



US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Inspection of Select Vet Centers in Southeast District 2 Zone 2

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Abbreviations

AED	automated external defibrillator
BLS	basic life support
HRSF	High Risk Suicide Flag
MVC	mobile vet center
OIG	Office of Inspector General
RCS	Readjustment Counseling Service
VCD	Vet Center Director
VCIP	Vet Center Inspection Program
VHA	Veterans Health Administration



Report Overview

The VA Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) provides a focused evaluation of the quality of care delivered at vet centers. Vet centers are community-based clinics that provide a wide range of psychosocial services to clients, including eligible veterans, active-duty service members, National Guard members, reservists, and their families, to support a successful transition from military to civilian life. This inspection report focuses on six randomly selected vet centers throughout Southeast district 2 zone 2: Ft. Lauderdale, Ft. Myers, Gainesville, Lakeland, and Naples in Florida; and San Juan in Puerto Rico.¹

VCIP inspections are one element of the OIG's oversight that evaluates key clinical and administrative processes associated with promoting quality care and service delivery at vet centers.²

This VCIP inspection focused on four review areas:

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

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

¹ VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021, was in effect during part of the OIG's inspection period. It was amended and replaced by VHA Directive 1500(2), *Readjustment Counseling Service*, January 26, 2021, amended December 30, 2021, replaced by VHA Directive 1500(3), *Readjustment Counseling Service*, January 26, 2021, amended June 5, 2023, and most recently replaced by VHA Directive 1500(4), *Readjustment Counseling Service*, amended November 21, 2023. Unless otherwise specified, the requirements in the December 2021 directive contain the same or similar language as the amended November 2023 document. Readjustment Counseling Service is divided into five districts. Each district consists of two to four zones. Each zone consists of 18 to 25 vet centers per zone.

² 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 service and 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 Readjustment Counseling Service policy and terminology, the OIG refers to veterans receiving such services as clients in this report.

Review Topics and Inspection Results

Suicide Prevention

The OIG found all six vet center directors (VCDs) were noncompliant with the requirement to have a licensed representative for the vet center attend the support VA medical facility's mental health executive council meetings.³ One VCD was noncompliant with the requirement to enter an outcome for one client on the High Risk Suicide Flag SharePoint site.⁴

The OIG issued two recommendations to select vet center leaders specific to suicide prevention activities.

Consultation, Supervision, and Training

The OIG found one vet center did not have an assigned clinical liaison from the support medical facility, nor an external clinical consultant who was independently licensed in mental health. Five vet centers were noncompliant with the requirement for an external clinical consultant to provide at least four hours of consultation per month for clinically complex cases.⁵ Three VCDs were noncompliant with auditing 10 percent of each counselor's electronic client records. Overall, staff at five vet centers were noncompliant with completing training requirements.

The OIG issued five recommendations to select vet center leaders specific to consultation, supervision, and training.

Outreach

The OIG found neither outreach staff nor the VCD developed outreach plans at two vet centers.⁶ Of the four vet centers with a completed outreach plan, all were missing one or more strategic

³ VHA Directive 1500(2). Readjustment Counseling Service requires a licensed vet center staff member to attend all support VA medical facility mental health executive council meetings to assist with care coordination and collaboration for clients. Each vet center aligns with a support VA medical facility to ensure access to clinical services and coordination of care for shared clients; VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015, replaced by VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023. Unless otherwise specified, the requirements in the September 11, 2008, handbook contain the same or similar language as the amended April 2023 directive. VA medical facilities are required to establish a mental health executive council that supports strategies, communication, and policies to improve mental health care.

⁴ The Readjustment Counseling Service High Risk Suicide Flag SharePoint site lists names of Readjustment Counseling Service clients identified by VA medical facilities as high risk. VCDs review the SharePoint site monthly to identify clients who currently receive or have received vet center services in the past 12 months to determine if client contact is needed, and if appropriate, complete follow-up.

⁵ The vet center that did not have an external clinical consultant was not assessed for this requirement.

⁶ VHA Directive 1500(2). In addition to readjustment counseling, vet centers offer community-based interactions through outreach services to help eligible individuals overcome barriers to accessing resources. Readjustment Counseling Service requires each vet center to have an annual written outreach plan.

components required in the outreach plan, and three of the four completed plans did not have tailored outreach activities specific to the cultural orientations that were identified in each plan.⁷

The OIG issued three recommendations to select vet center leaders specific to outreach.

Environment of Care

The OIG found one of the six vet centers noncompliant with completion of an annual fire and/or safety inspection, and a risk and vulnerability assessment completed by VA police or local law enforcement. Two vet centers were noncompliant with automated external defibrillator servicing requirements. Two vet centers were noncompliant with monthly fire extinguisher inspections and one vet center was noncompliant with monthly automated external defibrillator inspections. Four vet centers lacked an emergency or crisis plan that was current and one vet center was noncompliant with having an evacuation plan posted in a communal area.

The OIG made seven recommendations to select vet center leaders on the environment of care.

Conclusion

The OIG conducted a detailed inspection across four review areas and issued a total of 17 recommendations for improvement to the District Director and zone leaders in conjunction with select VCDs. Recommendations related to mental health executive council meetings, external clinical consultation hours, auditing of electronic client records, High Risk Suicide Flag SharePoint site requirements, and required training completion, are repeat findings from a prior OIG report.⁸ The number of recommendations should not be used as a gauge for the overall quality of care provided within the zone. The intent is for leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues, as well as other less critical findings that, if left unattended, may interfere with the delivery of quality care.

⁷ Cultural orientation includes “ethnic, gender, occupational and generational” details. VHA Directive 1500(2).

⁸ VA OIG, [Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers](#), Report No. 20-02014-270, September 30, 2021.

Comments

The Readjustment Counseling Service Chief Readjustment Counseling Officer and District Director concurred with the recommendations and provided an acceptable action plan (see appendixes B and C). Based on information provided, the OIG considers recommendations 1, 3-5, and 13-17 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.



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

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Purpose

The purpose of the VA Office of Inspector General (OIG) Vet Center Inspection Program (VCIP) is to conduct routine oversight of vet centers that provide readjustment services to clients.¹ The OIG reports findings to Congress and Readjustment Counseling Service (RCS) leaders so informed decisions can be made to improve care.

