DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Vet Center Inspection of North Atlantic District 1 Zone 4 and Selected Vet Centers

VCIP | REPORT #21-03269-123 | MAY 25, 2023

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Figure 1. *North Atlantic District 1 Zone 4 Vet Centers inspected: (from top to bottom, let to right) Baltimore, Maryland; Dundalk, Maryland; Raleigh, North Carolina; Richmond, Virginia*
Source: VA OIG inspection team virtual visit photographs.

Abbreviations

OIG	Office of Inspector General
RCS	Readjustment Counseling Service
VCD	vet center director
VCIP	Vet Center Inspection Program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

The VA Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) provides a focused evaluation of aspects of care delivered at vet centers. 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 4 and four selected vet centers: Baltimore and Dundalk, Maryland; Raleigh, North Carolina; and Richmond, 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 It was rescinded and replaced by VHA Directive 1500, *Readjustment Counseling Service*, January 26, 2021, then again by VHA Directive 1500(1), *Readjustment Counseling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 4 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]

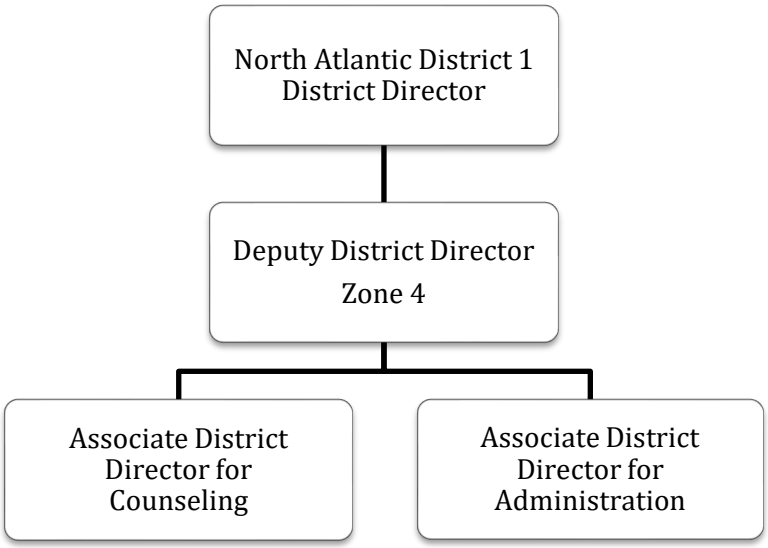

Figure 2. *North Atlantic, district 1 zone 4 leaders.*
Source: VA OIG analysis of district organizational chart.

At the time of the OIG inspection, district leaders worked together as a group for slightly over four months.[5] The District Director was appointed in December 2019. The Deputy District Director was assigned in September 2021, the Associate District Director for Counseling served in the position since May 2015, and the Associate District Director for Administration was assigned in April 2019.

[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.

District leaders were knowledgeable of basic concepts, and their roles in, quality improvement principles and practices. Two of four leaders reported not having enough time 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 4 conducted required 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 All Employee Survey results through various conference calls and small group meetings. Based on 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 (VCD) with 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 results were higher than national average regarding vet center location. However, results were slightly lower when compared to national averages specific to a welcoming environment, appointment scheduling convenience, recommendation of vet center services, feeling better as a result of services, and overall quality. The Deputy District Director noted high staff turnover, changes in group facilitators, and use of technology instead of face-to-face visits as the reasons for the lower scores.

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

[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.

[8] RCS policy does not define a serious suicide attempt. In the absence of an RCS definition of a serious suicide attempt, the OIG considered the client being transferred to the hospital an indicator of a serious suicide attempt that would have met the criteria for completion of a morbidity and mortality review.

The OIG found the Associate District Director for Administration noncompliant for the completion of administrative quality review remediation plans and the Associate District Directors for Counseling and Administration noncompliant with requirements of clinical and administrative remediation plan deficiency resolution. The OIG found the Associate District Director for Counseling noncompliant for morbidity and mortality review completion for serious suicide attempts. The OIG issued five recommendations.[9]

Suicide Prevention

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

The four selected vet centers inspected were compliant with required availability of nontraditional hours for appointments. 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] One of the four VCDs were noncompliant with the requirement of reviewing and dispositioning RCS High Risk Suicide Flag SharePoint clients.

The OIG issued a total of 10 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. Two 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, with acute, chronic, or both risk levels.

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[9] The OIG did not make recommendations for deficiencies identified in this report related to morbidity and mortality reviews as recommendations on the deficiencies were directed to the RCS Chief Officer, who has authority over all districts, in an 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 does 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 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 four recommendations specific to the four selected vet centers' suicide prevention and intervention processes.

Consultation, Supervision, and Training

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

Two VCDs were noncompliant with the requirement to provide ongoing and reoccurring supervision to clinical staff. The four VCDs were noncompliant with auditing 10 percent of each counselor's electronic client records. Overall, staff at all four vet centers were noncompliant with completing training requirements.

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

Environment of Care

Environment of care reviews evaluated the four selected vet centers with results and recommendations specific only to those sites. The four vet centers inspected generally complied with environment of care requirements. However, the OIG found one vet center noncompliant with the exterior being in good repair and three of the four vet centers noncompliant with the posting of Architectural Barriers Act Accessibility Standards for tactile exit signs.[13] The OIG identified two vet centers noncompliant with maintaining a current or comprehensive emergency and crisis plan. The OIG made three recommendations.

Conclusion

The OIG conducted a detailed inspection across five review areas and issued a total of 22 recommendations for improvement to the District Director. The number of recommendations should not be used as a gauge for the overall quality of care provided within the zone. The intent is for district leaders to use these recommendations as a road map to help improve operations and

[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).

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 recommendation 3 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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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 services."[4] Since opening vet centers in 1979, RCS was one of the first organizations to address

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

[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 provides readjustment counseling to eligible clients and their families who live at a distance from the vet center and provides services through contracted providers.

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

[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. Vet Center count from https://reports.vssc.med.va.gov/ as of January 2022; 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.

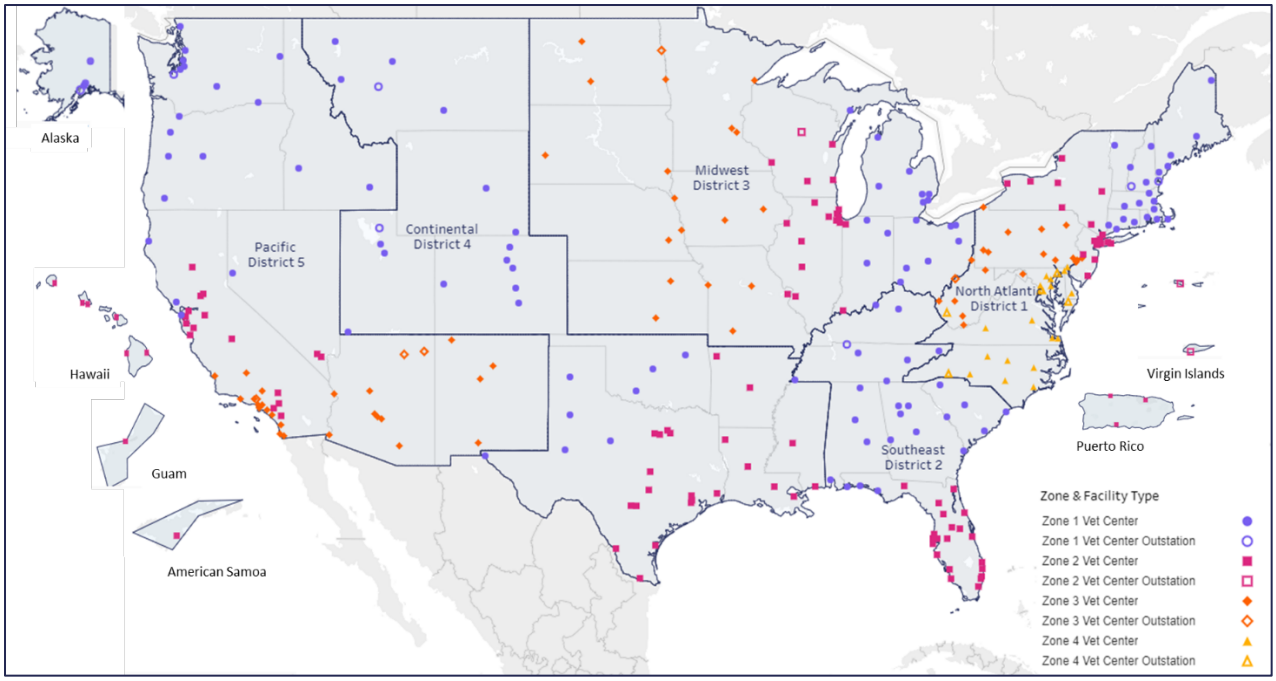

Figure 3. *Map of vet centers and vet center outstations. The placement of Alaska, American Samoa, Hawaii, Guam, Puerto Rico, and the Virgin Islands is not representative of their actual geographical locations.* [10]
Source: VA OIG-developed using VA Site Tracking (January 19, 2021) and RCS data (as 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
2003	Veterans of Operation Enduring Freedom (OEF)

[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
	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 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

[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).

