four vet centers were noncompliant with completing required trainings.

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

Environment of Care

Environment of care reviews evaluated the four selected vet centers with results and recommendations specific only to those sites. The four vet centers inspected generally complied with environment of care requirements. However, the OIG found three of four vet centers were noncompliant with posting Architectural Barriers Act Accessibility Standards for tactile exit signs.[13] The OIG identified one vet center noncompliant with privacy requirements. The OIG found two of four vet centers noncompliant with having current or comprehensive emergency plans. The OIG made three recommendations related to environment of 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. For the purpose of this report, the OIG considers a mental health professional a healthcare provider.

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

Conclusion

The OIG conducted a detailed inspection across five review areas and issued a total of 24 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 RCS and 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.

Comments

The RCS Chief Officer and District Director concurred with the recommendations. An action plan was provided (see responses within the body of the report for full text of RCS comments, and appendixes D and E for the Chief Officer and District Director memorandums). Based on information provided, the OIG considers recommendations 1, 4, 7, 17, and 23 closed. For the remaining open recommendations, the OIG will follow up on the planned actions to ensure that they have been effective and sustained.

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

Vet Center History

"RCS [Readjustment Counseling Service] is an autonomous organizational element in VHA [Veterans Health Administration] with direct line authority for the 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

[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 September 2010 handbook. Vet centers provide counseling interventions for psychological and psychosocial readjustment problems related to specific types of military deployment stressors. 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." VHA Handbook 1500.01, 2010; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). Policy Memorandum RCS-CLI-003, "Revised Clinical Site Visit (CSV) Protocol," January 25, 2019.

[3] 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.

services."[4] Since opening vet centers in 1979, RCS was one of the first organizations to address the psychological and social effects combat has on veterans before the American Psychiatric Association recognized posttraumatic stress disorder as an official diagnosis in 1980.[5]

While vet centers initially focused on Vietnam-era veterans, services are now offered to veterans of any combat theater, families, and active service members.[6] From inception of the vet center program in 1979 through 1985, an estimated 305,000 clients received services at vet centers; an RCS clinical program analyst reported 103,023 clients received care in fiscal year 2021 alone.[7] 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.[8] 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.[9]

[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). 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.

[5] VHA Handbook 1500.01.

[6] "Vet Centers (Readjustment Counseling): Vet Center Eligibility," accessed March 24, 2021, https://www.vetcenter.va.gov/Eligibility.asp; "Vet Centers (Readjustment Counseling): Who We Are," accessed January 7, 2020, https://www.vetcenter.va.gov/About_US.asp.

[7] General Accounting Office, Vietnam Veterans: A Profile of VA's Readjustment Counseling Program, Report No. GAO/HRD-87-63, August 1987; A fiscal year is a 12-month period that the federal government uses for accounting purposes running from October 1 through September 30.

[8] Blank Jr., Arthur S. "Apocalypse Terminable and Interminable: Operation Outreach for Vietnam Veterans." *Hospital and Community Psychiatry*. Volume 33, Number 11, November 1982. Blank Jr., Arthur S. "Apocalypse Terminable and Interminable: Operation Outreach for Vietnam Veterans." *Hospital and Community Psychiatry*. Volume 33, Number 11, November 1982

[9] *RCS Guidelines for Administration*; 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.

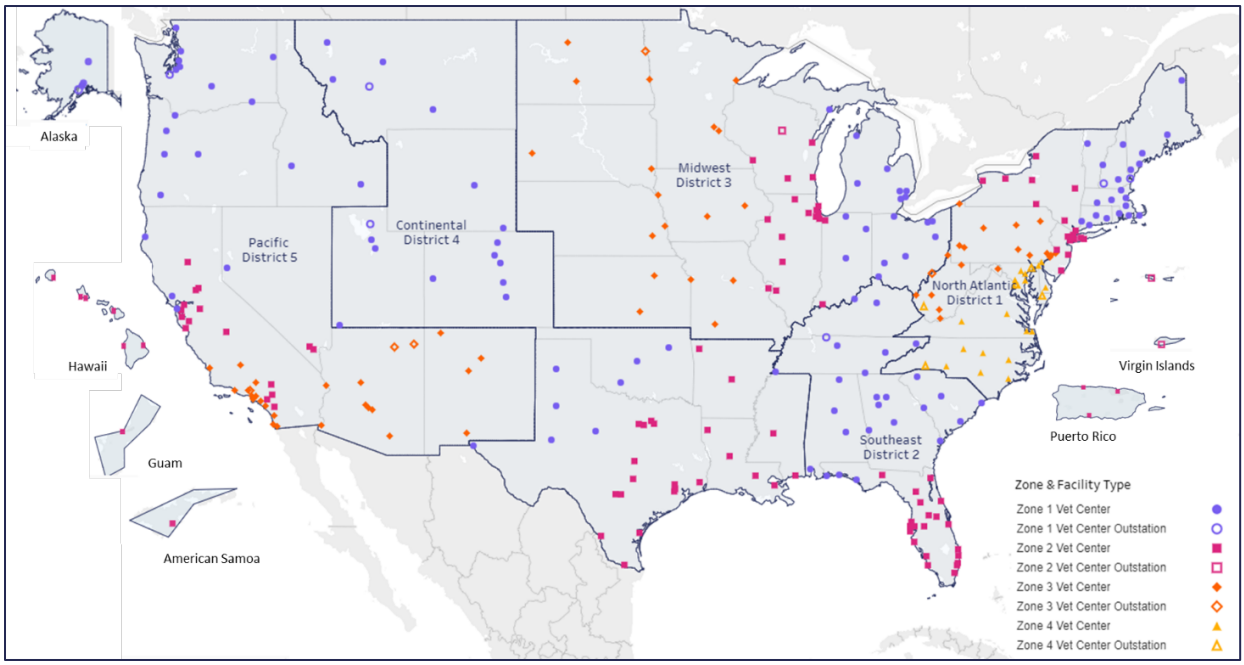

Figure 3. *Map of vet centers and vet center outstations. The placement of Alaska, American Samoa, Hawaii, Guam, Puerto Rico, and the Virgin Islands is not representative of their actual geographical locations.*[10]
Source: VA OIG-developed using VA Site Tracking (January 19, 2021) and RCS data (as of 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 services to surviving parents, spouses, children and siblings of service members who die of any cause while on active duty."[11] 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

[10] 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.

[11] "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)
2010	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	Active duty service members reporting sexual assault or harassment, without a Tricare referral are provided "counseling and care and services."
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‡
2021	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 all 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.[12] The RCS Chief Officer reports directly to the VA Under Secretary for Health and is responsible for strategic planning, coordination of readjustment counseling services with VA services, serving as a policy expert for

[12] "Vet Centers (Readjustment Counseling)," VA, accessed June 15, 2022. https://www.vetcenter.va.gov/. The Vet Center Call Center, reached at 1-877-WAR-VETS or 1-877-927-8387, is a toll-free, 24-hour per day, 7 days per week, confidential call center for veterans and their families to receive support regarding their military experience or any other readjustment issue. VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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 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.[13]

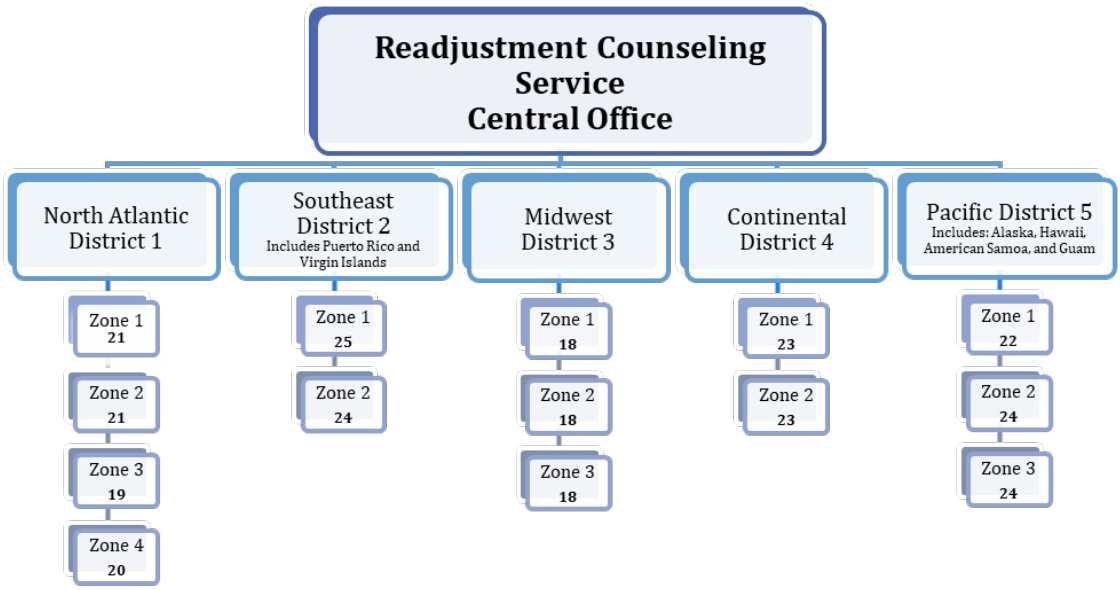

Figure 4. *RCS organizational district and zone structure.*
Source: VA OIG-developed using analysis of RCS information.
Note: The number of vet centers in each zone is denoted below the respective zone. The OIG did not assess RCS data for accuracy or completeness.

Electronic Client Record

Vet center services are not required to be recorded in a client's VA electronic health record.[14] An RCS National Service Support leader noted that prior to fiscal year 2003, RCS used a paper record system to record client visits and data. In fiscal year 2003, a web-based software system called RCSNet was implemented to collect client information. On January 1, 2010, RCSNet became the sole record keeping system for client services. RCSNet's independence from VA medical facilities and Department of Defense's electronic health record systems allows vet centers to maintain secure and confidential records that will not be disclosed to VA medical facilities, VA clinics, or the Department of Defense unless there is a signed release of

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

information.[15] An RCS leader reported collaborating with Cerner Corporation and the Office of Electronic Health Record Modernization to explore modernization of RCSNet; however, a determination has not been made.[16]

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.[17] The support VA medical facility director assigns a clinical liaison and an administrative liaison to aligned vet centers.[18] The support VA medical facility clinical liaison coordinates services for shared clients, assists in suicide prevention activities, and supports morbidity and mortality reviews.[19] The support VA medical facility administrative liaison provides support for procurement, engineering functions, commuter benefits, and fleet management for U.S. government vehicles.[20] Vet center staff collaborate with support VA medical facilities by participating on mental health councils and coordinating care with support VA medical facility suicide prevention coordinators for shared clients.[21]

Purpose and Scope

The purpose of the VA Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) is to conduct routine oversight of vet centers providing readjustment services to clients. This OIG inspection examined operations generally from January 1 through December 31, 2021. This report evaluates the quality of care delivered at North Atlantic district 1 zone 3 vet centers

[15] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); 38 C.F.R. § 17.2000–816 (e). Vet centers cannot disclose clients records unless a client authorizes release or there is a specific exemption.

[16] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). RCS central office is the national office responsible for program policy and supervision of RCS district offices, providing direct line supervision for vet center administrative and clinical functions. "Federal Government," Cerner Corporation, Cerner Government Services, accessed July 14, 2022, https://www.cerener.com/about. Cerner is a corporation that promotes secure technology to improve healthcare operations of federal health organizations to assist in providing more connected healthcare.

[17] *RCS Guidelines for Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[18] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). Support VA medical facilities are laterally aligned facilities identified to provide clinical collaboration to assist vet centers in better serving eligible individuals.

[19] *RCS Guidelines 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.