Background

RCS is an autonomous organizational element in the Veterans Health Administration (VHA) with authority and oversight of vet centers and all related provisions of readjustment counseling services. Vet centers are community-based facilities that provide a wide range of psychosocial services to clients to support a successful transition from military to civilian life. RCS was one of the first organizations to address the psychological and social effects combat has on veterans before the American Psychiatric Association recognized posttraumatic stress disorder as an official diagnosis in 1980.²

While vet centers initially focused on serving Vietnam-era veterans, over the years, eligibility for vet center services has continued to expand to include veterans of any combat theater, active-duty service members, National Guard members, and their families.³ In 2022, eligibility expanded to allow reserve members of the Armed Forces with a behavioral health condition or psychological trauma to receive services from vet centers.⁴ In fiscal year 2022, RCS provided

¹ VHA Directive 1500(1), *Readjustment Counseling Service*, January 26, 2021, amended May 3, 2021, was in effect during part of the OIG’s inspection period. It was amended and replaced by VHA Directive 1500(2), *Readjustment Counseling Service*, January 26, 2021, amended December 30, 2021, replaced by VHA Directive 1500(3), *Readjustment Counseling Service*, January 26, 2021, amended June 5, 2023, and most recently replaced by VHA Directive 1500(4), *Readjustment Counseling Service*, amended November 21, 2023. Unless otherwise specified, the requirements in the December 2021 directive contain the same or similar language as the amended November 2023 document. Vet centers provide “counseling interventions for psychological and psychosocial readjustment problems related to specific types of military service and 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 RCS policy and terminology, the OIG refers to veterans receiving readjustment 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, *Readjustment Counseling Service (RCS) Vet Center Program*, September 8, 2010.

³ VHA Directive 1500(2); “Who We Are,” Vet Centers (Readjustment Counseling), accessed June 4, 2019, https://www.vetcenter.va.gov/About_US.asp.

⁴ VHA Directive 1500(2); William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021, Pub. L. No. 116-283, 134 Stat. 3724 (2021) § 761.

counseling services to 286,907 clients, “totaling nearly 1.34 million visits and outreach contacts.”⁵

Vet center 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 mental health conditions.⁶ 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.⁷

Vet center services are recorded in RCSNet, a system of records that is only viewable by RCS staff.⁸ RCSNet’s independence from VA medical facilities and Department of Defense’s electronic health record systems allows vet centers to maintain secure and confidential records that are not disclosed to VA medical facilities, VA clinics, or the Department of Defense without a veteran’s signed release of information.⁹

RCS Organizational Structure

RCS is aligned under the VA Under Secretary for Health and has governance of 300 vet centers, 83 mobile vet centers (MVCs), 20 outstations, and the Vet Center Call Center.¹⁰ The RCS Chief Officer reports directly to the VA Under Secretary for Health and is responsible for strategic planning, coordinating readjustment counseling services with VA services, serving as a policy expert for readjustment counseling, being the direct line authority for all RCS staff, coordinating with human resources on recruitment and selection of staff, and supervising six RCS national officers. The RCS Operations Officer, who reports to the RCS Chief Officer, is responsible for daily operations and supervision of five district directors who oversee the districts.¹¹ RCS has five districts, each with two to four zones. Each zone has a range of 18 to

⁵ "Vet Centers (Readjustment Counseling)," VA, accessed February 7, 2023, <https://www.vetcenter.va.gov/index.asp>. A fiscal year is a 12-month period that the federal government uses for accounting purposes running from October 1 through September 30.

⁶ VHA Directive 1500(2).

⁷ VHA Directive 1500(2).

⁸ VHA Directive 1500(2).

⁹ VHA Directive 1500(2); 38 C.F.R. § 17.2000–816 (e).

¹⁰ VHA Directive 1500(2). Vet center outstations promote additional points of access for clients and are under the supervision of the nearest VCD. Outstations are distant from established vet centers, and while not having the same staffing requirements, outstations have at least one full-time counselor. The Vet Center Call Center, reached at 1-877-WAR-VETS or 1-877-927-8387, is a 24-hour per day, 7-day per week, confidential call center for eligible individuals and their families to receive support regarding their military experience or any other readjustment issue.

¹¹ VHA Directive 1500(2).

25 vet centers. Each vet center has a vet center director (VCD) who is responsible for all vet center operations.¹²

Scope

The OIG inspection team examined vet center operations from October 1, 2021, through September 30, 2022.¹³ The inspection team evaluated the quality of care delivered at vet centers and examined a broad range of key clinical and administrative processes for compliance with RCS policy. Specifically, this OIG inspection focused on four review areas that influence the quality of client care and service delivery at six randomly selected vet centers:

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

District, Zone, and Vet Center Selection

For this inspection, the OIG randomly selected district 2 for review. Within district 2, the OIG randomly selected six vet centers in zone 2: Ft. Lauderdale, Ft. Myers, Gainesville, Lakeland, and Naples in Florida; and San Juan, Puerto Rico.¹⁴ Zone 2 is noted in figure 1 below. See [appendix A](#) for the data profiles on the six selected vet centers.¹⁵

¹² VHA Directive 1500(2).

¹³ The review period was from October 1, 2021, through September 30, 2022, unless otherwise noted.

¹⁴ The OIG completed a separate inspection and report with findings and recommendations for District 2 Zone 1. VA OIG, *Inspection of Select Vet Centers in Southeast District 2 Zone 1*, Report No. 22-03939-142, April 18, 2024.

¹⁵ The underlined terms are hyperlinks to another section of the report. To return to the point of origin, press the “alt” and “left arrow” keys.

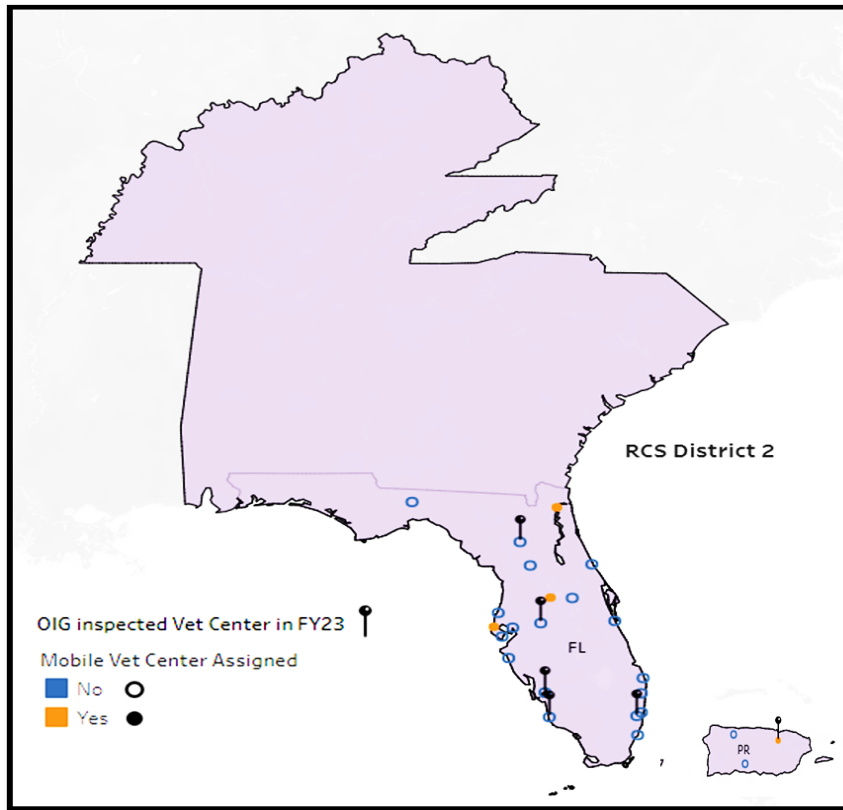


Figure 1. Map of Southeast district 2 zone 2 vet centers, including sites visited and vet centers with MVCs.