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]

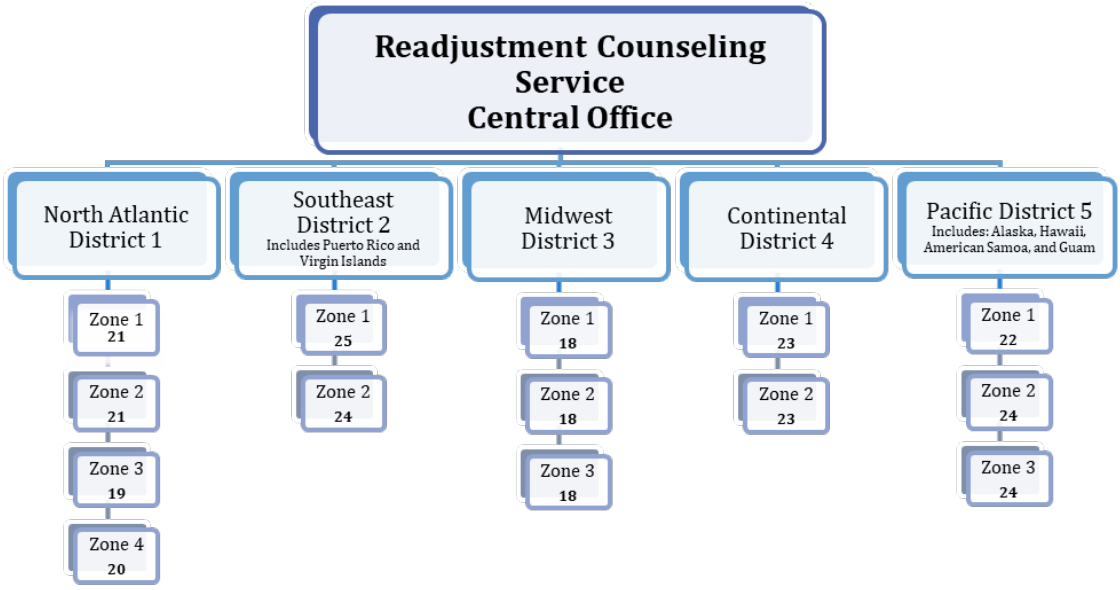

Figure 4. *RCS organizational district and zone structure.*
Source: VA OIG-developed using analysis of RCS information.
Note: The number of vet centers in each zone is denoted below the respective zone. The OIG did not assess RCS data for accuracy or completeness.

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 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

[13] VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). The OIG was informed there was an acting VCD for the Baltimore Vet Center in zone 4. For the remainder of this report, the acting Baltimore VCD in zone 4 is referred to as the Baltimore VCD.

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

clinics, or the Department of Defense unless there is a signed release of 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 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, 2021, through December 31, 2021. This report evaluates the quality of care delivered at North Atlantic district 1 zone 4 vet centers and examines a broad range of key clinical and administrative processes for compliance

[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, 2010; 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, 2010; 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 the support VHA medical facility.

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 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

[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, 2021, through December 31, 2021.

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).

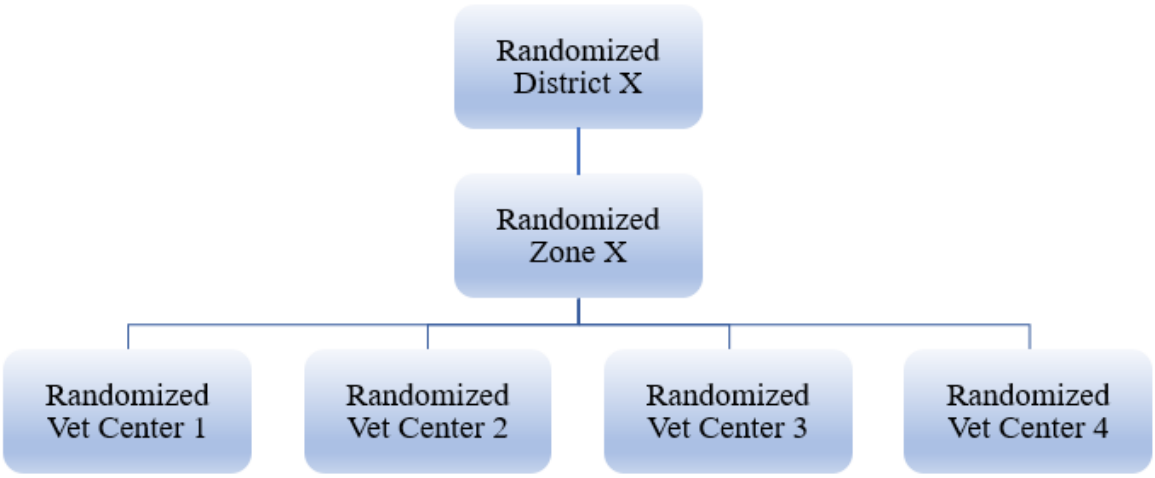

Figure 5. *Randomization and selection of inspection sites.*
Source: VA OIG.

For this inspection, the OIG randomly selected district 1 zone 4. Within zone 4, the OIG randomly selected the Baltimore and Dundalk Vet Centers in Maryland, the Raleigh Vet Center in North Carolina, and the Richmond Vet Center in Virginia. Zone 4 is noted in figure 6 below. For demographic profiles of zone 4 and the four selected vet centers see appendixes B and C. The OIG provided one-day notice to each vet center prior to formal evaluation for coordination of care as needed.[25]

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

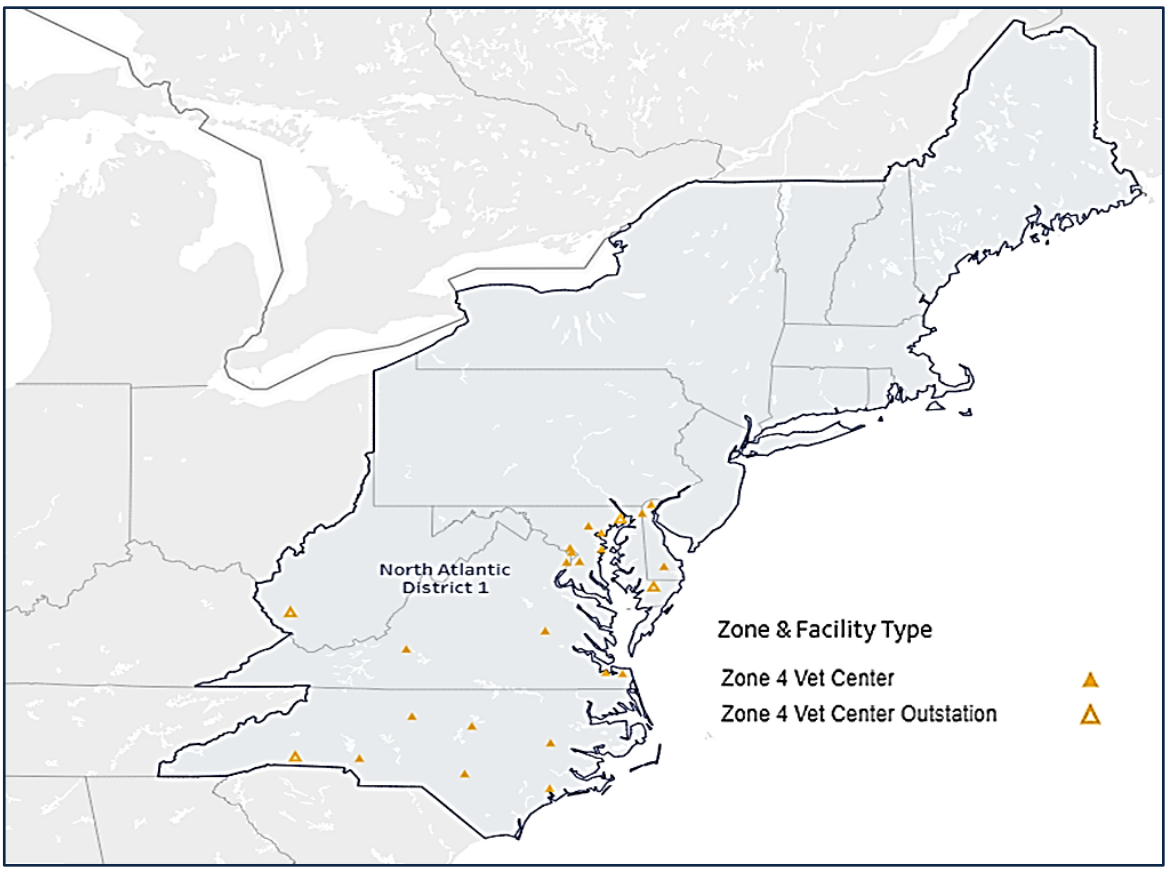

Figure 6. *Map of North Atlantic district 1 zone 4 vet centers.*
Source: Developed by VA OIG using VA Site Tracking.

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.[26]

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.

[26] 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.[27] "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.[28]

As noted, the OIG assessed leadership and organizational risks for district 1 zone 4 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[29]

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

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

[28] 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.

[29] The leadership and organizational risk questionnaire is a tool the OIG developed and used to ask VCDs zone-wide about quality management to evaluate knowledge and practices.

fiscal operations, outreach events, community relations, and clinical programs.[30] Figure 7 shows the leadership organizational structure for district 1 zone 4.