[20] *RCS Guidelines for Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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

and examines a broad range of key clinical and administrative processes for compliance with RCS policy. The OIG reports its findings to Congress and VHA, so informed decisions can be made on improving care.

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

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 February 7, 2022, and conducted on-site and virtual visits from February 7 through 18, 2022.[23] The OIG interviewed district leaders and four VCDs at the selected vet centers.

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

VHA issued a directive in January 2021 (amended May 3, 2021, and December 30, 2021) during the OIG's inspection period of VCIP operations discussed in this report.[24] 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

[22] The underlined terms are hyperlinks to a different section of the report. To return to the point of origin, press *alt* and *left arrow* keys.

[23] 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.

[24] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). The OIG inspection period for this report was January 1 through December 31, 2021.

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).

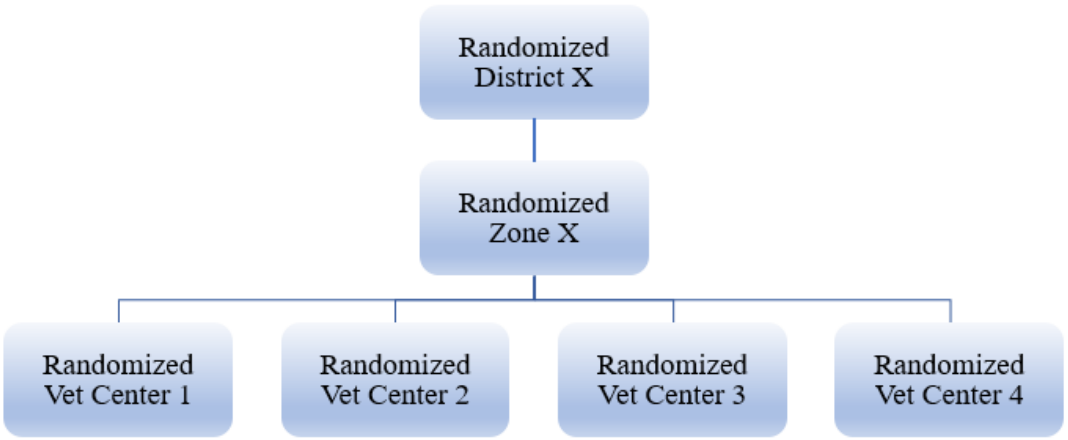

Figure 5. *Randomization and selection of inspection sites.*
Source: VA OIG.

For this inspection, the OIG randomly selected district 1 zone 3. Within zone 3, the OIG randomly selected Center City Philadelphia, Northeast Philadelphia, and Scranton Vet Centers in Pennsylvania; and the Huntington Vet Center in West Virginia.[25] Zone 3 is noted in figure 6 below. For demographic profiles of zone 3 and the four selected vet centers see appendixes B and C.[26] The OIG provided one-day notice to each vet center prior to formal evaluation, for coordination of client care as needed.

[25] For the purpose of this report, the Center City Philadelphia Vet Center will be referred to as the Center City Vet Center, and the Northeast Philadelphia Vet Center will be referred to as the Northeast Vet Center.

[26] *RCS Guidelines for Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). Vet centers are comprised of small multidisciplinary teams.

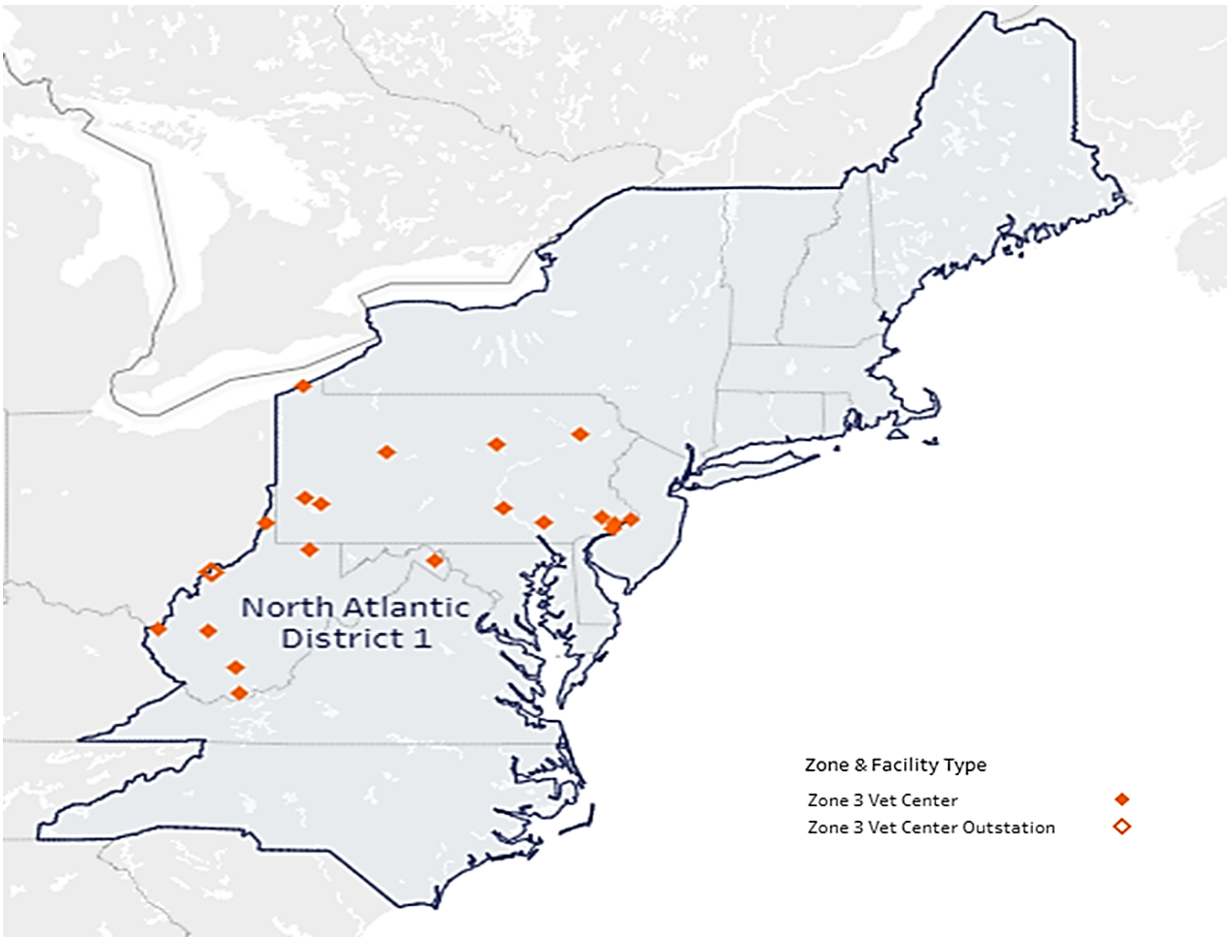

Figure 6. *Map of North Atlantic district 1 zone 3 vet centers.*
Source: Developed by VA OIG using VA Site Tracking.

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

The suicide prevention review included 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 findings and recommendations to the District Director.[27]

The consultation, supervision, and training review, and 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, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leadership if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted 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.

[27] For vet center clients shared with support VA medical facilities, the OIG also reviewed VHA electronic health records.

Results and Recommendations

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

Leadership and Organizational Risks

Leadership and organizational risks can affect a healthcare system's ability to provide safe and sustainable care.[28] "Leadership has been defined as the relationship between the individuals who lead and those who take the choice to follow." Effective healthcare leadership is essential for achieving quality of care.[29]

As noted, the OIG assessed leadership and organizational risks for district 1 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[30]

District Leadership Position Stability

The district director oversees the deputy district director who is responsible for an assigned zone (one deputy per zone). The deputy district director supervises zone associate district directors. The associate district director for counseling is responsible for providing guidance on various operations, including clinical quality reviews and morbidity and mortality reviews. The associate district director for administration is responsible for providing guidance on administrative operations and administrative quality reviews. VCDs report to deputy district directors and are responsible for the overall vet center operations including staff supervision, administrative and

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

[29] 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.

[30] 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, and clinical programs.[31] Figure 7 shows the leadership organizational structure for district 1 zone 3.

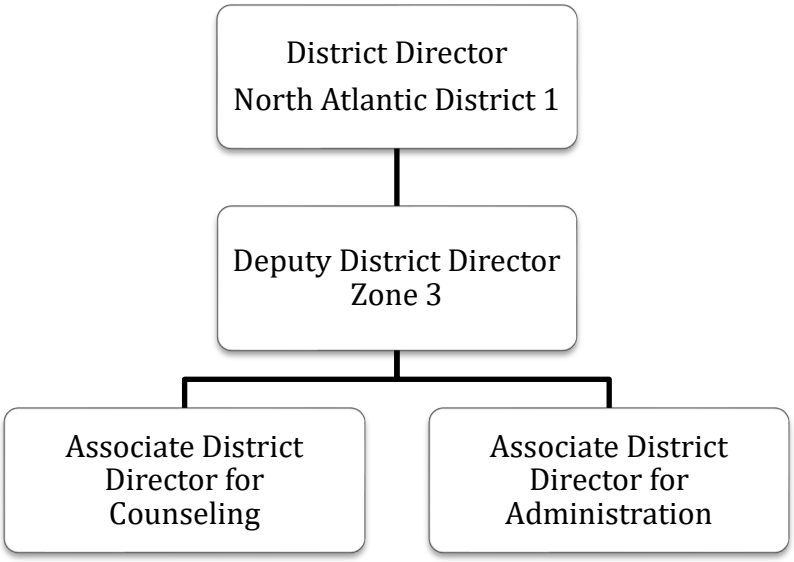

Figure 7. *District leaders.*
Source: VA OIG analysis of district organizational chart.

At the time of the OIG inspection, the District Director, Deputy District Director, and Associate District Director for Counseling had been working together for more than two years. The District Director had been in the role since December 2019. There was one vacant district leader position in the 12 months prior to the inspection. The associate district director for administration position was vacant for two months before being filled in October 2021. A district leader informed the OIG that the zone 3 Deputy District Director was on leave during the inspection; therefore, another Deputy District Director provided coverage.

During the 12 months prior to the inspection, of the 19 vet centers in the zone, two VCD positions were vacant. The Scranton Vet Center position was vacant for four months; however, a permanent director has been assigned. At the time of inspection, the Lancaster Vet Center position had been vacant for approximately one month, recruitment had been initiated; however, remained vacant with an acting VCD assigned.

The District Director stated there was a large degree of oversight and operational responsibilities assigned to the Deputy District Director, including mentorship, team building, quality reviews and the management of numerous requests for information. District leaders reported the amount of responsibilities for the Deputy District Director negatively impacted the time available to provide quality oversight, training, and coaching to staff.

[31] *RCS Guidelines for Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

Quality Improvement Activities

The OIG interviewed district leaders and sent a questionnaire to assess knowledge about healthcare quality improvement principles and practices. District leaders were knowledgeable about the basic concepts of, and their roles in, quality improvement. District leaders described quality improvement as a systematic and continuous effort to operationalize, evaluate, implement, sustain, and improve processes to support staff and improve client care. Three of four leaders did not feel there was 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.[32] 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.[33]

District 1 zone 3 conducted annual in-service trainings during the inspection period and developed training agendas for vet center staff positions. The District and Deputy Directors reported VCDs received notification of training requirements for the inspection period. District leaders reported the district office and RCS central office are responsible for assigning required VHA training to vet center staff in the Talent Management System.[34] District leaders reported relying on supervisors and the Talent Management System email alerts 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

[32] *RCS Guidelines for Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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

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

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

The OIG sent a questionnaire to district leaders that included questions related to the communication of, and changes implemented from, the All Employee Survey results. District leaders reported sharing the All Employee Survey results through zone calls, town hall meetings, and emails. Based on All Employee Survey results, district leaders streamlined communication, provided training, and encouraged sharing of resources and team building to reduce burnout. Additionally, work groups and cohorts were developed within each zone to discuss results and develop at least one project related to the All Employee Survey results to improve areas of concern.