Source: Developed by VA OIG using RCS vet center data.

The OIG announced the inspection to district leaders on November 28, 2022, and conducted on-site and virtual visits from November 29, 2022, through December 15, 2022, providing one-day advanced notification to each vet center inspected.¹⁶ The OIG interviewed VCDs and key staff at the selected vet centers, reviewed RCS practices and policies, and validated client record findings. Additionally, the OIG identified potential discrepancies and explored reasons for noncompliance, when indicated.

Prior OIG Reports

In the VCIP report published on September 30, 2021, the OIG made 22 recommendations to district leaders for quality reviews; suicide prevention; consultation, supervision, and training; and environment of care. All recommendations were closed on February 2, 2023. However, during this inspection, the OIG found sustained deficiencies related to mental health executive council meetings, High Risk Suicide Flag (HRSF) SharePoint site, external clinical

¹⁶ For the purposes of this report, district leaders refer to a combination of two or more of the following: District Director, Deputy District Director, Associate District Director for Counseling, and Associate District Director for Administration.

consultation hours, auditing of electronic client records, and required training completion requirements. A district leader reported the repeat findings from the previously published reports were due to RCS and VA medical facility staff turnover, staff scheduled and unplanned leave, emergency management operations, and RCSNet errors, resulting in the issuance of repeat recommendations in this report.¹⁷

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 leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted this 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.

In the absence of current VA, VHA, or RCS 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).

Review Topics and Summary of Results

The following section is an overview of requirements and methodology for each review topic, including a summary table of results. For specific vet center results see [Vet Center Results](#) and for all results and recommendations see [Overall Results and Recommendations](#).

Suicide Prevention

The American Foundation for Suicide Prevention reports that suicide has no single cause, but “most often occurs when stressors and health issues converge to create an experience of hopelessness and despair.”¹⁸ The VA National Veteran Suicide Prevention Annual Report, published in the fall of 2022, concludes that after “adjusting for population age and sex differences, the suicide rate for Veterans was 57.3% greater than for non-Veteran U.S. adults” in 2020.¹⁹ 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

¹⁷ VA OIG, [Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers](#), Report No. 20-02014-270, September 30, 2021.

¹⁸ The American Foundation for Suicide Prevention is a voluntary health organization that supports suicide research and education. “Risk factors, protective factors, and warning signs,” American Foundation for Suicide Prevention, accessed August 23, 2023, <https://afsp.org/risk-factors-protective-factors-and-warning-signs>.

¹⁹ VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

in crisis intervention.” VA 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.²⁰

Approaches for reducing suicide among military service members, veterans, and their family members should be rooted in a strong public health framework that addresses the full range of risk and protective factors through evidence-based, interdisciplinary approaches, and balances the role of policy, program execution, engagement, and evaluation.²¹

The OIG evaluated vet center staff’s compliance with the following requirements (see figure 2).

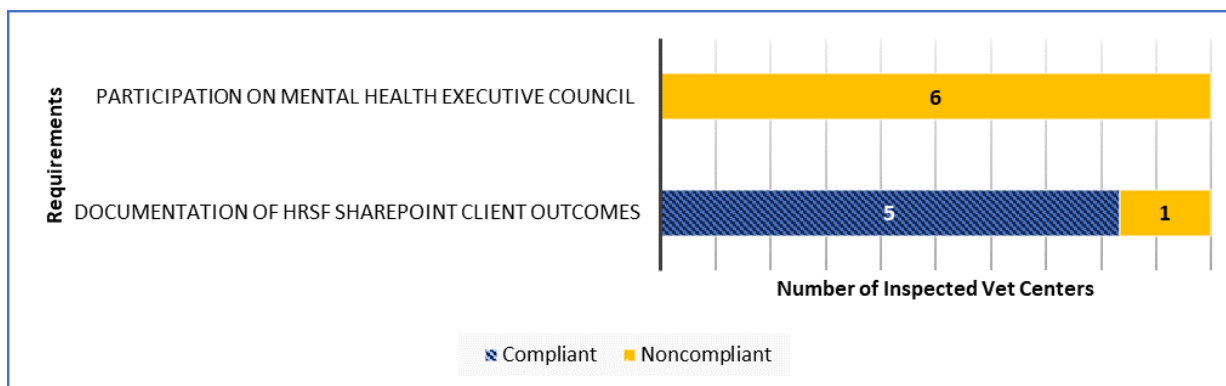


Figure 2. Suicide prevention review summary results across all vet centers inspected.

Source: OIG analysis of VCIP results.

Mental Health Executive Council Participation

RCS requires a licensed vet center staff member to be assigned to actively participate on all support VA medical facility mental health executive council meetings to assist with care coordination and collaboration for clients.²² Each vet center aligns with a support VA medical facility to ensure access to clinical services and coordination of care for shared clients.²³ VA medical facilities are required to establish a mental health executive council that supports strategies, communication, and policies to improve mental health care.²⁴

²⁰ VA Office of Mental Health and Suicide Prevention, *National Strategy for Preventing Veteran Suicide 2018 2028*, pp. 2, 4.

²¹ White House, *Reducing Military and Veteran Suicide: Advancing a Comprehensive, Cross-Sector, Evidence-Informed Public Health Strategy*, 2021, p. 5.

²² VHA Directive 1500(2).

²³ VHA Directive 1500(2).

²⁴ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

The OIG requested evidence of licensed vet center staff participation in VA medical mental health executive council meetings. The OIG reviewed attendance documentation to evaluate if required vet center staff attended mental health executive council meetings at an overall compliance rate of 90 percent for meetings held from October 1, 2021, through September 30, 2022.

High Risk Suicide Flag SharePoint Site

On May 11, 2020, RCS implemented an HRSF SharePoint site with names of RCS clients identified by VA medical facilities as high risk for suicide.²⁵ According to RCS leaders, the HRSF SharePoint site was later expanded to include clients with an increased predictive risk for suicide.²⁶ VCDs review the HRSF SharePoint site monthly to identify clients who currently receive or have received vet center services in the past 12 months. Vet center staff determine if client contact is needed, and if appropriate, complete follow-up. The VCD ensures documentation of actions taken is completed in RCSNet and the HRSF SharePoint site within five business days of receiving the HRSF SharePoint site list. Contacting high-risk clients is an opportunity to provide unique resources while increasing communication and coordination with VA, all of which may reduce client risk for suicide.