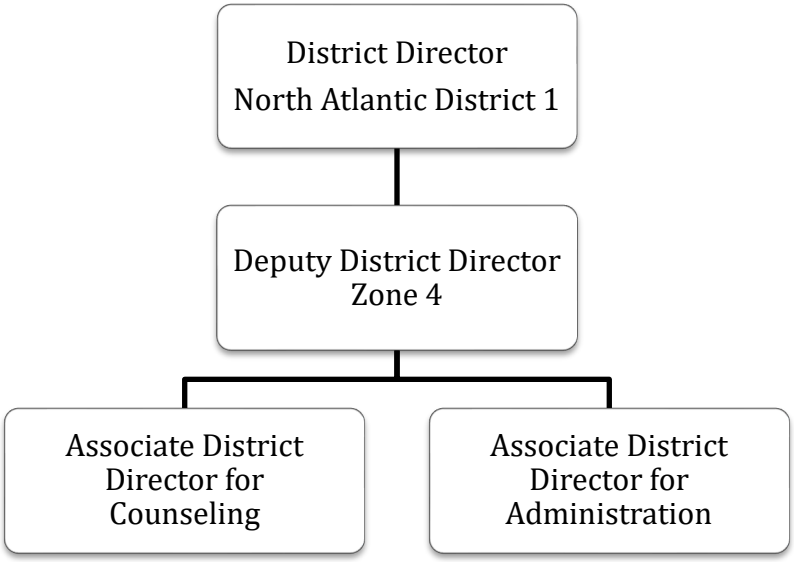

Figure 7. *District leaders.*
Source: VA OIG analysis of district organizational chart.

At the time of the OIG interviews, district leaders had been working together for slightly over four months. The District Director had been in the role since December 2019. According to documents provided by the district office, the Deputy District Director position was filled approximately four months prior to the inspection; however, the position was never vacant. The Deputy District Director was hired in September 2021, the Associate District Director for Counseling served in the position since May 2015, and the Associate District Director for Administration was assigned in April 2019.

During the 12 months prior to the inspection, five VCD positions were vacant for a range of three to five months. At the time of inspection, four VCD positions were vacant with candidate selections made for three of the positions and one position being reposted. However, a member of the district office confirmed acting VCDs were assigned for the duration of the vacancies. The District Director and the Associate District Director for Counseling shared several reasons for VCD vacancies, including staff burn out, organizational changes, and VCDs accepting senior level counselor positions with same pay scale level and less responsibility.

The District Director stated there was a large degree of oversight and operational responsibilities assigned to the Deputy District Director, including supervision of VCDs and Associate District Directors for Counseling and Administration. The District Director stated the position encompasses many roles such as mentoring; reviewing of quality site visits; and managing

[30] *RCS Guidelines and Instructions for Vet Center Administration*; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

complaints and performance appraisals, which results in overtime and impacts availability to train, mentor, and coach staff.[31]

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 provided examples of what quality improvement meant including a framework to evaluate, sustain, and implement changes; standardize processes; be consistent; and improve the quality of care and services. Two of four leaders did not feel they had enough time in a given week to support quality improvement activities.

District Annual In-service Training

RCS requires vet center staff to have a basic level of cross training to promote its mission of assisting veterans' post-war social and psychological readjustment, and to enhance small team functionality. [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 and using a wide variety of modalities, including face-to-face trainings or video conferencing.[33]

District 1 zone 4 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 receive notification of training requirements for the inspection period. District leaders report a member of the district office staff assign required VHA training 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

[31] RCS requires an annual quality review of all vet centers to ensure compliance with policies and procedures for the administration and provision of readjustment counseling.

[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 director's conference calls, all hands and zone calls, and small groups. Based on All Employee Survey results, district leaders streamlined communication, provided training, and encouraged sharing of resources and team building to reduce burnout.

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 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.

The OIG found district 1 zone 4 veteran feedback results were higher than national average regarding vet center location; however, slightly lower when compared to national averages specific to a welcoming environment, appointment scheduling convenience, recommendation of

[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) 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.

vet center services, feeling better as a result of services, and overall quality. Table 2 details the results of the Vet Center Service Feedback Survey.

The Deputy District Director attributed lower than national average feedback scores to high staff turnover rates, changes in group facilitators, and the use of technology instead of face-to-face visits. However, the Deputy District Director reported that technology specific training and assistance is now provided to clients.

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

Questions	District 1 Zone 4 Average Score*	RCS National Average Score*
I was treated in a welcoming and courteous manner by the Vet Center staff.	4.59	4.66
My appointments have been scheduled at a time that was convenient.	4.56	4.58
I would likely recommend the vet center to another Veteran, servicemember, or family member.	4.51	4.60
The Vet Center services were located conveniently in my community.	4.39	4.36
I feel better as a result of the services provided by the Vet Center staff.	4.24	4.40
How satisfied were you with the overall quality of services at the Vet Center?	4.37	4.50

Source: VA OIG-developed based on RCS National Service Support data provided by 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 15 district 1 zone 4 VCDs to evaluate perceptions about select quality improvement activities and organizational health.[40] All 15 questionnaires distributed were returned. 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 20 vet centers in district 1, zone 4, according to the District Director, four VCD positions were vacant at the time of the inspection (Alexandria, Baltimore, Chesapeake, and Roanoke Vet Centers) and the Sussex VCD was detailed outside of the district at the time of inspection; therefore, only 15 VCDs were available for receipt of the questionnaire.

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.

Sixty-seven percent of respondents indicated vet center staff speak up, offer ideas, and ask questions. When challenging situations arise, 80 percent of respondents reported the vet center team discussed the issues openly to find solution; however, only 53 percent believed asking district leaders for assistance when needed was easy. Overall, respondents indicated there was a process for vet center staff to report safety issues, errors, and concerns; review identified process issues; and take actions to make corrections. Sixty-seven percent of respondents believed district leaders communicate goals for quality improvement; however, some respondents indicated there are multiple barriers to implementing quality improvement activities. Some of these barriers included lack of training, inadequate resources to support quality improvement planning, and lack of quality results to identify areas that need improvement. Sixty-seven percent of respondents indicated they do not have enough time in a given week to support quality improvement activities.

Leadership and Organizational Risks Conclusion

The district leaders reported five vacant VCD positions across the zone in the 12 months prior to the inspection. District leaders attributed vacancies to burnout, organizational change, and VCDs accepting senior counselor positions with equivalent pay and less responsibility. District leaders also reported high workloads impacting VCD training, coaching, and vet center oversight. While some Vet Center Service Feedback Survey scores were positive for the zone, scores were lower than national averages in most measures, which the Deputy District Director attributed to high staff turnover and the use of technology instead of face-to-face visits. District leaders shared results and made changes based on the All Employee Survey. Some initiatives included more streamlined communication, training, and sharing of resources to reduce burnout. District leaders had a general understanding of quality improvement and perceived their role as important to driving and overseeing quality improvement activities; however, questionnaire responses indicated the District Director, Deputy District Director, and most VCDs did not feel there was enough time to support quality improvement activities, and a majority of VCDs did not find it easy to ask district leaders for assistance when needed. District leaders are implementing initiatives throughout the zone; therefore, the OIG did not make a recommendation related to questionnaire results at this time.

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,

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

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.

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 the deputy district directors ensure vet center clinical and administrative quality reviews are conducted each fiscal year. Deputy district directors are responsible for approving clinical and administrative quality reviews and remediation plans.[46]

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[42] RCS Guidelines for Administration; 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), requires 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.

[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, October 7, 2021.

Within 30 days of receiving the clinical or administrative quality site visit report, the VCD, with the help of the associate district director for counseling or administration, develops a remediation plan to resolved identified deficiencies.[47] Within 60 days from the date the deputy district director approves the remediation plan, the VCD is responsible for resolving all deficiencies.[48] 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.[49] Figure 8 depicts the vet center quality review remediation process.