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.[36] The results from the feedback survey provide district leaders and VCDs an opportunity to evaluate the effectiveness of readjustment counseling and services provided.[37] 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.[38]

In July 2021, RCS changed the method of collecting client feedback by implementing a program called Veterans Signals (VSignals).[39] As a result of the change to VSignals, the OIG reviewed the Vet Center Service Feedback Survey scores from fiscal year 2020 because a full year of results was not available for fiscal year 2021.

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

[36] Policy Memorandum RCS-NSS-001, "Readjustment Counseling Service (RCS) Customer Feedback Procedures," February 1, 2019.

[37] *RCS Guidelines for Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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

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

The OIG found district 1 zone 3 client feedback results were higher than the national average in all areas except convenience of appointment scheduling and vet center location in the community. The District Director surmised the higher than national average Vet Center Service Feedback Survey scores are a result of client's favorable view of vet centers. Table 2 details the results of the Vet Center Service Feedback Survey.

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

Questions	District 1 Zone 3 Average Score*	RCS National Average Score*
I was treated in a welcoming and courteous manner by the Vet Center staff.	4.78	4.66
My appointments have been scheduled at a time that was convenient.	4.57	4.58
I would likely recommend the vet center to another Veteran, servicemember, or family member.	4.65	4.60
The Vet Center services were located conveniently in my community.	4.22	4.36
I feel better as a result of the services provided by the Vet Center staff.	4.48	4.40
How satisfied were you with the overall quality of services at the Vet Center?	4.57	4.50

Source: Developed by VA OIG based on RCS National Service Support data provided by the North Atlantic District.
**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 type because it was most representative of client survey responses.*

Leadership and Organizational Risks Questionnaire Results

The OIG distributed a leadership and organizational risks questionnaire to all district 1 zone 3 VCDs to evaluate perceptions about select quality improvement activities and organizational health. Of the 17 questionnaires distributed, 16 were returned.[40] The questionnaire consisted of 15 items 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 item uses qualitative methodology to

[40] Although there were 19 vet centers in district 1, zone 3, one VCD position (Lancaster Vet Center) was vacant at the time of the inspection; the District Director informed the OIG that another VCD (DuBois Vet Center) was in the process of retiring with an acting VCD in place; one VCD (Northeast Vet Center) did not respond.

collect data by allowing VCDs to provide narrative responses related to quality improvement or to further explain any answers in the survey. All narrative responses were evaluated for immediate safety concerns or issues.

According to the quantitative data, VCDs indicated overall favorable results. VCDs reported vet center staff are able to speak freely, offer ideas, and ask questions. Additionally, VCDs reported having processes for all vet center staff to report safety issues, errors, and concerns.

VCDs indicated several barriers to quality improvement. Thirty-two percent of respondents disagreed or strongly disagreed when asked, "We use our quality results, such as chart audits, to identify areas that need to improve" and 63 percent of respondents did not have enough time in a week to support quality improvement activities.

Leadership and Organizational Risks Conclusion

District Leaders reported vacancies in two VCD positions and the zone 3 Deputy District Director position, with acting VCD's and an acting Deputy District Director assigned to provide coverage. District leaders had a general understanding of quality improvement and perceived their role as important to driving and overseeing quality improvement activities. VCD questionnaire responses indicated leaders supported psychological safety and just culture at vet centers. However, the majority of leaders reported not having enough time in a week to support quality improvement activities.

Quality Reviews

VHA leaders have articulated the goal to serve as the nation's leader in delivering high-quality and veteran-centered care.[41] 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.[42]

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 to management and delivery of readjustment counseling.[43] Based on objectives, the review is conducted by either the associate district director for counseling or the associate district director for administration.

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[41] VHA's Blueprint for Excellence–Fact Sheet, September 2014.

[42] *RCS Guidelines for Administration*, 2010; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[43] *RCS Guidelines for Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2) require clinical and administrative quality reviews to be completed annually. RCS-CLI-003, Revised Clinical Site Visit Protocol. January 25, 2019; RCS-CLI-015, October 7, 2021, further clarifies that clinical and administrative reviews are completed every fiscal year.

Clinical quality reviews included multiple areas of evaluation:

- Vet center team composition
- Access to vet center services
- Readjustment counseling productivity
- Active client caseloads
- Customer feedback[44]

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[45]

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.[46]

Within 30 days of receiving the site visit report, the VCD in conjunction with the site visiting associate district director for counseling or associate district director for administration must develop a remediation plan to address all identified deficiencies. The VCD is responsible for resolving all deficiencies within 60 days of the date the deputy district director approves the remediation plan.[47] 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.[48] Figure 8 depicts the vet center quality review remediation process.

[44] RCS-CLI-003.

[45] 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.

[46] RCS-CLI-001, November 2, 2018; RCS-CLI-003, January 25, 2019. VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); RCS-CLI-015.

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

[48] RCS-CLI-001, November 2, 2018.

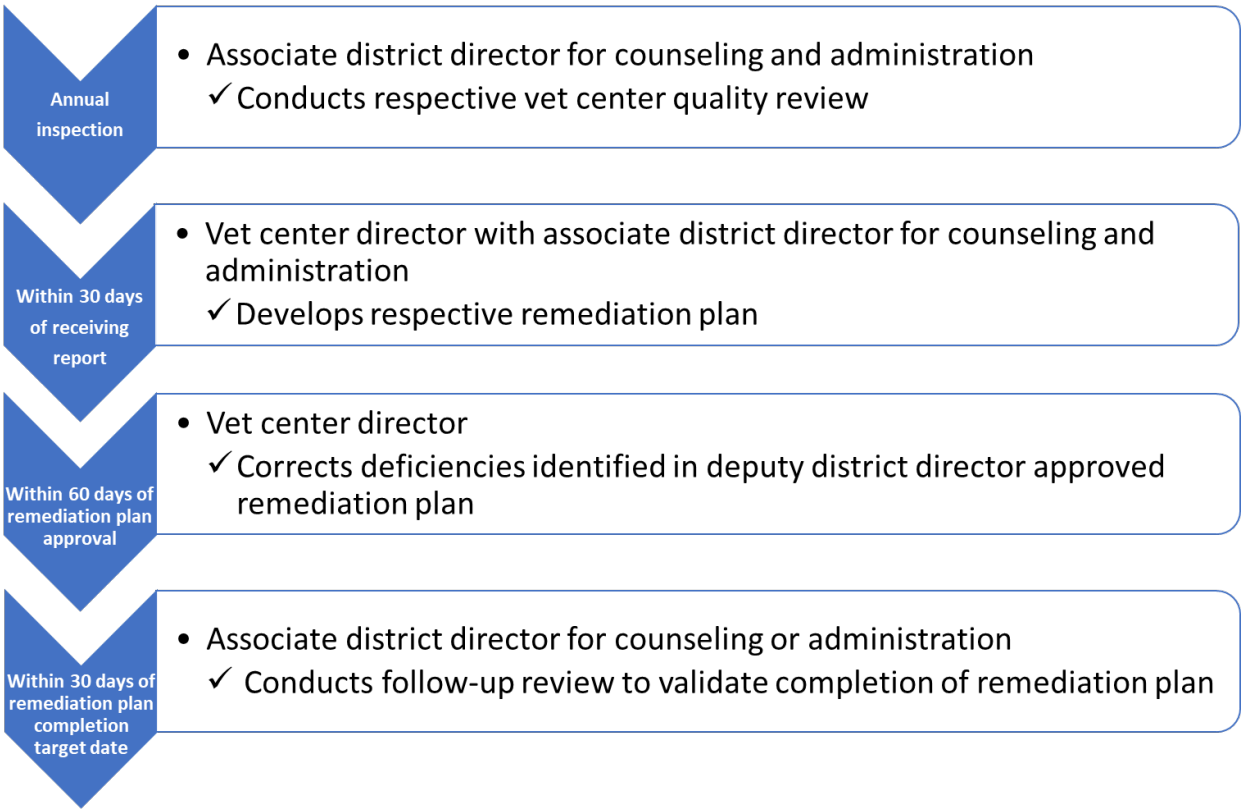

Figure 8. *Vet center quality review remediation process.*
Source: VA OIG-developed using RCS-CLI-001, November 2, 2018, and VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

The OIG evaluation for the clinical and administrative review processes for all district 1 zone 3 vet centers included interviewing district leaders and reviewing

- 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).[49]

Clinical and Administrative Quality Reviews Findings and Recommendations

The OIG found the Associate District Director for Counseling was compliant with the completion of vet center clinical quality reviews and remediation plans for identified deficiencies

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

for all 19 vet centers in district 1 zone 3. The Associate District Director for Administration was compliant for all administrative quality reviews; however, two vet centers with identified deficiencies did not have remediation plans.

The OIG identified the following findings:

- Clinical quality review remediation plans did not consistently include deficiency resolution, timely documentation, and evidence of resolution (four selected vet centers).
- Two administrative quality review remediation plans were not completed (zone wide).
- Administrative quality review remediation plans did not include deficiency resolution, timely documentation, and evidence of resolution (four selected vet centers).

Zone-Wide Clinical Quality Reviews and Remediation Plans

Clinical quality reviews were completed for 19 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.[50] On average, the quality site visit reports were approved within five days of the site visit; none of the 19 reports exceeded the 30-day time frame. Of the 19 completed quality site visit reports, 15 vet centers had clinical deficiencies identified; all vet centers with identified deficiencies had remediation plans.

Vet Center-Specific Clinical Remediation Plans and Deficiency Resolution

The OIG reviewed remediation plans for deficiency correction compliance for the clinical quality reviews conducted at the Center City, Huntington, Northeast, and Scranton Vet Centers.

Clinical remediation plans for all four selected vet centers addressed all deficiencies identified during the clinical quality reviews.

The OIG identified the following findings (see table 3):

- The four selected vet centers were noncompliant with documentation of deficiency resolution identified during the clinical quality site reviews.
    - The Center City Vet Center did not have sufficient documentation of resolution for three of six deficiencies.
    - The Huntington Vet Center did not have sufficient documentation of resolution for the one deficiency.

[50] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); RCS-CLI-001, November 2, 2018, RCS-CLI-003.

  - The Northeast Vet Center did not have sufficient documentation of resolution for two of three deficiencies.
  - The Scranton Vet Center did not have sufficient documentation of resolution for one of three deficiencies.
- All four vet centers lacked evidence of resolution for all deficiencies
- Documentation of timely resolution of deficiencies was not available for all deficiencies identified at the Center City, Huntington, Northeast, and Scranton Vet Centers.

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.[51] RCS requires deputy district director approval of remediation plans to establish the 60-day time frame for deficiency resolution.[52]

The acting Deputy District Director identified lack of resources, challenges in time management, not having clinical reminders within RCSNet, and staff training as contributing factors to the lack of documentation of deficiency resolution at the four selected vet centers. The OIG found that RCSNet does not have a location for remediation plans to record the deputy district director approval signature or date. The acting Deputy District Director and Associate District Director for Counseling explained the clinical quality review process includes deputy district director review of remediation plans, but approval could not be validated because it was not documented. The OIG was able to determine that there was documentation of resolution for some deficiencies; however, the RCSNet remediation plan did not indicate the date of resolution when items were completed. Due to these limitations, the OIG was not able to determine if the clinical deficiencies were resolved within the required time frame of 60 days from deputy district director approval of the remediation plan.