To evaluate compliance, the OIG performed a chart review of RCSNet documentation at the six selected vet centers to assess which clients still needed documentation in the HRSF SharePoint site on actions taken from October 1, 2021, through September 30, 2022.

Consultation, Supervision, and Training

Collaborative relationships between vet centers and VA medical facilities exist to improve veteran access to supportive health care for needs that go beyond the services that vet centers provide. Vet centers are assigned VA medical facility consultants, including a clinical liaison and external clinical consultant. Clinical liaisons assist in coordinating care, making referrals for shared VA medical facility clients, and coordinating suicide prevention activities. External clinical consultants provide consultation for clinically complex cases.²⁷

²⁵ VA Chief Officer, Readjustment Counseling Service (10RCS), “High Risk Suicide Flag Outreach,” memorandum to all vet center staff, April 27, 2020; SharePoint is “a secure place to store, organize, share, and access information from any device.” “What is SharePoint?” Microsoft, accessed July 15, 2021, <https://support.microsoft.com/en-us/office/what-is-sharepoint-97b915e6-651b-43b2-827d-fb25777f446f>.

²⁶ VA’s Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) program identifies veterans who have a higher risk for suicide through predictive analytics. Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 1, 2020.

²⁷ VHA Directive 1500(2).

VCDs are responsible for all vet center operations, including the supervision of vet center staff.²⁸ One supervisory task performed by VCDs is monthly counseling record reviews to ensure thoroughness, accuracy, and compliance with RCS guidance and procedures.²⁹

“VHA required training is determined by the Under Secretary for Health to achieve the mission, goals and objectives of VHA.”³⁰ Required trainings are developed to ensure the information shared is targeted to the appropriate audience, limited in the time spent to reach the training goal, and evaluated annually to determine whether to keep the training as a requirement.

The OIG evaluated compliance with the following requirements (see figure 3).

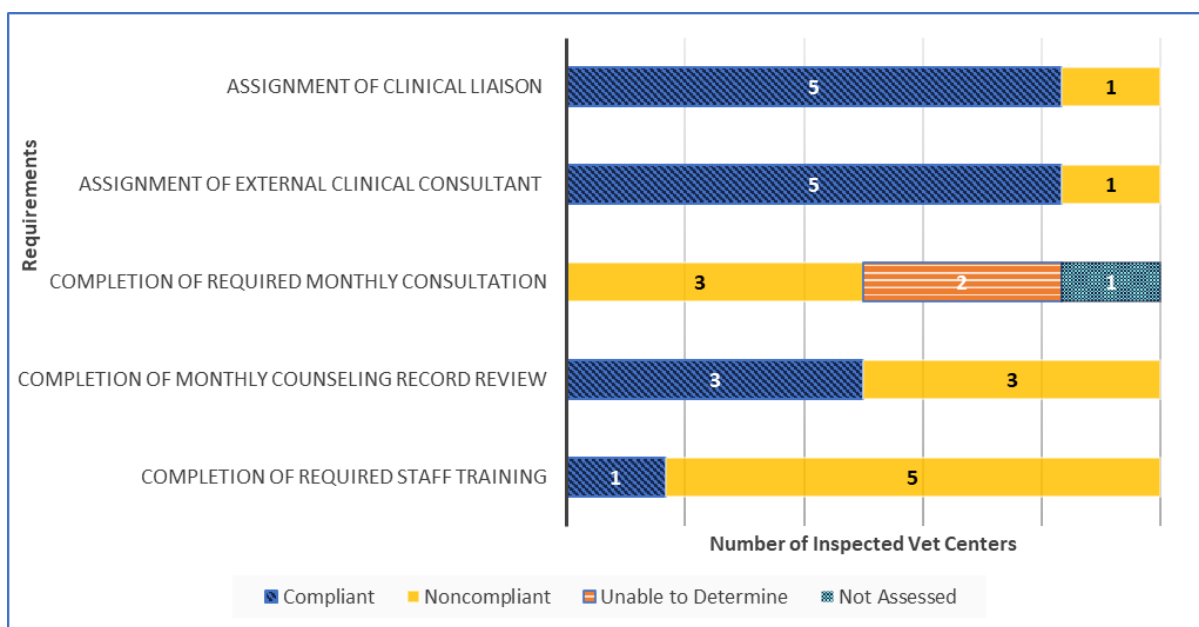


Figure 3. Consultation, supervision, and training review summary results across all vet centers inspected. Source: OIG analysis of VCIP results.

Consultation

The assigned clinical liaison must be a VA mental health professional, and the assigned external clinical consultant must be an independently licensed VA mental health professional who has completed the VA credentialing process.³¹ The external clinical consultant is required

²⁸ VHA Directive 1500(2).

²⁹ VHA Directive 1500(2).

³⁰ VHA Directive 1052, *Appropriate and Effective Use of VHA Employee Mandatory and Required Training*, June 29, 2018.

³¹ VHA Directive 1500(2); VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. “Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care provider to provide care or services in or for the VA health care system.”

to provide vet center counseling staff with four hours of monthly consultation for clinically complex cases.³²

To evaluate compliance with RCS requirements for consultation, the OIG interviewed VCDs and conducted a document review to assess whether each vet center had an assigned clinical liaison and an external clinical consultant. To determine compliance with the requirement of four hours of monthly consultation from the external consultant, the OIG reviewed external clinical consultation hours documentation from October 1, 2021, through September 30, 2022, for a compliance rate of 90 percent or greater.

Supervision

VCDs must ensure that a review of 10 percent of active counseling records monthly for each full-time counselor.³³

The OIG reviewed the VCDs' documentation of monthly counseling record reviews from July 1 through September 30, 2022. Specifically, the OIG evaluated if the VCDs reviewed 10 percent of active counseling records monthly for each full-time counselor for a 90 percent compliance rate.

Training

Vet center staff are required to complete specific trainings to ensure appropriate skills for assigned duties.³⁴ The OIG reviewed training records to determine vet center staff compliance with the following required trainings:³⁵

- Initial or annual S.A.V.E. training for nonclinical staff³⁶
- Initial or annual Skills Training for Evaluation and Management of Suicide for clinical staff³⁷

³² VHA Directive 1500(2).

³³ VHA Directive 1500(2).

³⁴ VHA Directive 1500(2).

³⁵ Hire dates and departure dates were provided by VCDs to determine which trainings were required.