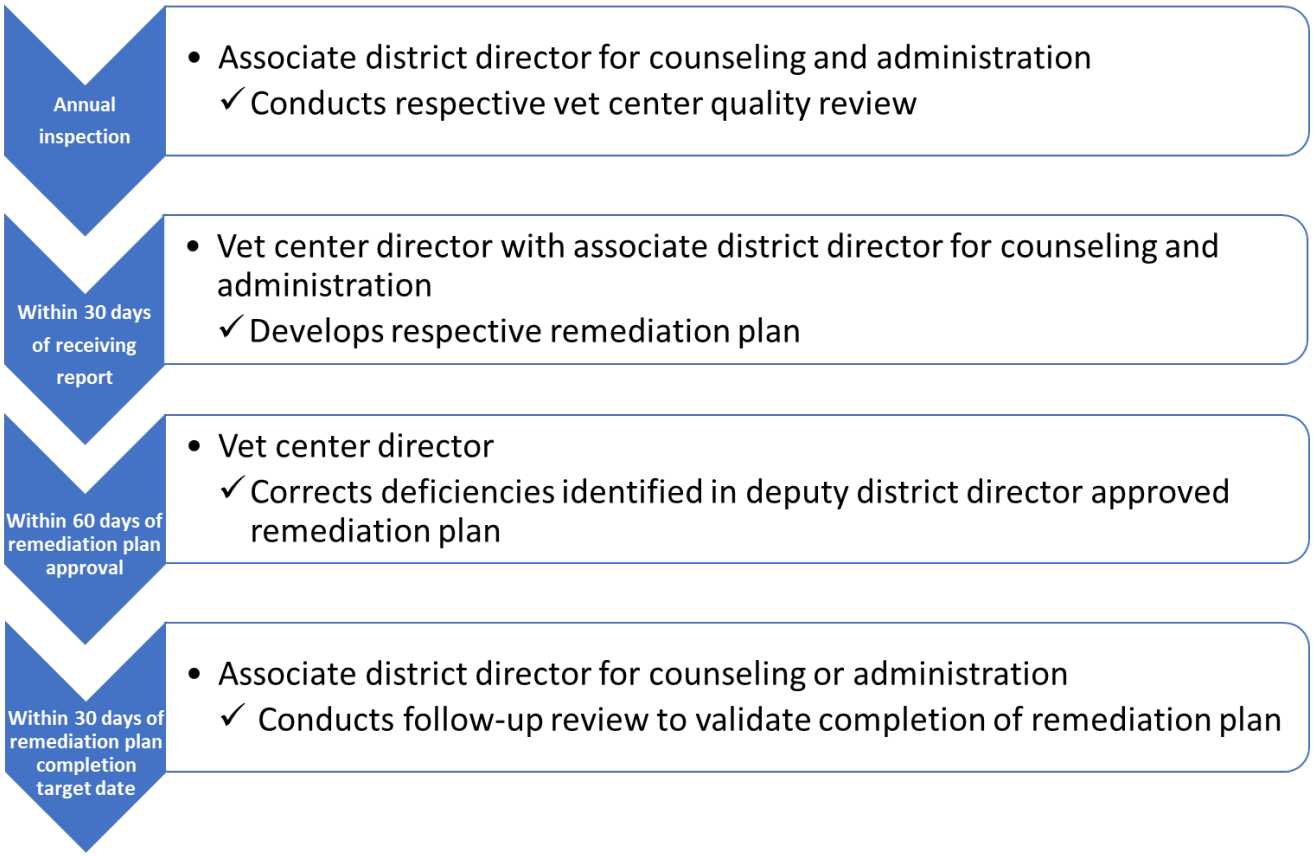

Figure 8. *Vet center quality review remediation process.*
Source: VA OIG-developed using RCS-CLI-001, November 2, 2018, and VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

The OIG evaluation for the clinical and administrative review processes for all district 1 zone 4 vet centers included interviewing district leaders and reviewing

- clinical and administrative site visit reports (zone-wide),

[47] RCS-CLI-001, November 2, 2018.
[48] RCS-CLI-001, November 2, 2018; RCS-CLI-003.
[49] RCS-CLI-001, November 2, 2018.

- clinical and administrative remediation plans (zone-wide),
- clinical and administrative deficiency resolution and timeliness (four selected vet centers), and
- evidence of clinical and administrative deficiency resolution (four selected vet centers).[50]

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 for all 20 vet centers in district 1 zone 4. The Associate District Director for Administration was compliant for all administrative quality reviews. However, one vet center with identified deficiencies, did not have a remediation plan.

The OIG identified the following findings:

- Clinical quality review remediation plans did not consistently include documentation of deficiency resolution and time frame of resolution and evidence of resolution (four selected vet centers).
- One administrative quality review remediation plan was not completed (zone-wide).
- Administrative quality review remediation plans did not include deficiency resolution and timely documentation and evidence of resolution (three of the four selected vet centers).

Zone-Wide Clinical Quality Reviews and Remediation Plans

Clinical quality reviews were completed for the 20 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.[51] On average, the quality site visit reports were approved within 12 days of the site visit; one of 20 reports exceeded the 30-day time frame. Of the 20 completed quality site visit reports, 19 vet centers had clinical deficiencies identified. All 19 vet centers with identified deficiencies had remediation plans.

[50] 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.

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

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 Baltimore, Dundalk, Raleigh, and Richmond Vet Centers. Clinical remediation plans for Baltimore, Dundalk, Raleigh, and Richmond Vet Centers addressed all deficiencies identified during the clinical quality reviews.

The OIG identified the following findings associated with the clinical quality site reviews (see table 3):

- Baltimore Vet Center did not have sufficient documentation of resolution for one of the three deficiencies.
- Dundalk Vet Center did not have sufficient documentation of resolution for one of the two deficiencies.
- Richmond Vet Center did not have sufficient documentation of resolution for the one deficiency identified.
- All four vet centers had a lack of evidence of resolution for the 13 total deficiencies.
- All four vet centers lacked documentation of timely resolution of deficiencies for the 13 deficiencies.

The Associate District Director for Counseling was knowledgeable of the clinical oversight process and able to discuss the process for ensuring site visits are completed, reviewed, and signed by the Deputy District Director. However, the Associate District Director for Counseling reported they did not have a process to evaluate the VCDs' actions to correct deficiencies or ask for evidence of deficiency resolution.

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.[52] RCS requires deputy district director approval of remediation plans to establish the 60-day time frame for deficiency resolution.[53]

The OIG found that RCSNet does not have a location for remediation plans to record the deputy district director approval signature or date. 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.

[52] 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.
[53] RCS-CLI-001.

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

	Baltimore	Dundalk	Raleigh	Richmond
Deficiencies Identified by the Associate District Director for Counseling	3	2	7	1
Deficiencies Identified in the Remediation Plan	3	2	7	1
Deficiencies with Documentation of Resolution	2	1	7	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 4 documents.
Note: The OIG examined remediation plans and evidence of deficiency resolution that corresponded to clinical quality reviews performed from October 1, 2020, through September 30, 2021.

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 Baltimore, Dundalk, Raleigh, and Richmond Vet Centers; takes indicated actions to ensure completion; and monitors compliance.

District Director Concur.

Clinical Quality Review remediation plans did not include documentation of deficiency resolution and the timeframe for resolution for Baltimore, Dundalk, Raleigh, and Richmond Vet Centers because a tracking system was not in place to ensure deficiency resolution. Following this finding, a 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) for these 4 Vet Centers. Currently, the DDD reviews the 30-day Action Plan developed by the Vet Center Director (VCD) within the designated timeframe within RCSNet.

Status: Ongoing

Target date for completion: May 1, 2023

Recommendation 2

The District Director determines reasons for lack of evidence for clinical quality review deficiency resolution for the Baltimore, Dundalk, Raleigh, and Richmond Vet Centers; takes indicated actions to ensure completion; and monitors compliance.

District Director Concur.

There was not a tracking system in place to ensure deficiency resolution. Following this finding, resolution of the clinical site visits and remediations are tracked and monitored in the dashboards and review of records in RCSNet in collaboration with the ADDC and DDD. Implementation of the Tracker began September 2022 and has been consistently used since then for Zone 4 clinical quality review remediations. Currently DDD reviews the 30-day Action plan developed by the VCD within the designated timeframe within RCSNet. The DDD will provide oversite to this process and will ensure consultation with the 4 VCDs.

Status: Ongoing

Target date for completion: June 1, 2023

Zone-Wide Administrative Quality Reviews and Remediation Plans

The OIG found district 1 zone 4 to be noncompliant with some requirements for administrative quality review remediation plans.

For each vet center in district 1 zone 4, the Associate District Director for Administration completed an administrative quality site review. On average, the administrative site visit reports were approved within 73 days of the site visit. Of the 20 completed administrative quality site visit reports, 17 vet centers had administrative deficiencies identified. Sixteen of the 17 vet centers had remediation plans. For the one site (Alexandria Vet Center) missing a remediation plan, the Associate District Director for Administration and the Deputy District Director stated it was due to the VCD leaving the position prior to submitting the plan and no follow-up from the acting VCD to complete one. Of the 16 remediation plans, 10 were not approved by the Deputy District Director.

Recommendation 3

The District Director determines reasons the administrative quality review remediation plan was not completed for one vet center within the zone, ensures completion, and monitors compliance.

District Director Concur.

There was not a tracking system in place to ensure deficiency resolution. The Administrative Site Visit remediation plan was not completed at the time of OIG inspection. The remediation plan has been completed and approved by the DDD. Readjustment Counseling Service (RCS) has implemented a process to have Administrative Site Visit reports entered in RCSNET. There is a tracking process in RCSNET to ensure all remediations are completed in a timely manner.

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 Baltimore, Dundalk, Raleigh, and Richmond Vet Centers.

The Baltimore Vet Center did not have deficiencies identified during the inspection period; therefore, no remediation plan was required. Administrative remediation plans for Dundalk, Raleigh, and Richmond Vet Centers identified all deficiencies identified during the administrative quality reviews.

The OIG identified the following findings during the administrative quality site review (see table 4):

- Dundalk Vet Center did not have sufficient documentation of resolution for the three deficiencies.
- Raleigh Vet Center did not have sufficient documentation of resolution for one of the five deficiencies.
- Richmond Vet Center did not have sufficient documentation of resolution for two of the four deficiencies.
- Dundalk, Raleigh, and Richmond Vet Centers did not have evidence of resolution for the 12 total deficiencies.
- Documentation of timely resolution of deficiencies was not available for the 12 total deficiencies for the Dundalk, Raleigh, and Richmond Vet Centers.

The Associate District Director for Administration reported a delay in the time of the site visit and the Deputy District Director approval was partly due to not having all information prepared prior to the visit and being side tracked during site visits and not prioritizing the site visit completion. The Associate District Director for Administration stated there is no follow-

up to verify deficiency resolution, and if a VCD does provide evidence of resolution, it is not kept or documented. The Associate District Director for Administration was in the position for only a few months during the inspection period and was unable to explain the lack of Deputy District Director signature on 10 of the 16 remediation plans. The Associate District Director for Administration shared awareness that remediation plans are to be completed in 60 days, however, does not go back and verify if this occurs.