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

	Center City Philadelphia	Huntington	Northeast Philadelphia	Scranton
Deficiencies Identified by the Associate District Director for Counseling	6	1	3	3
Deficiencies Identified in the Remediation Plan	6	1	3	3

[51] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); RCS-CLI-004, *Implementation of Automated Vet Center Clinical Site Visit (CSV) Operations*, November 4, 2019.

[52] RCS-CLI-001.

	Center City Philadelphia	Huntington	Northeast Philadelphia	Scranton
Deficiencies with Documentation of Resolution	3	0	1	2
Deficiencies with Documentation of Timely Resolution	0	0	0	0
Deficiencies with Evidence of Resolution	0	0	0	0

Source: VA OIG analysis based on district 1 zone 3 documents.
Note: The OIG examined remediation plans and evidence of deficiency resolution that corresponded to clinical quality reviews performed between October 1, 2020, and September 30, 2021.

Recommendation 1

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 Center City, Huntington, Northeast, and Scranton Vet Centers; takes indicated actions to ensure completion; and monitors compliance.

District Director Concur.

Clinical Quality Review remediation plans were completed for Fiscal Year (FY) 21 Vet Centers; however, a tracking system was not in place to ensure deficiency resolution. The Associate District Director for Counseling (ADDC), with oversight from the Deputy District Director (DDD) ensured all 4 Vet Centers completed remediation and now there is a current tracking system in place to monitor compliance.

Status: Requesting Closure

Target date for completion: N/A

OIG response: The OIG considers this recommendation closed.

Recommendation 2

The District Director determines reasons for lack of evidence that clinical quality review deficiencies were resolved at the Center City, Huntington, Northeast, and Scranton Vet Centers; takes indicated actions to ensure completion; and monitors compliance.

District Director Concur.

Clinical Quality Review remediation plans were completed for FY 21 Vet Centers; however, a tracking system was not in place to ensure deficiency resolution. Resolution of the clinical site visits and remediations for these 4 Vet Centers have been tracked and monitored in the dashboards with review of records in RCSNet by Vet Center Director (VCD) in collaboration with the ADDC and DDD. The goal is deficiency resolution before the next clinical site visit. The DDD will provide oversite with VCDs on all items that are deficient for consecutive clinical quality reviews.

Status: Ongoing

Target date for completion: October 1, 2023

Zone-Wide Administrative Quality Reviews and Remediation Plans

The OIG found district 1 zone 3 to be noncompliant with some requirements for administrative quality review remediation plans.

For each vet center in district 1 zone 3, the Associate District Director for Administration completed an administrative quality site review. On average, the administrative site visit reports were approved within 16 days of the site visit; however, 2 administrative quality site visit reports were signed outside of the 30 day requirement.[53] Of the 19 completed administrative quality site visit reports, 13 vet centers had administrative deficiencies identified. Eleven of the 13 vet centers had remediation plans; the Beckley and Bucks County Vet Centers did not have remediation plans. Of the 11 remediation plans, 10 were not approved by the Deputy District Director.

The OIG identified the following findings:

- Administrative quality review remediation plans were not completed for Beckley and Bucks County Vet Centers with identified deficiencies.

[53] One plan was not signed; therefore, this plan was not included in the average reported. Only 18 sites were used to determine the average of 16 days.

- Ten remediation plans did not include the Deputy District Director's approval and date of approval.

The Associate District Director of Administration reported being new to the position and did not complete any of the FY21 administrative site visits.

Recommendation 3

The District Director determines reasons administrative quality review remediation plans were not completed at the Beckley and Bucks County Vet Centers, ensures completion, and monitors compliance.

District Director Concur.

The Associate District Director for Administration (ADDA) moved to a new position in FY 21, and a tracking system was not in place. A new ADDA was hired in FY 22 and developed a tracking system to ensure remediation plans were completed for these 2 Vet Centers. Remediation plans are tracked, and a memorandum is sent to VCDs to ensure all Vet Centers complete a remediation plan that includes the DDD signature to validate approval of the plan. In FY 2023, Readjustment Counseling Service (RCS) implemented a process to have administrative quality reviews and remediations entered in RCSNet to ensure all remediation plans are completed in a timely manner.

Status: Ongoing

Target date for completion: October 1, 2023

Recommendation 4

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

District Director Concur.

There was no process in place to ensure the DDD approved the remediation plans. Administrative quality review remediation plans were previously paper memorandums with wet signatures by VCD and DDD. All FY 22 administrative quality review remediation plans have DDDs approval and date of approval included electronically. In FY 23 the administrative quality review remediations are entered into RCSNet.

Status: Requesting Closure

Target date for completion: N/A

OIG response: The OIG considers this recommendation closed.

Vet Center-Specific Administrative Remediation Plans and Deficiency Resolution

The OIG reviewed remediation plans for deficiency correction compliance for the administrative quality reviews conducted at the Center City, Huntington, Northeast, and Scranton Vet Centers.

The OIG found that the administrative remediation plans for the Center City, Huntington, Northeast, and Scranton Vet Centers identified all deficiencies identified during the administrative quality site reviews (see table 4).

The OIG identified the following findings:

- None of the selected vet centers were compliant with documentation of deficiency resolution identified during the administrative quality site reviews.
- None of the selected vet centers had evidence of resolution for identified deficiencies.
- Time frame of deficiency resolution could not be determined for all identified administrative deficiencies.

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

	Center City	Huntington	Northeast	Scranton
Deficiencies Identified by the Associate District Director for Administration	3	1	1	3
Deficiencies Identified in the Remediation Plan	3	1	1	3
Deficiencies with Documentation of Resolution	0	0	0	0
Deficiencies with Documentation of Timely Resolution	0	0	0	0
Deficiencies with Evidence of Resolution	0	0	0	0

Source: VA OIG analysis based on district 1 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.

Recommendation 5

The District Director determines reasons administrative quality review remediation plans did not include documentation of deficiency resolution and the time frame for

resolution for the Center City, Huntington, Northeast, and Scranton Vet Centers; takes indicated actions to ensure completion; and monitors compliance.

District Director Concur.

The ADDA moved to a new position in FY 21 and a tracking system was not in place. A new ADDA was hired in FY 22 and ensured remediation plans were completed for these 4 Vet Centers. Starting in FY 22 documentation of progress on deficiency resolution was included in the remediation plans of the administrative site visit report and these 4 Vet Centers are complete.

Status: Requesting Closure

Target date for completion: N/A

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

Recommendation 6

The District Director determines reasons for lack of evidence for administrative quality review deficiency resolution for the Center City, Huntington, Northeast, and Scranton Vet Centers; takes indicated actions to ensure completion; and monitors compliance.

District Director Concur.

The ADDA moved to a new position in FY 21 and a tracking system was not in place. A new ADDA was hired in FY 22 and developed a tracking system to ensure remediation plans were completed. Starting in FY 22 documentation of progress on deficiency resolution was included in the remediation plans of the administrative site visit report reviewed by ADDA and DDD. Resolution of the administrative site visit and remediations for these 4 Vet Centers are complete. They will be tracked and monitored by review of records in RCSNet by VCDs in collaboration with the ADDA and DDD, with a goal of deficiency resolution before the next administrative site visit. The DDD will provide oversite to this new process and will ensure discussion with VCDs about all items that are deficient for consecutive administrative quality reviews.

Status: Requesting Closure

Target date for completion: N/A

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

Morbidity and Mortality Reviews

VHA's National Patient Safety Improvement Handbook indicates careful evaluation and analysis of client safety events (events not primarily associated with the natural course of the client's illness or underlying condition), and corrective actions, are essential to reduce risk and prevent adverse events.[54] 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 the RCS central office leaders within 48 hours.[55]

Additionally, RCS requires completion of morbidity and mortality reviews for client safety events including serious suicide or homicide attempts, and death by suicide or homicide.[56] RCS has established a specific protocol for conducting morbidity and mortality reviews to evaluate 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.[57]

To examine the quality oversight process, the OIG interviewed district leaders and evaluated crisis reports and morbidity and mortality reviews completed for serious suicide or homicide attempts, and death by suicide, or homicide that occurred during the inspection period.[58] The OIG identified crisis reports completed for two serious suicide attempts and one death by homicide.

Morbidity and Mortality Reviews Findings and Recommendations

The OIG found morbidity and mortality reviews were not completed for the two serious suicide attempts and one death by homicide. Regarding the death by homicide, the Associate District Director for Counseling provided email documentation that shows contact with RCS central office to determine if a morbidity and mortality review was required. In the email, the Associate District Director for Counseling and Deputy District Director, in consultation with RCS central office, completed a case review in lieu of a morbidity and mortality review. District leaders

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

[55] *RCS Guidelines for Administration*; VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). 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.

[56] *RCS Guidelines for Administration*; VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[57] *RCS Guidelines for Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[58] *RCS Guidelines for 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.

believed there would be no value added in completing a morbidity and mortality review. RCS policy requires morbidity and mortality reviews to be completed for all deaths by homicide.[59]

District leaders did not have a process in place to complete morbidity and mortality reviews for serious suicide attempts. The acting Deputy District Director stated it was a judgment call and the Associate District Director for Counseling stated there is no clear guidance for completion of morbidity and mortality reviews for serious suicide attempts.

In its VCIP report, *Vet Center Inspection of Midwest District 3 Zone 1 and Selected Vet Centers*, Report No. 21-03231-38, January 19, 2023, the OIG made a recommendation related to morbidity and mortality reviews to the RCS Chief Officer:

> 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.

Therefore, the OIG did not make a recommendation related to morbidity and mortality reviews to the Chief Officer in this report.[60]

Recommendation 7

The District Director ensures completion of a morbidity and mortality review for the death by homicide, and ensures all future morbidity and mortality reviews are completed as required.

[59] *RCS Guidelines for Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[60] VA OIG, *Vet Center Inspection of Midwest District 3 Zone 1 and Selected Vet Centers*, Report No. 21-03231-38, January 19, 2023.

District Director Concur.

The 1 crisis alert for death by homicide was lacking definitive evidence that the veteran was involved in the conspiracy to commit homicide. A thorough District level record review was completed and reviewed with ADDC and DDD and RCS Office of Policy and Oversight. The determination of what is a serious homicide 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. On January 12, 2022, the ADDC placed a non-visit progress note into the record documenting the decision related to whether the event was deemed a serious homicide attempt and decision to not conduct a mortality and morbidity quality review (MMQR). Based on district review of the case an MMQR will not be conducted with justification.

Status: Requesting Closure

Target date for completion: N/A

OIG response: The OIG considers this recommendation closed.

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.[61] 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 United States by 20 percent by the year 2025 through implementation of a public health model.[62] 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."[63]

In 2017, the VA identified RCS as an important part of the VA's overall suicide prevention strategy.[64] VHA requires a shared responsibility for suicide prevention between RCS, the Office

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

[62] VA Office of Mental Health and Suicide Prevention, National Strategy for Preventing Veteran Suicide 2018 2028.

[63] The American Foundation for Suicide Prevention is a voluntary health organization that supports suicide research and education. American Foundation for Suicide Prevention, "About Suicide," accessed July 16, 2019, https://afsp.org/about-suicide.