³⁶ VA Secretary, *Agency-Wide Required Suicide Prevention Training*, memorandum to Under Secretaries, Assistant Secretaries and Other Key Officials, October 15, 2020; VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training*, May 11, 2022. S.A.V.E. is the acronym for the Signs of Suicide, Ask about Suicide, Validate Feelings and Encourage seeking help and expedited treatment training. Vet center nonclinical staff includes veterans outreach program specialist and program support assistant/office manager.

³⁷ VA Secretary, *Agency-Wide Required Suicide Prevention Training*; VHA Directive 1071, May 11, 2022. Skills Training for Evaluation and Management of Suicide is required within 90 days of hire for new clinical providers and annually for current clinical providers. VHA considers clinical staff to include psychologists, social workers, case managers, and vet center counselors.

- One-time lethal means safety education and counseling for clinical staff³⁸
- One-time military sexual trauma training for clinical staff³⁹
- Bi-annual basic life support (BLS) certification for all staff⁴⁰

Outreach

In addition to readjustment counseling, vet centers offer community-based interactions through outreach services to help eligible individuals overcome barriers to accessing resources. Vet centers “conduct face-to-face outreach to contact, inform, engage, and bring local eligible individuals into the Vet Center for needed services.” Collaborative referral networks with VA medical facilities and community partners help vet centers ensure clients receive services and coordinated care.⁴¹

“Culture competence is defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients.”⁴² The outreach plan reflects the unique sociocultural, geographic, and demographic variables of each veteran service area.⁴³ Tailored community outreach can help improve outcomes, quality of care, and contribute to elimination of health disparities related to race and ethnicity.⁴⁴ RCS emphasizes culturally competent outreach through “contact with local eligible individual’s representative of all gender and ethnic cultural affiliations, class and occupational statuses, generational levels, and specific combat theater experiences.”⁴⁵

³⁸ VHA memorandum, *Lethal Means Safety (LMS) Education and Counseling (VIEWS 7118915)*, March 17, 2022. Requirements for Lethal Means Safety (LMS) Education and Counseling training became effective on March 17, 2022. Lethal Means Safety (LMS) Education and Counseling training completion is required within 90 days of entering the position for new clinical providers or within 90 days of training assignment for current clinical providers.

³⁹ VHA Directive 1115.01 (1), *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017, amended May 8, 2020. Requirements for military sexual trauma training became effective on April 14, 2017. Military sexual trauma training completion is required within 90 days of entering the position for new clinical providers or within 90 days after training assignment for current clinical providers.

⁴⁰ The OIG reviewed vet center staffing spreadsheet, training records, or copy of BLS card. The OIG was informed by an RCS leader that all vet center staff are required to complete BLS on a bi-annual basis.

⁴¹ VHA Directive 1500(2).

⁴² “Cultural competence in Health Care: Is it important for people with chronic conditions?” Georgetown University, McCourt School of Public Policy, Health Policy Institute, accessed January 18, 2023, <https://hpi.georgetown.edu/cultural/>.

⁴³ VHA Directive 1500(2). Sociocultural variables are defined as “gender, ethnic, socioeconomic, and cultural orientations.”

⁴⁴ “Cultural competence in Health Care: Is it important for people with chronic conditions?” Georgetown University, McCourt School of Public Policy, Health Policy Institute.

⁴⁵ VHA Directive 1500(2).

The OIG evaluated vet center staff’s compliance with the following requirements (see figure 4).

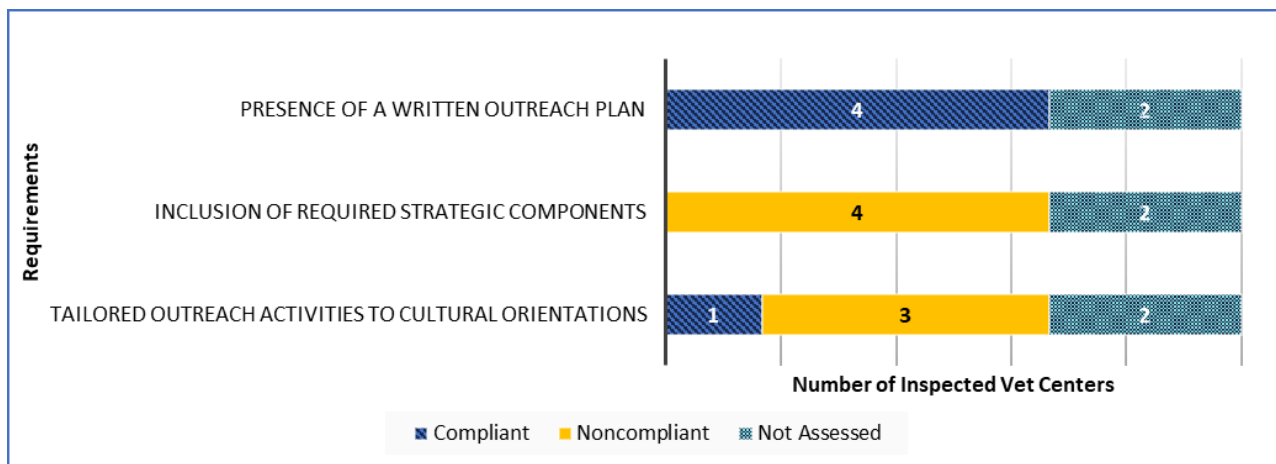


Figure 4. Outreach review summary results across all vet centers inspected.
 Source: OIG analysis of VCIP results.

Outreach Plan

RCS requires each vet center to have a written outreach plan, updated annually, that is developed by outreach staff under the supervision of the VCD.⁴⁶ The OIG requested the written outreach plan from each selected vet center and considered the vet center compliant if the written plans was active any time from October 1, 2021, through September 30, 2022.

Strategic Components of Outreach Plan

RCS policy requires each outreach plan to include the following strategic components to target outreach services:⁴⁷

- Presence of a strategic map of the vet center veteran service area identifying local eligible population concentrations⁴⁸
- Inclusion of background information regarding cultural orientations of the local eligible communities⁴⁹

⁴⁶ VHA Directive 1500(2).

⁴⁷ VHA Directive 1500(2).

⁴⁸ Strategic mapping can be in either narrative or visual format but must identify at least one eligible veteran population.

⁴⁹ VHA Directive 1500(2). Cultural orientation includes “ethnic, gender, occupational and generational” orientation.

- Identification of personal points of contact for non-VA medical facility community service providers⁵⁰
- Identification of strategic VA medical facility partners including clinical and administrative liaisons, the external clinical consultant, the suicide prevention coordinator, and the facility contact for prevention and management of disruptive behavior⁵¹
- Inclusion of strategic coordination with MVC operations⁵²

The OIG reviewed outreach plans that were active from October 1, 2021, through September 30, 2022, to determine if the plan contained the required strategic components. The OIG considered outreach plans with all required components to be compliant.