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

	Baltimore*	Dundalk	Raleigh	Richmond
Deficiencies Identified by the Associate District Director for Administration	0	3	5	4
Deficiencies Identified in the Remediation Plan	0	3	5	4
Deficiencies with Documentation of Resolution	N/A	0	4	2
Deficiencies with Documentation of Timely Resolution	N/A	0	0	0
Deficiencies with Evidence of Resolution	N/A	0	0	0

Source: VA OIG analysis based on district 1 zone 4 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.
**During the OIG inspection period, the Baltimore Vet Center did not have identified deficiencies in the administrative site review and therefore did not require a remediation plan or deficiency resolution.*

Recommendation 4

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

District Director Concur.

There was not a tracking system in place to ensure deficiency resolution. Documentation of progress on deficiency resolution is included in the remediation plans of the administrative site visit report, now located in RCSNet and is complete for these 4 Vet Centers.

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 5

The District Director determines reasons for lack of evidence for administrative quality review deficiency resolution for the Dundalk, Raleigh, and Richmond Vet Centers; takes indicated actions to ensure completion; and monitors compliance.

District Director Concur.

There was not a tracking system in place to ensure deficiency resolution. Documentation of progress on deficiency resolution has been included in the remediation plans of the administrative site visit report, now located in RCSNet and requires review and electronic signature for closure. The ADDA [Associate District Director for Administration] will monitor for compliance with DDD oversight for these 3 Vet Centers.

Status: Ongoing

Target date for completion: May 1, 2023

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]

[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.

Additionally, RCS requires completion of morbidity and mortality reviews for client safety events including serious suicide or homicide attempts, and deaths 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 deaths by suicide or homicide that occurred during the inspection period.[58] The OIG identified crisis reports completed for three serious suicide attempts.

Morbidity and Mortality Reviews Findings

The Associate District Director for Counseling stated morbidity and mortality reviews for serious suicide attempts are considered on a case-by-case basis. The Associate District Director for Counseling stated criteria for a serious suicide attempt has not been established and acknowledged the difficulty determining when to conduct a morbidity and mortality review. Through interviews with district leaders, the OIG found that prior to completion of a crisis report, vet center staff discuss the event with the Associate District Director for Counseling, who consults with RCS Central Office staff. When morbidity and mortality reviews are completed, zone leaders evaluate actions taken and make recommendations for improvement of vet center suicide prevention activities. Lessons learned are then shared with the field via email. In addition, RCS Central Office reports aggregate and summarize morbidity and mortality information on a nationwide level, and provided an example of related information shared with staff through a national huddle call.

The OIG found two of the three reported suicide attempts did not have corresponding morbidity and mortality reviews. Through review of client electronic health records, the OIG learned of the two suicide attempts that did not have a corresponding morbidity and mortality review, one was interrupted by police, and the other resulted in the client being intubated, both which the OIG considered to be serious suicide attempts requiring morbidity and mortality reviews.[59]

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[56] VHA Handbook 1500.01; *RCS Guidelines for Administration*, 2010; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). Prior to the 2021 directive, RCS referred to morbidity and mortality reviews as critical incident quality reviews.

[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.

[59] *Merriam-Webster.com Dictionary*, "intubate," accessed on February 20, 2019, https://www.merriam-webster.com/dictionary/intubation.

The Associate District Director for Counseling denied the need for conducting a morbidity and mortality review for the interrupted suicide attempt, and stated that the client was receiving the appropriate care by VA and vet center providers, therefore a morbidity and mortality review would not be beneficial. The Associate District Director for Counseling stated that RCS Central Office staff would have been consulted; however, consultation was not documented.

The Associate District Director for Counseling stated that a morbidity and mortality review was not conducted for the client whose overdose resulted in intubation as initial documentation suggested it was an accidental overdose. Upon electronic health record review, the OIG found documentation that five days post event, vet center staff contacted hospital staff and were informed client disclosed to medical team of taking an intentional overdose with suicidal intent. The Associate District Director of Counseling denied receiving updated information regarding the suicide attempt and stated there was not an established expectation for staff to share updated information with the district office.

In a 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]

Suicide Prevention

The VA National Veteran Suicide Prevention Annual Report published in the fall of 2021 found 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

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

[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*

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 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 vet center directors review the High Risk Suicide Flag list monthly and document a disposition on the site for all clients seen at the vet center within the previous 12 months.[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

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

[65] 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. RCS leader informed the OIG that the 2017 Memorandum of Understanding was discontinued on March 22, 2022.

[66] "Memorandum of Understanding between the VHA Office of Mental Health 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.

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

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

[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).

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 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 a RCSNet record review. However, 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 a RCSNet record review. 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

[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.

[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 four or less visits, and therefore, completion of the psychosocial assessment was not required.

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

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 that district 1 zone 4 vet center clinicians completed 48 percent of intakes, 87 percent of military histories, and 30 percent of suicide risk assessments (see table 5).

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	48	(35, 62)
Military History	60	87	(78, 95)
Suicide Risk Assessment	99†	30	(22, 39)

Source: VA OIG Analysis of district 1 zone 4, RCSNet electronic record reviews.
**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.*
†One client was excluded from suicide risk assessment sample as they were not seen for individual counseling sessions.

The OIG identified the following findings:

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

Recommendation 6

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

District Director Concur.

VCD and Readjustment Counselors were not consistently trained completing psychosocial assessment and monitoring compliance. District 1 is providing 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 and will be monitored through monthly chart audits. Additionally, all new VCDs are trained on this tool during new Vet Center Director training in District 1. ADDC will monitor for compliance with DDD oversight.

Status: Ongoing

Target date for completion: September 1, 2023

Recommendation 7

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

District Director Concur.

VCD and Readjustment Counselors were not consistently trained in completing suicide risk assessments on the first clinical visit and monitoring compliance. The VCDs and Readjustment Counselors will be trained on completion of risk assessments to meet VHA Directive 1500 (2) standards during FY23 face-to-face training. The VCD and ADDC will monitor compliance through review of dashboard data, regular RCSNet record reports reviewed by VCD, and with support from zone ADDC and oversight from the DDD.

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)."[79] Furthermore, vet center counselors are required to consult and coordinate care with the support VA medical

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

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.[80] Vet center staff are required to follow confidentiality requirements when coordinating care with the support VA medical facility.[81]

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 4 vet centers from October 1, 2020, through September 30, 2021.[82]

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 with 60 days.[83]
- Timely notification to the support VA medical facility suicide prevention coordinator if client posed a significant safety risk.[84]
    - 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 4 were noncompliant with requirements for shared high risk clients with the support VA medical facility related to suicide prevention and intervention.

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[80] "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).

[81] 38 C.F.R. § 17.2000–816 (e).

[82] There was a total of 50 clients at high risk for suicide during this time period in zone 4; the records of all 50 were 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.

[83] "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(2).

[84] 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.

The OIG found that of the 35 client records reviewed, 14 records had documented coordinated care with the support VA medical facilities.[85] Of those 14, only 5 followed confidentiality requirements.[86] Overall, 14 percent of records reviewed followed requirements for care coordination while maintaining confidentiality.[87]

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 for suicide within 60 days.
- For clients where coordination occurred with VA medical facilities, vet center clinical staff did not consistently follow confidentiality requirements.

Recommendation 8

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

District Director Concur.

VCD and Readjustment Counselors were not consistently trained coordinating care with the support VA medical facility for shared clients. District 1 will provide training to VCDs and Readjustment Counselors on the process of collaborating and coordinating care with VA Medical Center (VAMC) providers on all shared clients, especially those with increased suicide risk, and ensuring that a Release of Information (ROI) is obtain in FY 23 District 1 Training. Compliance is monitored during monthly chart audits conducted by the VCDs. ADDC will monitor with DDD oversight.

Status: Ongoing

Target date for completion: September 1, 2023

[85] The OIG excluded 15 clients which were closed cases. Client cases are closed when interventions are completed or when a client no longer participates in counseling services.

[86] The OIG identified only five vet center client records compliant with reporting significant safety risks. The OIG omits calculations for the electronic record review requirements when the number of clients is less than 11.

[87] The OIG estimated that 95 percent of the time, the true compliance rate for consultation and coordination and following confidentiality requirements was between 3.0 and 27.0 percent. The estimate and confidence interval was calculated using sampling weights based on the proportions of each population sampled. *Merriam-Webster.com Dictionary*, "confidence interval," accessed January 21, 2021, https://www.merriam-webster.com/dictionary/confidence%20interval.

Recommendation 9

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

District Director Concur.

VCD and Readjustment Counselors were not consistently providing ROIs for clients when consulting with supporting VA medical facility. District 1 will provide training to VCDs and Readjustment Counselors in FY23, on the process of consultation and coordination of care with VAMC providers and ensuring the ROI is obtained. Compliance is monitored through monthly chart audits conducted by the VCDs and the RCSNet report provided to the ADDC for 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 who is assessed at intermediate to 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), 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 identified 50 randomly selected 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 4 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 4 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 categories (see table 6).

In district 1 zone 4, the OIG found that 86 percent of records reviewed were noncompliant with RCS requirements for completion of a safety plan and 64 percent were noncompliant with RCS consultation requirements.