[64] Deputy Under Secretary for Health for Operations and Management (10N), "Memorandum of Understanding between the VHA Office of Mental Health and Suicide Prevention and the VHA Readjustment Counseling Service," August 15, 2017. An RCS leader informed the OIG that the 2017 Memorandum of Understanding was discontinued on March 22, 2022.

of Mental Health and Suicide Prevention, and VHA suicide prevention coordinators. VHA 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.[65] 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 of active clients.[66]

VHA requires each support 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.[67]

On May 11, 2020, RCS implemented a SharePoint site for High Risk Suicide Flag clients organized by zone.[68] In June 2021, RCS informed the OIG that the SharePoint site was expanded to include the Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) data.[69] RCS requires VCDs complete a monthly review of the High Risk Suicide Flag SharePoint and document a disposition on the site for all clients seen at the vet center within the previous 12 months.[70] 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.[71]

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 between RCS and VA medical facility shared high risk clients (zone-wide)
- Safety plans and consultation (zone-wide)

[65] "Memorandum of Understanding between the Office of Mental Health and Suicide Prevention and Readjustment Counseling Services," November 13, 2017.

[66] "Memorandum of Understanding between the VHA Office of Mental Health and Suicide Prevention and the VHA Readjustment Counseling Services," August 15, 2017.

[67] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

[68] 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.

[69] Increased predictive risk for suicide was developed by VA's REACH VET program to determine veterans who have a higher risk for suicide through predictive analytics.

[70] RCS Memorandum RCS-CLI-006, "High Risk Suicide Flag Outreach," April 27, 2020.

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

- Access (four selected vet centers)
- Care coordination and collaboration with VA medical facilities (four selected vet centers)
- High risk suicide flag SharePoint 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 record reviews 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 fifth visit unless there is documentation of an extenuating circumstance that would prevent completion of these portions in a timely manner.[72] Psychosocial assessments are used to gather information about the client's history including pre-military development, military history, war related readjustment concerns, and level of functioning to complete a clinical evaluation.[73]

RCS also requires the completion of a suicide risk assessment during the first counseling encounter.[74] 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.[75]

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 a sample of clients new to vet centers from November 1, 2020, through October 31, 2021.[76] The sample included 60 client records with five or more visits, and 40 clients with four

[72] RCS-CLI-003; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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

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

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

[76] The sub-population size was randomly selected and weighted for the sample.

or less visits.[77] The OIG reviewed the 60 client records with five or more visits, and assessed clients only if there were five or more individual clinical 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. The OIG reviewed client records to determine timely completion of suicide risk assessments by evaluating the first clinical note for reference to and completion of a suicide risk assessment.[78]

The OIG was able to determine intake and military history completion through an RCSNet record review. At the time of the inspection, due to RCSNet limitations, the OIG was unable to determine if intake and military history sections were completed by the fifth visit as required.

The OIG was able to determine suicide risk assessment completion through RCSNet record reviews. However, the OIG was unable to determine if the risk assessment date in RCSNet or the database was the creation or completion date of the assessment despite the OIG having access to the database. Due to RCSNet limitations, the OIG reviewed the first clinical visit note for documentation that the clinician completed the suicide risk assessment.

Zone-Wide Psychosocial and Suicide Risk Assessment Findings

The OIG estimated district 1 zone 3 vet center clinicians completed 85 percent of military histories, 32 percent of intakes, and 48 percent of suicide risk assessments (see table 5).

[77] RCS-CLI-003. 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. Of the 100 clients sampled, 60 client records were reviewed for completion of the intake, military history, and suicide risk assessment. The remaining 40 client records were used to evaluate completion of the suicide risk assessment as this client group had less than four visits, and therefore, completion of the psychosocial assessment was not required.

[78] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); October 12, 2020, per an RCS leader, RCS implemented a new risk assessment in the RCSNet individual intake procedural section. The risk assessment is 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 November 1, 2020 – October 31, 2021

Electronic Client Record Section	Number of Client Records Reviewed	Estimated Compliance (%) Completed Zone Wide	95% Confidence Interval*
Intake	60	32	(20, 43)
Military History	60	85	(75, 93)
Suicide Risk Assessment	97†	48	(38, 59)

Source: VA OIG Analysis.
**Merriam-Webster. Confidence interval is "a group of continuous or discrete adjacent values that is used to estimate a statistical parameter (such as a mean or variance) and that tends to include the true value of the parameter a predetermined proportion of the time if the process of finding the group of values is repeated a number of times," accessed on January 21, 2021, https://www.merriam-webster.com/dictionary/confidence%20interval.*
†Three clients were excluded from the suicide risk assessment sample because two were seen for administrative (not clinical) visits and one was seen for bereavement services.

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 8

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

District Director Concur.

District 1 zone 3 VCDs and Readjustment Counselors were not consistently trained on completion of psychosocial assessment. District 1 will provide training to VCDs and Readjustment Counselors on completion and time-specific requirements of the intake portion of the psychosocial assessment during FY 23 training. District 1 VCDs will be trained on the clinical compliance dashboards in March and April 2023. VCDs will monitor through monthly chart audits with DDD oversight.

Status: Ongoing

Target date for completion: September 1, 2023

Recommendation 9

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.

District 1 zone 3 VCDs and Readjustment Counselors were not consistently trained on completion of risk assessments. District 1, Zone 3 ADDC will provide training to the VCD and Readjustment Counselors on completion of risk assessments to meet RCS standard during FY 23. The Vet Center Director and ADDC will monitor compliance through review of dashboard data, regular RCSNet record reports reviewed by VCD, and with support from zone ADDC. DDD will provide oversight.

Status: Ongoing

Target date for completion: September 1, 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)." Further, vet center counselors 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.[79] Vet center staff are required

[79] "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services," 2017; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

to follow confidentiality requirements when coordinating care with the support VA medical facility.[80]

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 1 zone 3 vet centers from October 1, 2020, through September 30, 2021.[81]

The OIG evaluated each client record for the following:

- Consultation and coordination of services with shared support VA medical facility within 60 days from placement of the high risk flag.
    - Adherence to confidentiality requirements if consultation and coordination occurred within 60 days.[82]
- Timely notification to the support VA medical facility suicide prevention coordinator if client posed a significant safety risk.[83]
    - 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 1 zone 3 were noncompliant with requirements for shared clients with the support VA medical facility related to suicide prevention and intervention. The OIG found that of the 30 client records reviewed, 18 records had documented coordinated care

[80] 38 C.F.R. § 17.2000–816 (e).

[81] There was a total of 50 clients at high risk during the inspection period in zone 3; the population was reviewed. The OIG extracted the sample from the RCS High Risk Suicide Flag SharePoint site, which includes high risk for suicide and REACH VET clients. Data extraction period was adjusted (three months before inspection period) to allow for time for RCS clinical staff to complete the required care coordination following the high risk flag placement.

[82] "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).

[83] 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. 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.

with the support VA medical facilities as required.[84] Of those 18, only 3 followed confidentiality requirements.[85] Overall, 10 percent of records reviewed followed requirements for care coordination while maintaining confidentiality.[86]

The OIG reviewed 43 client records for RCS significant safety risk requirements and identified 16 with significant safety risks.[87] Of the 16, only 3 records had documentation of timely notification to the VA medical facility suicide prevention coordinator, with none following confidentiality requirements. Overall, none of the records reviewed followed requirements for care coordination with suicide prevention coordinators while maintaining confidentiality.

The OIG identified the following findings:

- Vet center clinical staff did not consistently consult or coordinate with VA medical facilities on shared clients who were deemed high risk within 60 days.
- For clients where coordination occurred with VA medical facilities, vet center clinical staff did not consistently follow confidentiality requirements.
- For clients who posed a significant safety risk, counselors did not consistently provide timely notification to suicide prevention coordinators at the VA medical facility.
- For clients who posed a significant safety risk, counselors did not follow confidentiality requirements when providing timely notification to suicide prevention coordinators at the VA medical facility.

Recommendation 10

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.

[84] The OIG excluded 20 clients of which 17 were excluded because the case status was closed, 2 were excluded due to clinical notes demonstrating the case was closed, and 1 was excluded because the client was not seen during the inspection period. Client cases are closed when interventions are completed or when a client no longer participates in counseling services.

[85] The OIG omits calculations for the electronic record review requirements when the number of clients is less than 11.

[86] The OIG estimated that 95 percent of the time, the true compliance rate for consultation and coordination and following confidentiality requirements was between 0 and 22.0 percent.

[87] The OIG excluded 7 of the 50 client records and reviewed the remaining 43 for significant safety risks. Of the 7 that were excluded, 5 were excluded because the client was not seen during the review period, and 2 were excluded due to inconclusive evidence to consider them as compliant or noncompliant.

District Director Concur.

District 1 zone 3 VCDs and Readjustment Counselors were not consistently trained in care consultation and care coordination. District 1 will provide training to VCD and Readjustment Counselors regarding the importance of collaborating and coordinating care with VA Medical Center (VAMC) providers on all shared clients, especially those with increased risk, and ensuring that a Release of Information (ROI) is obtained. Compliance is monitored during monthly chart audits conducted by the VCD's and monthly quality record reports by ADDC.

Status: Ongoing

Target date for completion: September 1, 2023

Recommendation 11

The District Director verifies clinical staff follow confidentiality requirements when consulting and coordinating care with the support VA medical facility for shared clients at high risk for suicide, and monitors compliance across all zone vet centers.

District Director Concur.

District 1 zone 3 VCDs and Readjustment Counselors were not consistently trained in following confidentiality requirements when consulting and coordinating care with the support VA medical center. District 1 will provide training to VCDs and Readjustment Counselors on the importance of communicating the benefits of consultation and coordination of care with VAMC providers to the client at the beginning of Vet Center services and to obtain permission for this collaboration through a ROI form as appropriate. Compliance is monitored through monthly chart audits conducted by the VCDs and RCSNet report provided to the ADDC for oversight.

Status: Ongoing

Target date for completion: September 1, 2023

Recommendation 12

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

District Director Concur.

District 1 zone 3 VCDs and Readjustment Counselors were not consistently trained in timely notification to the suicide prevention coordinator. District 1 will provide training to VCDs and Readjustment Counselors regarding the importance of notifying the suicide prevention staff at the local VA medical facility in a timely manner while ensuring the confidentiality requirements are met. Staff will document that contact in the client record. Compliance will be monitored through monthly chart audits and with monthly quality record reports provided by Zone ADDC for all active cases with a risk rating higher than low. DDD will provide oversight.

Status: Ongoing

Target date for completion: September 1, 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. 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. Counselors are also required to complete a safety plan and seek consultation for any client that is assessed at intermediate or high risk for suicide, in either acute, chronic, or both categories.[88]

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.[89] Safety plans identify coping strategies and support resources clients may 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 clients with tools to avoid re-entering a suicidal state.[90]

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

[88] 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).

[89] 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).

[90] Suicide Prevention Program Guide, November 2020.

prevention coordinator within 30 days "for individuals assessed to be at intermediate to High risk either acute, chronic, or both."[91]

Electronic Client Records

The OIG randomly selected 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 1 zone 3 vet centers from November 1, 2020, through October 31, 2021.[92]

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

Overall, the OIG found district 1 zone 3 vet centers noncompliant 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 suicide risk level in either acute, chronic, or both risk levels (see table 6).

In district 1 zone 3, the OIG found that 78 percent of records reviewed were noncompliant with RCS requirements for completion of a safety plan and 53 percent were noncompliant with RCS consultation requirements.

The OIG excluded 1 of 50 client records from the review for administrative reasons.

[91] 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.

[92] For clients with multiple risk assessments on the same date, the OIG reviewed all valid documented risk assessments at intermediate or high suicide risk level in either acute, chronic, or both categories that were not duplicates or created in error.

Table 6. Estimated Compliance Rate for Safety Plans and Consultation
November 1, 2020 – October 31, 2021

Electronic Client Record Review Area	Number of Client Records Reviewed	Estimated Compliance (%) Completed Zone Wide	95% Confidence Interval
Safety Plans	**49**	**22**	**(12,35)**
Consultation	**49**	**47**	**(33,61)**

Source: VA OIG Analysis.