Tailored Outreach Activities

RCS requires that each outreach plan have activities tailored to the cultural background information identified in the plan.⁵³ The OIG reviewed submitted outreach activities and interviewed VCDs to determine if outreach activities targeted specific cultural identities listed in the outreach plan. The vet center outreach plan was considered compliant if the plan demonstrated at least one activity tailored to cultural orientation.

Environment of Care

Environment of care refers to the physical environment, equipment and systems, and individuals who occupy a space. The environment should “support all Veterans’ dignity, privacy, safety, and security.”⁵⁴

The OIG evaluated compliance with the following requirements (see figure 5).

⁵⁰ Personal points of contact were considered a specific person or role at an identified non-VA community agency.

⁵¹ VHA Directive 1500(2). The OIG reviewed the plan for the presence of all five required VA medical facility strategic partners and associated contact information.

⁵² VHA Directive 1500(2).

⁵³ VHA Directive 1500(2).

⁵⁴ VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. VCDs are responsible for ensuring all environment of care requirements are met per RCS, “RCS Administrative Site Visit (ASV) Protocol,” provided to the OIG on October 7, 2021.

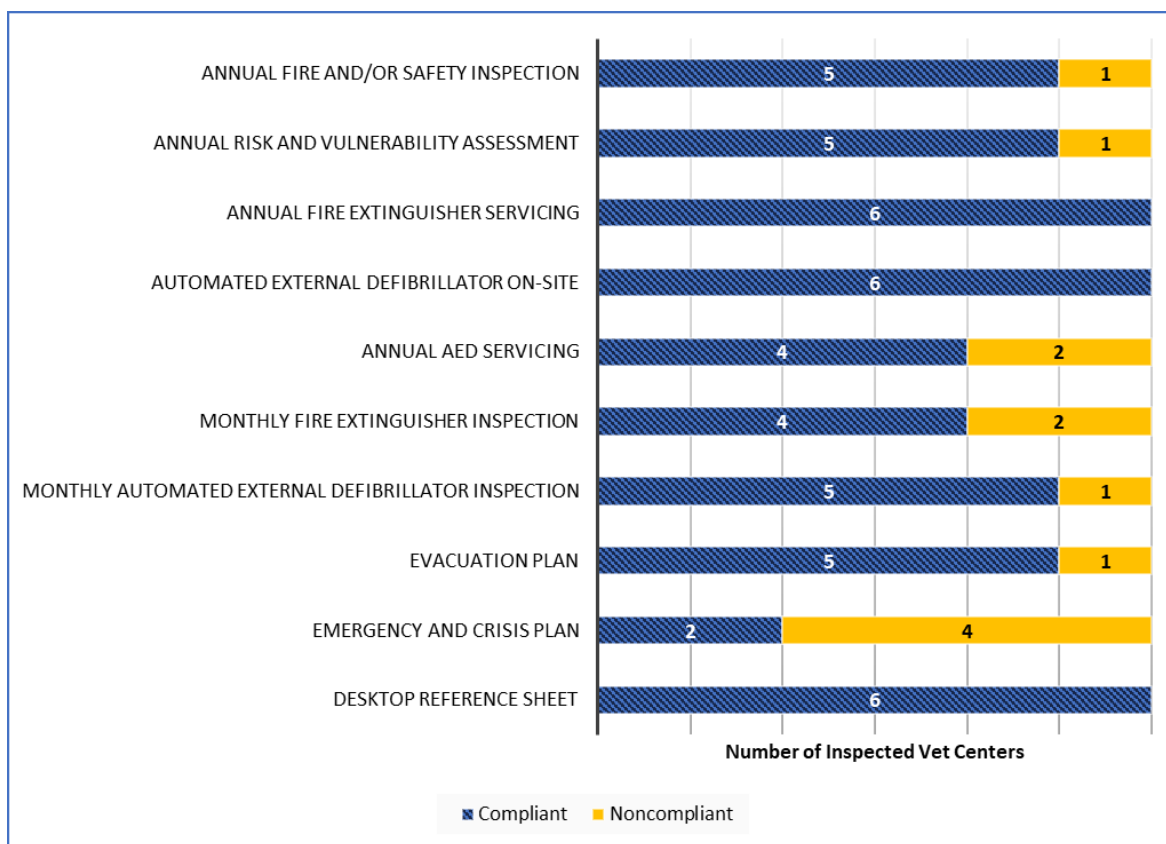


Figure 5. Environment of care review summary results across all vet centers inspected.

Source: OIG analysis of VCIP results.

Physical Environment

Vet centers are required to have a fire and/or safety inspection and a risk and vulnerability assessment annually. The risk and vulnerability assessment must be completed by VA police or local law enforcement. Vet centers must also have fire extinguishers and an automated external defibrillator (AED) available for staff, both requiring annual servicing and monthly inspections to ensure proper functioning.⁵⁵ RCS requires vet centers to display an evacuation plan in a common area of the vet center for occupants to reference in the event of an emergency.⁵⁶

The OIG evaluated the physical environment of each selected vet center through interviews, document reviews, and on-site inspections. During the on-site inspection, the OIG located and reviewed documentation on the fire extinguishers, AEDs, and evacuation plans for

⁵⁵ The device can analyze the heart’s rhythm and then deliver an electrical shock, if necessary, to attempt to re-establish an effective rhythm. “What is AED?” American Red Cross, accessed August 8, 2022, <https://www.redcross.org/take-a-class/aed/using-an-aed/what-is-aed>.

⁵⁶ “RCS, Administrative Site Visit (ASV) Protocol.”

compliance.⁵⁷ Documentation reviews included evaluation of annual fire and/or safety inspections and annual risk and vulnerability assessments.⁵⁸

General Safety

RCS requires a “community coordinated critical event plan, including a desktop reference sheet” outlining staff response to a suicidal or homicidal client, in person or on the phone.⁵⁹ Vet centers must also have a current emergency and crisis plan that includes contingencies for

- phone and computer disruptions;
- weather and natural disasters;
- site, facility, and building emergencies;
- site, facility, and building temporary relocation;
- management of disruptive behavior;
- violence in the workplace, including an active shooter plan; and
- handling of suspicious mail and bomb threats.⁶⁰

The OIG evaluated the general safety of each selected vet center through interviews, document reviews, and on-site inspections. During the on-site inspection, the OIG reviewed desktop reference sheets for compliance. Documentation reviews included evaluation of current emergency and crisis plans.⁶¹

⁵⁷ “RCS, Administrative Site Visit (ASV) Protocol.” RCS requires fire extinguishers and AEDs to be serviced annually and inspected monthly; For the yearly review elements, the OIG accepted documents from January 1, 2021, through the date of inspection. For the monthly review elements, the OIG reviewed the prior three months from date of inspection.