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	50	14	(6, 24)
Consultation	50	36	(24,50)

Source: VA OIG analysis of district 1 zone 4, RCSNet electronic record reviews.

[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] A sample of 50 clients, assessed at intermediate or high, acute or chronic, risk level during the inspection period, was used for the evaluation. For clients with multiple risk assessments during the inspection period, the OIG evaluated one randomly selected risk assessment assessed at intermediate or high, acute or chronic risk level. No clients were excluded from this sample.

Recommendation 10

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.

VCD and Readjustment Counselors were not thoroughly trained on completing safety plans for clients assessed at intermediate or high suicide risk level. District 1 will provide FY 23 training to VCDs and Readjustment Counselors on completing a safety plan when a client is assessed at any risk level above low or any elevated risk level (intermediate or high) for either acuity or chronicity. The VCD and ADDCs and will monitor compliance via RCSnet reports. DDD will provide oversight.

Status: Ongoing

Target date for completion: September 1, 2023

Recommendation 11

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

District Director Concur.

VCD and Readjustment Counselors were not consistently trained in consulting with VCD, external consultant and ADDC or support VA medical facility on client's suicide risk assessment. District 1 will provide FY 23 training to VCDs and Readjustment Counselors on ensuring regular and ongoing consultation with the VCD, the External Consultant, and/or the Suicide Prevention Coordinator when there are changes in risk levels as authorized by RCS privacy rules. The VCD and ADDC will monitor compliance via chart audits and RCSnet reports of records due. The 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 4:

- Baltimore Vet Center, Maryland

- Dundalk Vet Center, Maryland
- Raleigh Vet Center, North Carolina
- Richmond Vet Center, Virginia

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.

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 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 causes analysis procedures involving shared clients[96]

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

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

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 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, 2021, 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. Critical event plans are coordinated with the community and include a desktop reference sheet, for vet center staff, outlining how to respond when a client presents as suicidal or homicidal either on the phone or in person.[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 and a root cause analysis is conducted, vet center staff should be included in the root cause analysis

[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. RCS-CLI-006, April 27, 2020.

[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

[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.

investigation and receive relevant outcome information from the support VA medical facility root cause analysis team when cases are reviewed.[103]

The OIG reviewed all clients who died by suicide from Veterans Integrated Service Network (VISN) 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.

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 all four vet centers complied with having nontraditional hours, allowing clients easier access to services. None of the vet centers in district 1 zone 4 had shared clients with the support VA medical facilities who died by suicide during the OIG inspection period; therefore, vet center staff did not participate in root cause analysis investigations.

The OIG found issues related to

- vet center participation in mental health council meetings,
- monthly review of the High Risk Suicide Flag SharePoint site,
- 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

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

[104] VISN 4, 5, and 6 is comprised of all the support VA medical facilities that collaborate with vet centers in district 1 zone 4.

representation from Readjustment Counseling Centers (Vet Centers) in this Council."[105] The mental health councils are responsible for

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

RCS requires a licensed vet center staff member to participate in all support VA medical facility mental health council meetings. Participation is required to reinforce vet center and support VA medical facility partnerships, assist with care coordination for clients receiving vet center and support VA medical facility services, and aid in 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 OIG found all four vet centers noncompliant with attending mental health council meetings. The Baltimore and Dundalk VCDs reports rotating meeting attendance and sharing minutes among all acting VCDs for awareness, but could not provide evidence of attendance for two months of the inspection period. The Raleigh VCD reported attending meetings when possible and provided minutes, but the minutes did not provide evidence of meeting attendance. The Richmond VCD provided documentation that the support VA medical facility did not have mental health council meetings throughout the inspection period, and, therefore, did not attend.

Recommendation 12

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 Baltimore, Dundalk, Raleigh, and Richmond Vet Centers; and takes action as indicated to ensure compliance with Readjustment Counseling Services requirements.

[105] VHA Handbook 1160.01.

[106] VHA Handbook 1160.01.

[107] RCS Guidelines for Administration; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2); RCS-CLI-003, January 25, 2019.

District Director Concur.

VCDs were not consistently collaborating with the support VAMC clinical and administrative liaisons. In FY 23 District 1 VCD training, the requirement of regular participation in Mental Health Council meetings will be reviewed. The 4 VCDs have been instructed to participate monthly and document their participation in the RCSnet oversite tracker. Compliance is reviewed by ADDCs.

Status: Ongoing

Target date for completion: May 1, 2023

RCS High Risk Suicide Flag SharePoint

RCS requires VCDs to review a national SharePoint site monthly that lists clients designated as high risk for suicide by VHA facilities and clients at an increased predictive risk for suicide who were active at vet centers within the previous 12 months. Once reviewed, VCDs are responsible for determining a plan of action for clients on the list and documenting a disposition on the SharePoint site.[108]

The Raleigh VCD was noncompliant with dispositioning clients on the High Risk Suicide Flag SharePoint site. The OIG identified two clients were not dispositioned during the inspection period. The VCD reported an oversight in not dispositioning the two clients and believed all clients were dispositioned.

During interviews, the OIG found both Raleigh and Richmond VCDs did not have accurate knowledge of the type of clients on the High Risk Suicide Flag SharePoint site, even though both acknowledged receiving training.

Recommendation 13

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

[108] RCS-CLI-006, April 27, 2020.

District Director Concur.

VCD lacked training in utilization of High risk Suicide Flag SharePoint. The Raleigh VCD will receive specific training on the utilization and process for the Suicide Prevention SharePoint by the ADDC during FY 23 training. VCDs work in collaboration with the ADDC and monitors completion of these lists monthly. DDDs will provide oversight.

Status: Ongoing

Target date for completion: May 1, 2023

Recommendation 14

The District Director determines reasons the Raleigh and Richmond Vet Center Directors did not have accurate knowledge of type of clients on the High Risk Suicide Flag SharePoint site, takes actions to ensure vet center directors incorporate relevant information from the SharePoint site to safely disposition clients, and monitors compliance.

District Director Concur.

Richmond and Raleigh VCD lacked training on monitoring utilizing the High risk Flag SharePoint site. The ADDC will provide specific individual trainings to VCD's of Raleigh and Richmond on the High risk Suicide Flag SharePoint site and will continue to be monitored by the ADDC.

Status: Ongoing

Target date for completion: May 1, 2023

Critical Event Plan

All four vet centers had a critical event plan. During on-site visits, the OIG found Baltimore and Dundalk Vet Centers staff could not locate the desktop reference outlining the basic steps to follow in the event of a suicidal or homicidal client presenting in person or on the phone.

Recommendation 15

The District Director determines the reasons for noncompliance with staff access to critical event plans that included a desktop reference at the Baltimore and Dundalk Vet Centers and takes actions as indicated to ensure compliance with Readjustment Counseling Service requirements.

District Director Concur.

VCD's lacked maintaining a critical event plan as a desktop reference. District 1 created a critical event plan and desktop reference that these 2 Vet Centers will utilize.

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.

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.[109]

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 ongoing communication with the suicide prevention coordinator; however, did not have a formal written process in place.

In a VCIP report, *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, Report No. 20-02014-270, September 30, 2021, the OIG made a recommendation related to standardized communication between suicide prevention coordinators and vet center staff to the Under Secretary for Health:

> The Under Secretary for Health ensures that the Chief Officer collaborates with the Office of Mental Health and Suicide Prevention to determine reasons for noncompliance with a standardized communication and collaboration process between suicide prevention coordinators and vet centers in accordance with the 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.[110]

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

[110] 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.

Consultation, Supervision, and Training

Each vet center is assigned a clinical liaison and an external clinical consultant from the support VA medical facility.[111] Clinical liaisons help coordinate care for clients with the support VA medical facility, whereas external clinical consultants provide guidance on clinically complex cases.[112]

Vet centers are comprised of small multidisciplinary teams, are community-based, and traditionally located outside of VA medical facilities. Vet center teams are at least four staff consisting minimally of a VCD, an office manager, a counselor, and an outreach program specialist.[113] Vet centers are required to have at least one VHA-qualified licensed mental health professional on staff.[114]

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
- Family counseling for military-related issues
- Bereavement counseling for family members or caregivers
- Counseling for conditions related to military sexual trauma[115]

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."[116] Following the initial mandated training, staff were required to complete the corresponding refresher courses for their positions.[117] On October

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

[112] RCS-CLI-003, January 25, 2019; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2).

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

[114] RCS Guidelines for Administration; VHA Directive 1500; VHA Directive 1500(1); VHA Directive 1500(2). VA News, February 3, 2016, *Preventing Veteran suicide: a call to action*. 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.

[115] 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.

[116] 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 recently used a VA medical facility in the year of, or the year prior to their death.

[117] VHA Directive 1071.

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

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

Military sexual trauma is reported to support VA medical facility 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.[120]

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

Consultation

Clinical Liaison

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

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.[122] 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

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

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

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

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

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

consultants also complete peer case reviews and assist vet center clinicians in the treatment of complex veteran cases.[123]

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

- Vet center staffing spreadsheets
- Documentation demonstrating external clinical consultation of four hours a month[124]

VHA-Qualified Mental Health Professional

Each vet center is required to maintain one licensed and credentialed VHA-qualified mental health professional.[125] 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, 2021, through December 31, 2021.
2. If the vet center had more than one VHA-qualified mental health provider on staff,
    a. the OIG randomly selected one individual, and
    b. requested credentialing documentation of that individual from RCS's Consolidated Human Resources Management Office.