Recommendation 13

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

District Director Concur.

District 1 zone 3 VCDs and Readjustment Counselors were not consistently trained in the completion of safety plans for clients that are assessed at intermediate or high risk level in either acute, chronic or both categories. District 1 will provide training to VCDs and Readjustment Counselors on the process of completing a safety plan when a client is assessed at any risk level higher than low or any elevated risk level (intermediate or high) for either acuity or chronicity. The VCD and ADDC will monitor compliance via RCSNet reports.

Status: Ongoing

Target date for completion: September 1, 2023

Recommendation 14

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 following a client's suicide risk assessment as required, and monitors compliance across all zone vet centers.

District Director Concur.

District 1 zone 3 VCDs and Readjustment Counselors were not consistently trained in regular and ongoing consultation with either the External Consultant, or the Suicide Prevention Coordinator when there are changes in risk levels as authorized by RCS privacy rules. District 1 will provide training to VCDs 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 monthly quality record reports provided by ADDC. DDD will provide oversight.

Status: Ongoing

Target date for completion: September 1, 2023

Vet Center-Specific Suicide Prevention

The remainder of the report provides inspection findings at the following randomly selected vet centers in district 1 zone 3:

- Center City Vet Center, Pennsylvania
- Huntington Vet Center, West Virginia
- Northeast Vet Center, Pennsylvania
- Scranton Vet Center, Pennsylvania

Access

In the 2017 Memorandum of Understanding, RCS core values include providing veterans with appointments outside of regular business hours to include appointment availability in the mornings, evenings, and weekends at all vet centers.[93] To assess for compliance, the OIG interviewed VCDs and reviewed documents provided for available nontraditional hours at each vet center.

[93] VHA, "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services," 2017.

Care Coordination and Collaboration with Support 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.[94] The 2017 Memorandum of Understanding outlines the following responsibilities:

- Standardization of a communication process between RCS and support 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[95]
- 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[96]

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.[97] 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.[98] 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, the

[94] *RCS Guidelines 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."

[95] 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.

[96] VHA, "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services," 2017.

[97] RCS-CLI-006, High Risk Flag Suicide Outreach, April 27, 2020.

[98] Microsoft, *"SharePoint,"* accessed July 15, 2021, https://support.microsoft.com/en-us/office/what-is-sharepoint-97b915e6-651b-43b2-827d-fb25777f446f. SharePoint is a website to securely store, organize, share, and access information. RCS-CLI-006, April 27, 2020.

RCS Clinical Program and Training Analyst reported that the SharePoint site was expanded to include clients with an increased predictive risk for suicide.[99]

The OIG requested documentation of clients identified on the High Risk Suicide Flag SharePoint site from the district office and any documented disposition from January 1, through December 31, 2021, to evaluate compliance with RCS requirements for high risk clients.

Critical Event Plan

Vet centers are required to have a critical event plan that is coordinated with the community and includes 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.[100]

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.[101] The review consists of an interdisciplinary team of individuals familiar with the event and staff with varying educational backgrounds and experience. The team works together to understand the "what" and "why" of the events and identify changes that could be made to reduce the likelihood of reoccurrence.[102] If a death by suicide occurs with a shared client, a root cause analysis is conducted, and vet center staff should be included in the root cause analysis review and receive notification of the relevant outcomes of the root cause analysis report.[103]

The OIG reviewed all clients who died by suicide from Veterans Integrated Service Networks (VISNs) 4, 5, and 6 offices between November 1, 2020, and October 31, 2021.[104] The list was cross referenced with RCS clients to determine shared clients between VA medical facilities and the four selected vet centers.

[99] 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.

[100] RCS-CLI-003, January 25, 2019.

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

[102] VHA Handbook 1050.01, March 2011.

[103] *RCS Guidelines for Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[104] VISNs 4, 5, and 6 include all the support VA medical facilities that collaborate with and support district 1 zones 3 and 4 vet centers and leaders.

Vet Center-Specific Suicide Prevention Findings and Recommendations

The OIG requested the following:

- Evidence of the VCD's or designee's participation in support 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

The OIG found the vet centers complied with nontraditional hours allowing clients easier access to services. None of the vet centers in district 1 zone 3 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. All four VCDs complied with requirements to review and enter a disposition on the High Risk Flag SharePoint site. The OIG found issues related to

- vet center participation in mental health council meetings,
- critical event plans that included a desktop reference sheet, and
- standardized communication process between vet centers and suicide prevention coordinators at support VA medical facilities.

Mental Health Council

VA medical facility mental health council meetings are comprised of essential mental health disciplines and specialty programs. VA medical facilities "are encouraged to include representation from Readjustment Counseling Centers (Vet Centers) in this Council."[105] Mental health councils are responsible for

- proposing program improvement and innovation,
- coordinating communication, and
- evaluating mental health policy impact.[106]

[105] VHA Handbook 1160.01.
[106] VHA Handbook 1160.01.

RCS requires a licensed vet center staff member to participate in all VA medical facility mental health council meetings. Participation is required to reinforce vet center and VA medical facility partnerships, assist with care coordination for clients receiving vet center and VA medical facility services, and aid critical responses and suicide prevention.[107] Although RCS requires participation, the OIG did not find a policy or guidance specifying how attendance was tracked and requested evidence of attendance.

The Center City VCD reported not attending the mental health council during the inspection period and cited confusion around the name of the meeting as the reason for not attending. The VCD reported making efforts to attend the mental health council meeting but being told the meeting was not being held. In November 2021, the VCD learned the facility has a mental health leadership committee and began attending those meetings in January 2022. The Huntington VCD reported occasional attendance at the mental health council and cited prioritizing conflicting responsibilities as the reason for non-attendance. The Northeast VCD indicated working with the Center City VCD to clarify the appropriate meeting to attend and indicated a plan to rotate monthly attendance between the four Philadelphia area vet centers so that each VCD attends quarterly. The Scranton VCD reported the mental health council meeting was not being held due to the pandemic.

Recommendation 15

The District Director, in collaboration with the support VA medical facility clinical or administrative liaisons, determines the reasons for noncompliance with staff participation on the mental health council for the Center City, Huntington, Northeast, and Scranton Vet Centers, and takes actions as indicated to ensure compliance with Readjustment Counseling Service requirements.

District Director Concur.

District 1 zone 3 VCDs were not consistently participating in the Mental Health Council meetings. In FY 23 District 1 VCD training, the requirement of participation in the Mental Health Council meetings will be reviewed. VCDs are to participate monthly and document their participation in the RCSNet Oversight Tracker. This will be monitored by the ADDC with DDD oversight.

Status: Ongoing

Target date for completion: September 1, 2023

[107] *RCS Guidelines for Administration*; RCS CLI-003; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

Critical Event Plan

The Center City and Northeast Vet Centers did not have a current critical event plan nor desktop reference outlining the basic steps to follow in the event of a suicidal or homicidal client presenting in person or on the phone. Both VCDs indicated not being aware of the need for a desktop reference, and believed the documentation provided to the OIG met the requirement.

Recommendation 16

The District Director determines the reasons for noncompliance with critical event plans with desktop reference at the Center City and Northeast Philadelphia Vet Centers, and takes actions as indicated to ensure compliance with Readjustment Counseling Service requirements.

District Director Concur. Staff lacked follow through on maintaining a critical event plan and desktop reference at these centers. District 1 created a critical event plan and desktop reference for these Vet Centers to utilize. ADDC will ensure Center City and Northeast Vet Centers have the documents in place prior to their FY 23 clinical site visit. Status: Ongoing Target date for completion: October 1, 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, suicide prevention coordinators, and RCS.[108]

The OIG found that although each of the vet centers inspected had informal contact with the suicide prevention coordinators at the support VA medical facility, none of the four vet centers had a standardized communication process. All four VCDs reported having a regularly scheduled monthly meeting with the VA medical facility's suicide prevention coordinator; however, did not have a formal written process.

[108] VHA, "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services," 2017. In the absence of RCS or VHA policy on how the relationship is formalized between the Office of Mental Health and Suicide Prevention, suicide prevention coordinators, and RCS, the OIG considered written documentation providing guidance and a process for communication between vet center clinical staff and suicide prevention coordinators as compliant.

In *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 Office of Mental Health and Suicide Prevention and RCS 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.[109]

Consultation, Supervision, and Training

Each vet center is assigned a clinical liaison and an external clinical consultant from the support VA medical facility.[110] Clinical liaisons help coordinate care for clients with the support VA medical facility, whereas external clinical consultants provide guidance on clinically complex cases.[111]

Vet centers are comprised of small multidisciplinary teams, are community-based, and traditionally located outside of VA medical facilities. Vet center teams consist of at least four staff including, at minimum, a VCD, an office manager, a counselor, and an outreach program specialist.[112] Vet centers are required to have at least one VHA-qualified licensed mental health professional on staff.[113]

VCDs provide staff supervision, participate and 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

[109] 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.

[110] *RCS Guidelines for Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[111] RCS-CLI-003; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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

[113] *RCS Guidelines for Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). 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. For the purpose of this report, the OIG considers a mental health professional a healthcare provider.

- Family counseling for military-related issues
- Bereavement counseling for family members or caregivers
- Counseling for conditions related to military sexual trauma[114]

In February 2016, the VHA Under Secretary for Health "reinforced the need for constant vigilance with regard to suicide prevention activities and recognized the need to review and certify suicide prevention training annually." Following the initial mandated training, staff were required to complete the corresponding refresher courses for their positions.[115] On October 15, 2020, VHA updated the suicide prevention training course and refresher requirements for all staff.[116]

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.[117]

Military sexual trauma is reported to VA providers at a rate of 1 in 3 for women and 1 in 50 for men. RCS clinical staff are required to complete military sexual trauma training.[118]

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

- Clinical liaison
- External clinical consultant
- VHA-qualified mental health professional
- Supervision
- Staff training

[114] 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.

[115] 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, 7 had used a VA medical facility in the year of, or the year prior to, their death.

[116] VHA Memorandum, "Agency-Wide Required Suicide Prevention Training," October 15, 2020.

[117] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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

Consultation

Clinical Liaison

The clinical liaison is a mental health professional, appointed from the support VA medical facility.[119]

External Clinical Consultant

External clinical consultants are assigned by the support VA medical facility director to provide a minimum of four hours per month of consultation. "External clinical consultants must be VHA mental health professionals who are independently licensed and have completed the VA credentialing process." If the support VA medical facility is unable to provide an external clinical consultant, the vet center is authorized to seek services from the private sector.[120] External clinical consultants provide consultation when a client presents as suicidal or homicidal to assess the probability of suicide or homicide and develop an intervention. External clinical consultants also complete peer case reviews and assist vet center clinicians in the treatment of complex veteran cases.[121]

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

- Vet center staffing spreadsheets
- Documentation demonstrating external clinical consultation of four hours per month[122]

VHA-Qualified Mental Health Professional

Each vet center is required to maintain one licensed and credentialed VHA-qualified mental health professional.[123] 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 January 1, through December 31, 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 Resources Management Office.

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

[120] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[121] RCS-CLI-003, *RCS Guidelines for Administration,* 2010*;* VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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

[123] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

Supervision

VCDs are to provide individual supervision to all vet center staff on an ongoing basis.[124] If the VCD is not a VHA-qualified mental health professional, a licensed clinical designee must assist with the supervision of clinical staff.[125] VCDs must also complete monthly chart audits of 10 percent of every counselor's active client records.[126]

The OIG evaluated supervision through interviews with the four VCDs and reviewed documentation of monthly supervision from October 4, through December 31, 2021, and monthly chart audits from January 1, through December 31, 2021, for all full-time counselors on staff.