⁵⁸ “RCS, Administrative Site Visit (ASV) Protocol.” RCS requires fire and/or safety inspections and risk and vulnerability assessments to be completed each calendar year. For these review elements, the OIG accepted documents from January 1, 2021, through the date of inspection.

⁵⁹ Vet Center Clinical Site Visit (CSV) Report: Procedural Background Information, accessed from internal RCS website on January 23, 2023.

⁶⁰ “RCS, Administrative Site Visit (ASV) Protocol.”

⁶¹ The OIG evaluated “current” as being reviewed or updated within two years of the date of inspection. “RCS, Administrative Site Visit (ASV) Protocol.”

Vet Center Results

The following section provides an overview of each vet center inspected, along with detailed results specific to each element reviewed. For an overview of all results see [Overall Results and Recommendations](#).

Ft. Lauderdale Vet Center

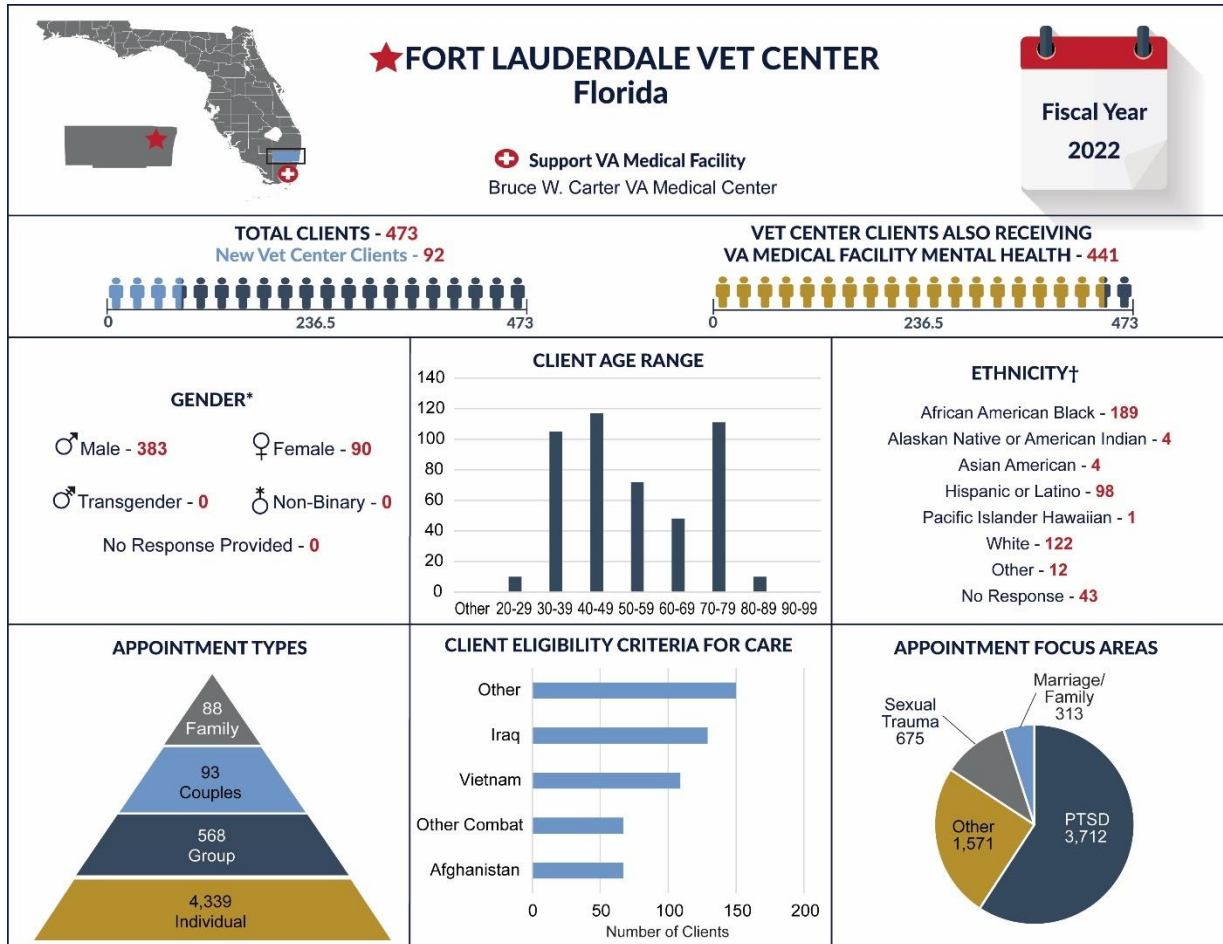


Figure 6. Client demographics across Ft. Lauderdale Vet Center during fiscal year 2022.

Source: OIG created graphic utilizing RCS demographic data. Figures may not be exact replications of approximate percentages.

*Gender is self-reported by RCS clients, according to an RCS leader.

†RCSNet functionality allows for the selection of one ethnicity category per client according to an RCS leader.

‡Age represents “age at date of last visit” according to an RCS leader.

The Ft. Lauderdale Vet Center serves clients throughout Broward County, Florida. The Bruce W. Carter VA Medical Center provides supportive services to the vet center. The vet center has various military installations in its service area, including Coast Guard bases, an Air Reserve

Base, and a National Guard Base, as well as several colleges and universities, including Florida Atlantic University, Nova University, Barry University, and Broward College.

The Ft. Lauderdale VCD reported coordinating with Jacksonville Vet Center staff to utilize the MVC. During the review period, the Ft. Lauderdale Vet Center used the MVC for at least two outreach events.⁶² The vet center conducted 150 events during the review period.

According to the VCD, the Ft. Lauderdale Vet Center has had an acting VCD since May 2022, and additional staff included three readjustment counselors, a veteran outreach program specialist, and an office manager.⁶³ One counselor position was vacant as of October 2022. The readjustment counseling staff were comprised of two licensed clinical social workers, a licensed clinical mental health counselor, and a licensed professional counselor.

Findings

Suicide Prevention

The OIG determined the VCD entered an outcome for all clients listed on the HRSF SharePoint site.

The OIG identified the following deficiency:

Mental health executive council participation: The VCD stated mental health executive council meetings occurred every two weeks and attendance rotated with designated VCD's from the Miami and West Palm Vet Centers. The VCD could not provide documentation of attendance as the support VA medical facility staff member who managed the meeting was no longer an employee, and no other staff had copies of the attendance records.

Consultation, Supervision, and Training

Consultation

The OIG determined support VA medical facility leaders assigned a clinical liaison and an external clinical consultant licensed in mental health to the vet center.

The OIG identified the following deficiency:

External clinical consultation hours: Counselors did not receive four hours of external clinical consultation for 4 of 12 months reviewed. For 1 month during the review period, external clinical consultation meetings were canceled as they were scheduled on holidays and were not rescheduled. The VCD was unable to provide documentation to support four hours for the other 3 months.