Supervision

VCDs are to provide individual supervision to all vet center staff on an ongoing basis.[126] If the VCD is not a VHA-qualified mental health professional, a clinically licensed designee must assist with the supervision of clinical staff.[127] VCDs must also complete a monthly chart audit of 10 percent of every full-time counselor's active client records.[128]

The OIG evaluated supervision through interviews with the four VCDs and reviewed documentation of monthly supervision from October 3 through December 31, 2021, and monthly chart audits from January 1, 2021, through December 31, 2021, for all full-time counselors on staff.

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

[124] A staffing spreadsheet was requested from vet centers within this report to provide information on appointed liaisons, consultants, and their associated service lines

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

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

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

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

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 S.A.V.E. or S.A.V.E. refresher training.[129] 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.[130]

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

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

Consultation, Supervision and Training Findings and Recommendations

The OIG found all four vet centers had a clinical liaison from the support VA medical facility and at least one licensed and credentialed VHA-qualified mental health professional on staff. The Baltimore, Dundalk, and Richmond Vet Centers had external clinical consultants appointed from the support VA medical facility. The Raleigh Vet Center did not have an external clinical consultant appointed for one month of the inspection period. The Raleigh VCD reported being aware of these requirements and hiring an external clinical consultant from the community in the past; however, the VCD was directed by district leaders to stop using community providers. The Associate District Director for Counseling confirmed not hiring community external clinical consultants, but was unaware of the reason. As of February 2021, the Raleigh Vet Center was assigned an external clinical consultant from the VISN office; therefore, the OIG did not make a recommendation on this finding.

The OIG identified concerns related to

- external clinical consultant,
- supervision,

[129] 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.

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

[131] VHA Directive 1115.01; VHA Handbook 1500.01

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

- monthly audit, and
- staff training.

External Clinical Consultant

RCS requires four hours of external clinical consultation monthly.[133] The OIG found all four VCDs documented consultation hours. However, the Baltimore, Dundalk, and Raleigh Vet Centers were noncompliant with the external clinical consultation requirement. Baltimore and Dundalk VCDs reported scheduling four hours a month of consultation; however, both provided insufficient documentation of external clinical consultation. The Raleigh VCD reported consultation occurred for two hours as it was difficult to get a consultant for four hours a month. The Richmond Vet Center was compliant with meeting the required four hours of external clinical consultation per month.

Recommendation 16

The District Director determines reasons for noncompliance with a process for completing and tracking four hours of external clinical consultation per month at the Baltimore, Dundalk, and Raleigh Vet Centers; ensures vet center directors implement processes; and monitors compliance.

District Director Concur.

VCD and Readjustment Counselors were not consistently completing and monitoring compliance of the 4 hours of monthly external consultations at these 3 Vet Centers. The VCDs and ADDCs will monitor and track the frequency and length of time of all external consultation meetings through RCSNET Oversight Tracker. Compliance is monitored monthly by the ADDCs, with the monthly quality record report.

Status: Ongoing

Target date for completion: June 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.[134]

The OIG found Baltimore and Dundalk Vet Centers were noncompliant with the provision of staff supervision on a weekly basis. The Baltimore VCD provided one week of supervision for

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

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

two employees during the inspection period. The Dundalk VCD reported not having supervision routinely and expressed an expectation for experienced staff to seek out supervision when needed.

Recommendation 17

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

District Director Concur.

VCD and Acting VCD at these 2 Vet Centers were inconsistent in providing individual supervision. The VHA Directive 1500(2) indicates that the VCD is responsible for providing individual supervision to all Vet Center staff on an ongoing basis. VCDs will document supervision date, time, and content of supervision meeting monthly. ADDC and ADDA will ensure compliance during clinical site visit.

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

The Baltimore VCD completed 25 percent of the monthly chart audits and the Dundalk VCD completed 33 percent during the inspection period. The Baltimore VCD was unable to provide an explanation for lack of completion by the former VCD. The Dundalk VCD reported being unable to complete all audits due to competing priorities such as providing alternate VCD coverage and clinical responsibilities. The Raleigh and Richmond VCDs completed audits for most months in the inspection period. However, both Raleigh and Richmond VCDs reported being unable to determine prior caseload numbers in RCSNet, and therefore, the OIG was unable to determine if 10 percent of each counselor's caseload was reviewed.

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

Recommendation 18

The District Director verifies and determines reasons for noncompliance with monthly chart audits at the Baltimore, Dundalk, Raleigh, and Richmond Vet Centers; ensures chart audits are completed as required; and monitors compliance.

District Director Concur.

VCDs at these 4 Vet Centers were not consistently completing 10% of clinical staff charts monthly. Updates to RCSnet have made tracking chart auditing accurate and up to date. In RCSnet, VCDs capture monthly chart audit reports to ensure 10% chart audit compliance. ADDC monitors compliance with monthly quality record report. DDD provides oversight.

Status: Ongoing

Target date for completion: August 1, 2023

Staff Training

RCS requires completion of mandatory trainings for both clinical and non-clinical staff.[136] The OIG determined some clinical staff at the Baltimore, Dundalk and Raleigh Vet Centers were noncompliant with completion of annual suicide prevention and refresher trainings. The Baltimore, Dundalk, and Raleigh Vet Centers had either clinical or non-clinical staff who did not complete annual in-service training for fiscal year 2021. All four vet centers had clinical staff that were noncompliant with completing military sexual trauma training.

The Dundalk VCD stated it was two years since annual in-service training had occurred due to the 2019 COVID pandemic. The Deputy District Director told the OIG that position specific annual in-service training was provided to vet center staff during the fiscal year.

The acting Baltimore VCD reports reviewing Talent Management System (TMS) trainings and discussing with staff when trainings need to be completed. The Dundalk and Richmond VCDs reports staff at the district assign trainings and they are alerted when trainings are overdue. The Raleigh VCD reports multiple people assign staff trainings. The Richmond VCD never received a master list of required trainings and only reviewed trainings that were due or overdue.

Recommendation 19

The District Director determines reasons employees at the Baltimore, Dundalk, Raleigh, and Richmond Vet Centers did not complete required trainings; ensures all staff complete mandatory trainings; and monitors compliance.

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

District Director Concur.

VCDs were not consistently monitoring and assigning required TMS trainings. DDD will review TMS assignments of supervisors in the field for accurate monitoring of required trainings. VCDs and DDD will provide training compliance oversight.

Status: Ongoing

Target date for completion: June 1, 2023

Environment of Care

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

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 interior furnishings to determine if they were clean and in good repair. The OIG also assessed each vet center for a welcoming or non-institutional environment decorated with military appreciation items, including an informal space for clients and families to interact.[139]

General Safety

The Architectural Barriers Act of 1968 applies to buildings or facility spaces leased in whole or in part by the United States after August 12, 1968.[140] Facilities subject to the Architectural Barriers Act must comply with the Architectural Barriers Act Accessibility Standards.[141] The

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

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

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

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

[141] 41 C.F.R. § 102–76.65(a).

OIG evaluated if vet centers were compliant with Architectural Barriers Act Accessibility Standards related to people with disabilities including entrances, parking spaces, and exit signs.[142]

Vet centers are also required to have a current emergency and crisis plan that addresses "contingencies for phone and computer disruptions, weather/national disaster emergency plan, site/facility/building emergency plan, site/facility/building temporary relocation plan, management of disruptive behavior plan, violence in the workplace plan (including active shooter plan), and handling of suspicious mail and bomb threats."[143] The OIG reviewed and assessed if 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.[144] Any documents or items displaying confidential or sensitive information must be secured. RCS requires vet centers to have space for group counseling and ensures auditory privacy when sensitive client information is discussed.[145] The OIG assessed 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 designated 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 sound-proofed counseling spaces and a space for informal social interaction for clients and their 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:

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

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

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

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

- Presentable exterior
- Architectural Barriers Act Accessibility Standards compliant exit signage
- Current emergency and crisis plans

Exterior

The OIG found the accessible parking space for persons with disabilities at the Richmond Vet Center was not clearly marked. The paint was faded and the signage was partially hidden. The VCD reported being unaware until the on-site inspection that the parking space was faded.

Recommendation 20

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

District Director Concur. The Richmond Vet Center needs handicapped parking spots repainted. The front door is not American with Disabilities Act (ADA) compliant. The ADDA is working with the landlord to correct the exterior of the Richmond Vet Center. Status: Ongoing Target date for completion: October 1, 2023

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* [braille] signs complying with 703.1, 703.2, and 703.5."[146] The OIG found Baltimore, Dundalk, and Raleigh Vet Centers did not have tactile signs posted near any exit doors. The Baltimore and Dundalk VCDs acknowledged awareness of the requirement for tactile signs. The Baltimore VCD reported not having time to address the issue. The Dundalk VCD did not explain the absence of the signage. The Raleigh VCD reported being unaware of the requirement.

[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).

Recommendation 21

The District Director evaluates and determines reasons for noncompliance with tactile (braille) signage at the Baltimore, Dundalk, and Raleigh Vet Centers and ensures all exit doors are compliant with Architectural Barriers Act Accessibility Standards.

District Director Concur.

There is a need to install braille signs on the exits. Baltimore and Dundalk have installed the braille signage at their exit doors. Raleigh Vet Center ordered braille signage March 10, 2023.