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 within 90 days of entering their position or as an annual refresher.[127] In October 2020, VHA updated requirements for all clinicians implementing *Skills Training for Evaluation and Management of Suicide* to be completed within 90 days of hire or as an annual refresher training.[128]

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.[129] All vet center staff, regardless of position, are required to complete in-service training annually.[130]

To determine compliance, the OIG requested training records and proof of attendance for required training completed for all staff employed from January 1, through December 31, 2021.

[124] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); RCS-CLI-003.

[125] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); RCS-CLI-003.

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

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

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

[129] VHA Directive 1115.01.

[130] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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 and an assigned external clinical consultant. The OIG identified concerns related to

- clinical liaison,
- external clinical consultation hours,
- supervision,
- monthly audit, and
- staff training.

Clinical Liaison

The Center City, Huntington, and Northeast Vet Centers had clinical liaisons appointed by the support VA medical facilities.[131]

The Scranton Vet Center had a clinical liaison appointed from the support VA medical facility; however, that individual was a registered nurse and not a mental health professional. The Scranton VCD reported believing that past work experience of the clinical liaison would have met the requirement.

Recommendation 17

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

[131] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

District Director Concur.

VCD was not aware of the requirement of an appointment of a clinical liaison at the Scranton Vet Center. As of June 1, 2021, the Chief of Psychology at Wilkes-Barre VA Medical Center, has been assigned as the Clinical Liaison for the Scranton Vet Center. ADDC will monitor the active appointment of the liaison and DDD will provide ongoing oversight for this assignment.

Status: Requesting Closure

Target date for completion: N/A

OIG response: The OIG considers this recommendation closed.

External Clinical Consultation Hours

RCS requires four hours of external clinical consultation monthly.[132] The OIG found all four VCDs documented consultation hours. However, only the Huntington Vet Center met the required four hours of external clinical consultation per month.

The Center City and Northeast VCDs reported participating in a joint external clinical consultation weekly but were not able to provide documentation of the required four hours per month. Both VCDs reported the consultation, if missed, was not made up. The Center City VCD reported the consultation time was sufficient whereas the Northeast VCD indicated the time was insufficient for the vet center. The Scranton VCD was unable to provide documentation of external clinical consultation for the inspection period and attributed the lack of documentation to incomplete record keeping by previous individuals in the VCD position. The VCD shared implementing a process to meet the four-hour requirement.

Recommendation 18

The District Director determines reasons for noncompliance with a process for completing and tracking four hours of external clinical consultation per month at the Center City, Scranton, and Northeast Vet Centers; ensures Vet Center Directors implement processes; and monitors compliance.

[132] *RCS Guidelines for Administration*, 2010; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); RCS-CLI-003.

District Director Concur.

Staff was inconsistent in using any tracking system for external consultation hours in these 3 Vet Centers. VCDs and ADDC monitor and track the frequency and length of time of all external consultation meetings through RCSNet Oversight Tracker. Compliance is monitored monthly by the VCDs, and the monthly quality record report provided by the ADDC.

Status: Ongoing

Target date for completion: July 1, 2023

Supervision

RCS policy requires ongoing supervision to help with staff cohesion, problem solving, client case coordination, and the coordination of services with external VA partners. According to the District Director, RCS does not specify how supervision is tracked to ensure completion.[133]

The OIG found that Center City, Huntington, Northeast, and Scranton Vet Centers were noncompliant with the provision of staff supervision. The Center City VCD reports meeting with staff for one hour every two weeks but did not provide evidence for the entire inspection period. The Huntington VCD reported being unaware of the RCS requirement for supervision and did not have a regular schedule for clinical supervision. The Northeast VCD reported documenting scheduled supervision; however, did not always reschedule supervision when missed. The Scranton VCD cited being new to the position and not having a computer as reason for noncompliance with clinical supervision.

Recommendation 19

The District Director determines reasons for noncompliance with staff supervision provided by vet center directors at the Center City, Huntington, Northeast, and Scranton Vet Centers; ensures staff supervision occurs as required; and monitors compliance.

[133] RCS-CLI-003; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

District Director Concur.

VCDs were inconsistent in providing staff supervision and documenting its occurrence. The VHA Directive 1500(2) 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." These VCDs will document supervision date, time, and content of supervision meeting. ADDC and/or ADDA will check for compliance during annual clinical or administrative quality review.

Status: Ongoing

Target date for completion: October 1, 2023

Monthly Audit

Oversight of clinical services is one of the main responsibilities of a VCD. A methodology used to complete oversight is accomplished through chart audits. RCS policy requires VCDs complete a monthly 10 percent audit of each full-time counselor's active client caseload.[134] The OIG found that all four VCDs were noncompliant with conducting chart audits.

The Center City VCD completed audits for most months in the inspection period; however, believed the 10 percent requirement was an annual average and fell short of the 10 percent on several months across counselors. The Northeast VCD completed audits for 10 of 12 months in the inspection period and the Huntington VCD provided evidence of regular chart audits; however, neither VCD documented the caseload numbers; therefore, the OIG was unable to determine if 10 percent of caseloads were reviewed. The Scranton VCD provided inconsistent documentation of chart audits and caseload numbers for the inspection period and, therefore, was noncompliant.

Recommendation 20

The District Director verifies and determines reasons for noncompliance with monthly chart audits at the Center City, Huntington, Northeast, and Scranton Vet Centers; ensures chart audits are completed as required; and monitors compliance.

[134] RCS-CLI-003; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

District Director Concur.

Monthly chart audits were conducted but VCDs in these 4 Vet Centers did not ensure a full 10% compliance rate for each staff. In RCSNet, these VCDs will capture monthly chart audit report to ensure full 10% chart review compliance. ADDC will monitor compliance with monthly quality record report and DDD will provide oversight to ensure compliance.

Status: Ongoing

Target date for completion: July 1, 2023

Staff Training

RCS requires completion of mandatory trainings for both clinical and non-clinical staff.[135] The OIG found non-clinical staff at all four vet centers compliant with completion of annual suicide prevention and refresher training; however, clinical staff were noncompliant with suicide prevention training. Additionally, clinical staff at the Center City, Huntington, and Northeast Vet Centers were noncompliant with completing military sexual trauma training, and had either clinical or non-clinical staff who did not complete annual in-service training for fiscal year 2021. The Northeast VCD was unaware of how trainings are assigned and Center City, Huntington, and Scranton VCDs reported the district office assigns training.

The District Director told the OIG that annual in-service training for fiscal year 2021 was conducted for each vet center position.

Recommendation 21

The District Director determines reasons employees at the Center City, Huntington, Northeast, and Scranton Vet Centers did not complete required trainings; ensures all staff complete mandatory trainings; and monitors compliance.

District Director Concur.

FY 21 annual mandatory training did not meet compliance in these centers. VCD will ensure completion of required Talent Management System (TMS) assignments for Vet Center staff. DDD will provide compliance oversight through verification.

Status: Ongoing

Target date for completion: July 1, 2023

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

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."[136] RCS requires that the office space promotes interaction amongst eligible clients and their families and facilitates access to readjustment counseling services.[137]

The environment of care review evaluated compliance at the four selected vet centers. The OIG completed on-site inspections and reviewed relevant documents. The OIG evaluated the environment, general safety, and privacy.

Physical Environment

To evaluate compliance with environmental cleanliness, the OIG inspected the exterior to assess if it appeared clean, neat, and presentable, and reviewed the interior to determine if furnishings 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.[138]

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

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 plan (including active

[136] VHA Directive 1608, Comprehensive Environment of Care Program, June 21, 2021.

[137] VHA Handbook 1500.01; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

[138] VHA Handbook 1500.01; RCS, Administrative Site Visit (ASV) Protocol; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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

[140] 41 C.F.R. § 102–76.65(a).

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

shooter plan), handling of suspicious mail and bomb threats."[142] The OIG reviewed and assessed whether emergency and crisis 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.[143] Any documents or items displaying confidential or sensitive information must be secured.[144] RCS requires vet centers to have space for group counseling and ensures auditory privacy when sensitive client information is discussed.[145] The OIG 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 inspected all areas within the selected vet centers and found general compliance with the exterior and interior being clean, and the interiors being decorated with veteran memorabilia. The vet centers had furnishings that were clean and in good repair. All four vet centers had soundproofed counseling spaces and a space for informal social interaction for clients and families. 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 Accessibility Standards compliant exit signage
- Secure room for the storage of client records
- Current emergency and crisis plans

Architectural Barriers Act Accessibility Standards

RCS requires that each vet center follow the Architectural Barriers Act Accessibility Standards 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 three of four vet centers noncompliant in one element of general safety. The Center City VCD reports having the signs on order. The Northeast VCD was unaware of the requirement for tactile

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

[143] RCS, Administrative Site Visit (ASV) Protocol; VHA Handbook 1500.01, 2010; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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

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

[146] 36 C.F.R. § Pt. 1191, App. D. Architectural Barriers Act Accessibility Standards (codified at Appendices C and D to 36 C.F.R. part 1191).

(braille) signage. The OIG found one of three egresses at the Huntington Vet Center lacked a tactile sign.

Recommendation 22

The District Director evaluates and determines reasons for noncompliance with tactile (braille) signage at the Center City, Huntington, and Northeast Vet Centers, and ensures all exit doors are compliant with Architectural Barriers Act Standards.

District Director Concur.

ADDA left the position in FY 21 and did not track evidence of installation of signage at the Center City, Huntington, and Northeast Vet Centers. Vet Centers are in the process of providing evidence of installation.

Status: Ongoing

Target date for completion: June 1, 2023

Privacy

RCS requires that "Confidential/sensitive information is appropriately secured."[147] The OIG found the Center City Vet Center's file storage room, which contained unsecured paper client records waiting to be shredded, was also being used as an office by the Veterans Outreach Program Specialist.

Recommendation 23

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

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

District Director Concur.

All RCS records are to be scanned into RCSNet and then shredded. Several records were found to have not been shredded during the original shredding contract. All unsecured records at Center City have been shredded on February 28, 2023. All staff have completed the VA Privacy and Information Security Awareness training.

Status: Requesting Closure

Target date for completion: N/A

OIG response: The OIG considers this recommendation closed.

Emergency Plan

RCS requires vet centers to have a current and comprehensive emergency and crisis plan.[148] The OIG found the Huntington and Scranton Vet Centers compliant; however, the Center City and Northeast Vet Centers were noncompliant with comprehensive emergency and crisis plans. The Center City Vet Center emergency and crisis plan was not current and did not have a policy for bomb threats. The Northeast Vet Center emergency and crisis plan included a temporary relocation and evacuation plan but lacked contingencies for phone and computer disruptions, management of disruptive behavior, violence in the workplace, bomb threats, and handling of suspicious mail. During an interview, the VCD reported reviewing the policies in preparation for annual site visits and receiving updates from the district office when updates were available.

Recommendation 24

The District Director reviews reasons for noncompliance with having a current and comprehensive emergency and crisis plan at the Center City and Northeast Vet Centers, ensures completion of a current and comprehensive emergency and crisis plan, and monitor's compliance.

[148] RCS policy does not define current emergency and crisis plans; in the absence of an RCS definition of a current emergency and crisis plan, the OIG considered the plan to be current if updated within two years from the date of inspection.

District Director Concur.

VCD at Center City and Northeast did not maintain a current and comprehensive emergency and crisis plan. These centers will receive an updated Emergency and Crisis plan. VCDs will ensure staff have a full understanding of the emergency and crisis plan. ADDC and/or ADDA will review the plan to ensure compliance during their annual clinical and administrative quality reviews.