Status: Ongoing

Target date for completion: May 1, 2023

Emergency Plan

RCS requires vet centers to have a current and comprehensive emergency and crisis plan.[147] The OIG found the Raleigh and Richmond Vet Centers were noncompliant. The Raleigh emergency plan was dated 2018, and referenced VHA directives and documentation processes no longer applicable. The VCD reported not being able to recall when the emergency and crisis plan was last updated. The Richmond emergency and crisis plan was outdated. The VCD was aware the plan needed updating, but reported staffing issues and the need to prioritize other tasks as the reason why the emergency and crisis plan was not current.

Recommendation 22

The District Director reviews reasons for noncompliance with maintaining a current and comprehensive emergency and crisis plan at the Raleigh and Richmond Vet Centers and ensures all emergency and crisis plans are updated and comprehensive as required.

[147] 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.

The 2 VCDs lacked an updated Emergency and Crisis Plan. District 1 created an updated Emergency and Crisis Plan for these Vet Centers and this will be implemented by June 1, 2023. VCDs will ensure review with all staff and ADDCs will ensure overall Vet Center compliance.

Status: Ongoing

Target date for completion: June 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 22 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 Quality Reviews (Selected Vet Centers)	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 Baltimore, Dundalk, Raleigh and Richmond Vet Centers, takes indicated actions to ensure completion, and monitors compliance. 2. The District Director determines reasons for lack of evidence for clinical quality review deficiency resolution for the Baltimore, Dundalk, Raleigh, and Richmond Vet Centers; takes indicated actions to ensure completion; and monitors compliance.
Administrative Quality Reviews (Zone)	Administrative quality review remediation plans	3. The District Director determines reasons the administrative quality review remediation plan was not completed for the one vet center within the zone, ensures completion, and monitors compliance.
Administrative Quality Reviews (Selected Vet Centers)	Administrative quality review remediation plans and deficiency resolution.	4. The District Director determines reasons administrative quality review remediation plans did not include documentation of deficiency resolution and the time frame of resolution for the Dundalk, Raleigh, and Richmond Vet Centers; takes indicated actions to ensure completion; and monitors compliance. 5. The District Director determines reasons for lack of evidence for administrative quality review deficiency resolution for the Dundalk, Raleigh, and Richmond Vet Centers; takes indicated actions to ensure completion; and monitors compliance.
Suicide Prevention (Zone-Wide Electronic Record Review)	**Requirement**	**Recommendation**

Intake Assessment	Completion of psychosocial assessments within five visits	6. The District Director ensures the intake portion of the psychosocial assessment is completed and monitors compliance across all zone vet centers.
Suicide Risk Assessment	Completion of suicide risk assessments during the first clinical encounter	7. The District Director ensures suicide risk assessments are completed on the first clinical visit and monitors compliance across all zone vet centers.
High Risk Client Care Coordination	Flagged High Risk care coordination	8. The District Director ensures clinical staff consult and coordinate care with the support VA medical facility for shared clients flagged as high risk for suicide and monitors compliance across all zone vet centers.
Confidentiality Requirements	Confidentiality and coordination with VA medical facilities	9. The District Director verifies clinical staff follow confidentiality requirements when consulting and coordinating care with the support VA medical facility for shared clients at high risk for suicide and monitors compliance across all zone vet centers.
Safety Plan Completion	Safety plans	10. 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.
High Risk Client Consultation	Consultation following suicide risk level changes	11. The District Director ensures clinical staff consult with the vet center director, external clinical consultant, associate district director for counseling, or support VA medical facility mental health provider following a client's suicide risk assessment as required; and monitors compliance across all zone vet centers.
Suicide Prevention (Vet Center)	**Requirement**	**Recommendation**
Suicide Prevention and Intervention (Vet Center)	Mental Health Council participation with VA medical facilities	12. 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 Baltimore, Dundalk, Raleigh, and Richmond Vet Centers; and takes action as indicated to ensure compliance with Readjustment Counseling Services requirements.

	Monthly review and documentation in RCS High Risk Suicide Flag SharePoint Site	13. The District Director determines reasons for noncompliance with High Risk Suicide Flag SharePoint site requirements and the tracking of continuity of care for clients at risk at the Raleigh Vet Center and takes action to ensure requirements are met, and monitors compliance. 14. The District Director determines reasons the Raleigh and Richmond Vet Center Directors did not have accurate knowledge of type of clients on the High Risk Suicide Flag SharePoint site, takes actions to ensure vet center directors incorporate relevant information from the SharePoint site to safely disposition clients, and monitors compliance.
	Critical Event Plan	15. The District Director determines the reasons for noncompliance with staff access to critical event plans that included a desktop reference at the Baltimore and Dundalk Vet Centers and takes actions as indicated to ensure compliance with Readjustment Counseling Service requirements.
Consultation, Supervision and Training	**Requirement**	**Recommendation**
External Clinical Consultation	Documentation of four hours of external clinical consultation per month	16. The District Director determines reasons for noncompliance with a process for completing and tracking four hours of external clinical consultation per month at the Baltimore, Dundalk, and Raleigh Vet Centers; ensures vet center directors implement processes; and monitors compliance.
Supervision	Supervision with clinical staff members	17. The District Director determines reasons for noncompliance with staff supervision provided by vet center directors at the Baltimore and Dundalk Vet Centers, ensures staff supervision occurs as required, and monitors compliance.
Monthly Audit	Monthly 10 percent active client record audit for each full-time counselor	18. The District Director verifies and determines reasons for noncompliance with monthly chart audits at the Baltimore, Dundalk, Raleigh, and Richmond Vet Centers; ensures chart audits are completed as required; and monitors compliance.
Training	Completion of all mandatory trainings	19. The District Director determines reasons employees at the Baltimore, Dundalk, Raleigh, and Richmond Vet Centers did not complete required trainings; ensures all staff complete mandatory trainings; and monitors compliance.

Environment of Care	Requirement	Recommendation
Physical Environment	Exterior	20. The District Director evaluates and determines reasons for noncompliance with a presentable exterior at the Richmond Vet Center and ensures all exterior grounds are in good repair.
General Safety	All exit signage Architectural Barriers Act Accessibility Standards compliant	21. The District Director evaluates and determines reasons for noncompliance with tactile (braille) signage at the Baltimore, Dundalk, and Raleigh Vet Centers and ensures all exit doors are compliant with Architectural Barriers Act Accessibility Standards.
	Updated Emergency and Crisis Plans	22. The District Director reviews reasons for noncompliance with maintaining a current and comprehensive emergency and crisis plan at the Raleigh and Richmond Vet Centers and ensures all emergency and crisis plans are updated and comprehensive as required.

Appendix B: District 1 Zone 4 Profile

Table B.1. Zone 4 Profile
(October 1, 2020,–September 30, 2021)

Profile Element	District 1 Zone 4	
Total Budget Dollars		$17,469,424.20
Unique Clients*		7961
New Clients		2012
Veteran Clients		5472
Active Duty Clients		278
Spouse/Family Clients		2489
Bereavement Clients		570
Position	**Authorized**	**Filled**
Total Full-time	148	133
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	20	16
Clinical Staff	84	77
Vet Center Outreach Program Specialist‡	20	18
Vet Center Office Staff	20	18
Contract Providers	0	0

Source: VA OIG analysis of information from District 1 Zone 4.
**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 Specialist conduct outreach in order to engage, 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 4 operated on a total budget of $17,469,424.20, and served 7961 unique clients, 2012 new clients, 5472 veteran clients, 278 active duty clients, 2489 spouses and family members, and 570 bereavement clients. There was a total of 148 authorized full-time positions, with 133 of those positions filled throughout the zone.

Appendix C: Vet Center Profiles

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

Table C.1. FY21 Vet Center Profiles

Profile	Baltimore Vet Center	Dundalk Vet Center	Raleigh Vet Center	Richmond Vet Center
Total Budget Dollars*	$909,136.89	$761,790.89	$882,697.61	$716,342.97
Unique Clients**	545	243	434	274
Veteran Clients	521	225	381	244
Bereavement Clients	27	13	16	11
Active Duty Clients	9	5	25	13
Spouse/Family Clients	92	77	160	119
New Clients	158	61	143	85
Total Number of Positions	**Baltimore Vet Center**	**Dundalk Vet Center**	**Raleigh Vet Center**	**Richmond Vet Center**
Total Authorized Full-time Positions	8	6	7	7
Total Filled Positions	5	6	6	7
Total Vacancies	3	0	1	0
Total Part-time Positions	0	0	0	0

Source: VA OIG analysis of information provided by district 1 zone 4.
**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 4 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 4.* 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–North Atlantic District 1 Zone 4 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 4.
2. I have reviewed the draft report and request closure of recommendation three since the remediation plan has been completed and approved by the DDD and Readjustment Counseling Service (RCS) has implemented a process to have Administrative Site Visit reports entered in RCSNET. There is a tracking process in RCSNET to ensure all remediations are completed in a timely manner.

   I have reviewed the draft report and request closure of recommendation four since documentation of progress on deficiency resolution is included in the remediation plans of the administrative site visit report.

   I am also requesting closure of recommendation 15 since District 1 created a critical event plan and desktop reference that all District 1 Vet Centers are utilizing.
3. I concur with the other recommendations and comments and action plans are provided in the attachment.
4. 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

OIG Contact and Staff Acknowledgments

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