Status: Ongoing

Target date for completion: August 1, 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 24 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

Quality Reviews	Requirement	Recommendation
Clinical and Administrative Quality Reviews (Zone)	Clinical quality review remediation plans and deficiency resolution	1. 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 Center City, Huntington, Northeast, and Scranton Vet Centers; takes indicated actions to ensure completion; and monitors compliance.
		2. The District Director determines reasons for lack of evidence that clinical quality review deficiencies were resolved at the Center City, Huntington, Northeast, and Scranton Vet Centers; takes indicated actions to ensure completion; and monitors compliance.
	Administrative quality review remediation plans	3. The District Director determines reasons administrative quality review remediation plans were not completed at the Beckley and Bucks County Vet Centers, ensures completion, and monitors compliance.
		4. The District Director determines the reasons administrative quality review remediation plans do not include the Deputy District Director's approval and date of approval as required, and ensures compliance.
Administrative Quality Reviews (Selected Vet Centers)	Administrative quality review remediation plans and deficiency resolution	5. The District Director determines reasons administrative quality review remediation plans did not include documentation of deficiency resolution and the time frame for resolution for the Center City, Huntington, Northeast, and Scranton Vet Centers; takes indicated actions to ensure completion; and monitors compliance.

		6. The District Director determines reasons for lack of evidence for administrative quality review deficiency resolution for the Center City, Huntington, Northeast, and Scranton Vet Centers; takes indicated actions to ensure completion; and monitors compliance.
Mortality and Morbidity Reviews (Zone)	Completion of mortality and morbidity reviews for all serious suicide attempts and homicide completions of active clients	7. The District Director ensures completion of a morbidity and mortality review for the death by homicide, and ensures all future morbidity and mortality reviews are completed as required.
Suicide Prevention (Zone-Wide Electronic Record Review)	**Requirement**	**Recommendation**
Intake Assessment	Completion of psychosocial assessments within five visits	8. 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	9. The District Director ensures suicide risk assessments are completed on the first clinical visit, and monitors compliance across all zone vet centers.
High Risk Client Care Coordination	Flagged High Risk for Suicide care coordination	10. 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.
Confidentiality Requirements	Confidentiality and coordination with VA medical facilities	11. 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 Risks and Notification	Following confidentiality requirements when coordinating care with VA medical facilities and timely notification to the suicide prevention coordinator	12. The District Director confirms clinical staff make timely notification to the suicide prevention coordinator at the support VA medical facility for clients with significant safety risks, and monitors compliance across all zone vet centers.

Safety Plan Completion	Safety plans	13. The District Director ensures clinical staff complete safety plans for clients that are assessed at intermediate or high suicide risk level in either acute, chronic, or both categories as required, and monitors compliance across all zone vet centers.
Client Consultation for At Risk Clients	Consultation following suicide risk level changes	14. 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 following a client's suicide risk assessment as required, and monitors compliance across all zone vet centers.
Suicide Prevention and Intervention (Vet Center)	**Requirement**	**Recommendation**
Suicide Prevention and Intervention (Vet Center)	Mental Health Council participation with VA medical facilities	15. The District Director, in collaboration with the support VA medical facility clinical or administrative liaisons, determines the reasons for noncompliance with staff participation on the mental health council for the Center City, Huntington, Northeast, and Scranton Vet Centers, and takes actions as indicated to ensure compliance with Readjustment Counseling Service requirements.
	Crisis Plans	16. The District Director determines the reasons for noncompliance with critical event plans with desktop reference at the Center City and Northeast Philadelphia Vet Centers, and takes actions as indicated to ensure compliance with Readjustment Counseling Service requirements.
Consultation, Supervision and Training	**Requirement**	**Recommendation**
Clinical Liaison	Assigned clinical liaison	17. The District Director determines reasons for noncompliance with the appointment of a clinical liaison at the Scranton Vet Center, ensures assignment of a mental health professional as liaison, and monitors compliance.

External Clinical Consultation	Documentation of four hours of external clinical consultation per month	18. The District Director determines reasons for noncompliance with a process for completing and tracking four hours of external clinical consultation per month at the Center City, Scranton, and Northeast Vet Centers; ensures Vet Center Directors implement processes; and monitors compliance.
Supervision	Supervision with clinical staff members	19. The District Director determines reasons for noncompliance with staff supervision provided by vet center directors at the Center City, Huntington, Northeast, and Scranton Vet Centers; ensures staff supervision occurs as required; and monitors compliance.
Monthly Audits	Monthly 10 percent active client record audit for each full-time counselor	20. The District Director verifies and determines reasons for noncompliance with monthly chart audits at the Center City, Huntington, Northeast, and Scranton Vet Centers; ensures chart audits are completed as required; and monitors compliance.
Training	Completion of all mandatory trainings	21. The District Director determines reasons employees at the Center City, Huntington, Northeast, and Scranton Vet Centers did not complete required trainings; ensures all staff complete mandatory trainings; and monitors compliance.
Environment of Care	**Requirement**	**Recommendation**
General Safety	All exit signage Architectural Barriers Act Standards compliant	22. The District Director evaluates and determines reasons for noncompliance with tactile (braille) signage at the Center City, Huntington, and Northeast Vet Centers, and ensures all exit doors are compliant with Architectural Barriers Act Standards.
Privacy	Confidential/sensitive information secured	23. The District Director reviews reasons for noncompliance with securing confidential and sensitive information at the Center City Vet Center, and ensures all vet center employees safely and securely store protected health information.

Emergency Preparedness	Updated Emergency and Crisis Plans	24. The District Director reviews reasons for noncompliance with having a current and comprehensive emergency and crisis plan at the Center City and Northeast Vet Centers, ensures completion of a current and comprehensive emergency and crisis plan, and monitor's compliance.

Appendix B: District 1 Zone 3 Profile

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

Profile Element	District 1 Zone 3	
Total Budget Dollars	$14,700,048.25	
Unique Clients*	5,372	
New Clients	1,168	
Veteran Clients	1,432	
Active Duty Clients	81	
Spouse/Family Clients	3,364	
Bereavement Clients	365	
Position	**Authorized**	**Filled**
Total Full-time	127	116
District Director and District Administrative Staff†	3	3
Zone Leaders (Deputy District Director, Associate District Directors for Counseling and Administration), and Zone Administrative Staff	4	4
Vet Center Director	19	18
Clinical Staff	67	62
Vet Center Outreach Program Specialist‡	18	14
Vet Center Office Staff	19	18
Contract Providers	0	0

Source: VA OIG analysis of information from District 1 Zone 3.
**RCS describes unique clients as 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 excludes the district director and district administrative staff
‡Vet Center Outreach Program Specialists are responsible for vet center outreach services. Veteran Outreach Program Specialists conduct outreach in order to educate and encourage eligible individuals to obtain needed services at the vet center.

Profile Summary: From October 1, 2020, through September 30, 2021, district 1 zone 3 operated on a total budget of $14,700,048.25 and served 5,372 unique clients; 1,168 new clients; 1,432 veteran clients; 81 active duty clients; 3,364 spouses and family members; and 365 bereavement clients. There was a total of 127 authorized full-time positions, with 116 of those positions filled throughout the zone.

Appendix C: Vet Center Profiles

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

Table C.1. FY21 Vet Center Profiles

Profile	Center City Philadelphia Vet Center	Huntington Vet Center	Northeast Philadelphia Vet Center	Scranton Vet Center
Total Budget Dollars*	$888,617.69	$914,529.74	$763,304.43	$800,480.49
Unique Clients†	192	353	308	307
Veteran Clients	174	341	297	290
Bereavement Clients	20	30	22	13
Active Duty Clients	6	3	4	4
Spouse/Family Clients	161	86	150	178
New Clients	60	51	76	44
Total Number of Positions	**Center City Philadelphia Vet Center**	**Huntington Vet Center**	**Northeast Philadelphia Vet Center**	**Scranton Vet Center**
Total Authorized Full-time Positions	7	8	6	7
Total Filled Positions	7	7	6	6
Total Vacancies	0	1	0	1
Total Part-time Positions	0	0	0	0

Source: VA OIG analysis of information provided by district 1 zone 3.
**Total budget dollars include salaries/benefits; office supplies, operating supplies/materials; janitorial, alarm, waste disposal, utilities; vet center leases, facility renovations/improvements and furniture.*
†RCS describes unique clients as the number of clients seen at the vet center during the inspection period and could include bereavement, active duty, or spouse/family clients.

Appendix D: RCS Chief Readjustment Counseling Officer Memorandum

Department of Veterans Affairs Memorandum

Date: April 3, 2023

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

Subj: Vet Center Inspection of North Atlantic District 1 Zone 3 and Selected Vet Centers

To: Director, Office of Healthcare Inspections (54VC00)
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 1 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:)

Pedro Ortiz
Deputy Chief Officer, Readjustment Counseling Service
for
Michael Fisher
Chief Officer, Readjustment Counseling Service

Appendix E: RCS North Atlantic District 1 Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 29, 2023

From: District Director, North Atlantic District 1 (RCS1)

Subj: Vet Center Inspection of North Atlantic District 1 Zone 3 and Selected Vet Centers

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Vet Centers Inspection Program-District 1 Zone 3.
2. I have reviewed the draft report and request closure of recommendation one since a manual tracking system was developed for all clinical site visits that is completed and monitored by Associate District Director for Counseling (ADDC), with oversight from the Deputy District Director (DDD). Implementation of the Tracker began in October 2021 and has been consistently used since then for tracking Zone 3 clinical quality review remediations. Currently DDD reviews the 30-day Action plan developed by the Vet Center Director (VCD) within the designated timeframe.

I have reviewed the draft report and request closure of recommendation four.
All FY 22 administrative quality review remediation plans have DDDs approval and date of approval included electronically. In FY 23 the administrative quality review remediations are entered into RCSNet.

I have reviewed the draft report and request closure of recommendation five. A new ADDA was hired in FY 22 and developed a tracking system to ensure remediation plans were completed. Starting in FY 22 documentation of progress on deficiency resolution was included in the remediation plans of the administrative site visit report.

I have reviewed the draft report and request closure of recommendation six. In FY 22 a new tracking system was developed to ensure remediation plans were completed. Starting in FY 22 documentation of progress on deficiency resolution was included in the remediation plans of the administrative site visit report reviewed by ADDA and DDD. RCS Office of Policy and Oversight (OPO) has created an administrative site visit report in RCSNet, and as of FY 23, paper processes will no longer be used. Resolution of the administrative site visit and remediations will be tracked and monitored by review of records in RCSNet by VCDs in collaboration with the ADDA and DDD, with a goal of deficiency resolution before the next administrative site visit. The DDD will provide oversite to this new process and will ensure discussion with VCDs about all items that are deficient for consecutive administrative quality reviews.

I have reviewed the draft report and request closure of recommendation seven. A thorough record review was completed and reviewed with ADDC and DDD and RCS Office of Policy and Oversight. The determination of what is a serious homicide 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. On 1/19/22 the ADDC placed a non-visit progress note into the record documenting the decision related to whether the event was deemed a serious homicide attempt and decision to not conduct a morbidity and mortality review. Based on district review of the case an MMQR will not be conducted.

I have reviewed the draft report and request closure of recommendation seventeen. As of June 1, 2021, the Chief of Psychology at Wilkes-Barre VA Medical Center, has been assigned as the Clinical Liaison for the Scranton Vet Center. VCD will ensure a clinical liaison is appointed, ADDC will monitor the active appointment of the liaison and DDD will provide ongoing oversight for this assignment.

I am also requesting closure of recommendation twenty-three. All unsecured records at Center City have been shredded on February 28, 2023. All staff have completed the VA Privacy and Information Security Awareness training.

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:)

Joanne Boyle,
District Director

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