⁶² The review period was from October 1, 2021, through September 30, 2022, unless otherwise noted.

⁶³ For the remainder of this report, the acting Ft. Lauderdale VCD is referred to as the Ft. Lauderdale VCD. The VCD was also the director for the Melbourne Vet Center.

Supervision

The OIG identified the following deficiency:

Record review: Of the OIG-reviewed time frame, the VCD performed record reviews for all three months; however, the reviews fell below the required 10 percent of reviewed active counseling records for all months.

Training

The OIG determined that all required staff completed the S.A.V.E., Skills Training for Evaluation and Management of Suicide, and BLS trainings.

The OIG identified the following deficiencies:

- Three out of four staff completed lethal means safety education and counseling training for clinical staff.
- One out of four staff completed military sexual trauma training for clinical staff.

The VCD reported not being aware the lethal means safety training was mandatory.

Outreach

The OIG determined the vet center had an outreach plan for fiscal year 2022. The outreach plan contained information regarding the cultural orientations of the local eligible communities, such as documentation of rural service areas and Reserve and National Guard stations. The plan also documented strategic coordination with MVC operations. The outreach activities were tailored to the cultural background information identified in the outreach plan.

The OIG identified the following deficiency:

Outreach plan: The outreach plan did not include required strategic components, such as a map of the veteran service area, personal points of contact for non-VA service providers, or VA medical facility partners.

Environment of Care

The OIG determined that the fire and/or safety inspection, risk and vulnerability assessment, and servicing of on-site fire extinguishers and the AED were completed annually. Staff completed monthly AED checks. The vet center also had building evacuation plans posted in communal areas, and a critical event plan with a desktop reference sheet outlining basic steps staff would follow in the event of a mental health crisis.

The OIG identified the following deficiencies:

Fire extinguisher inspection: Of the three months the OIG reviewed, all three fire extinguishers were missing one of the monthly inspections. The VCD could not provide a reason for the missed inspections but reported staff were unclear on whether the vet center or VA medical

facility was responsible for monthly monitoring, which may have contributed to missed inspections.

Emergency and crisis plan: The OIG found a complete emergency and crisis plan with all required components documented; however, the plan was not current. The VCD was unable to provide details on the last update of the plan.

Ft. Myers Vet Center

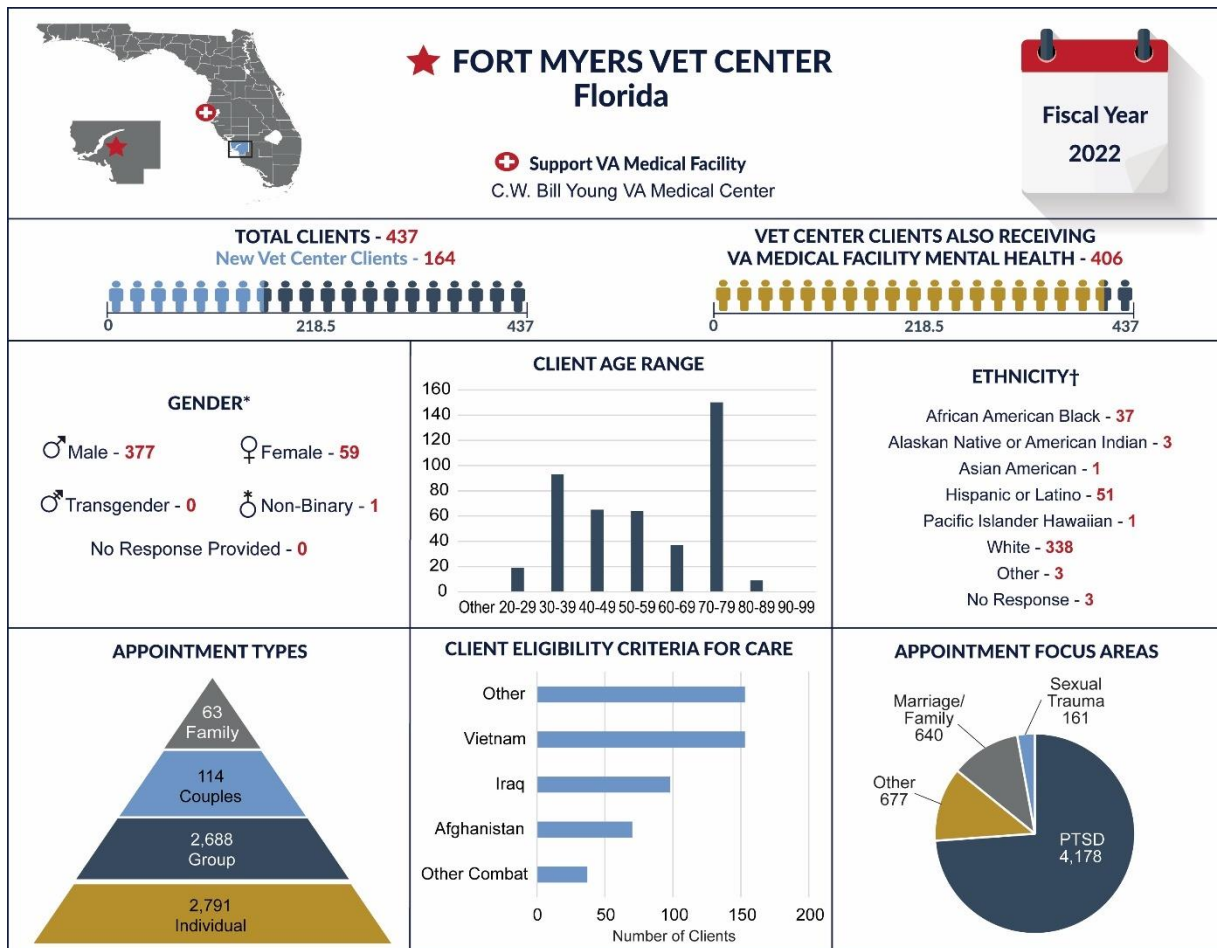


Figure 7. Client demographics across Ft. Myers Vet Center during fiscal year 2022.

Source: OIG created graphic utilizing RCS demographic data. Figures may not be exact replications of approximate percentages.

*Gender is self-reported by RCS clients according to an RCS leader.

†RCSNet functionality allows for the selection of one ethnicity category per client according to an RCS leader.

‡Age represents “age at date of last visit” according to an RCS leader.

The Ft. Myers Vet Center is in southwest Florida and serves clients in Lee, Charlotte, Hendry, and Glades counties.⁶⁴ C.W. Bill Young VA Medical Center, specifically the Lee County VA Clinic, provides supportive services to the vet center.⁶⁵ The Ft. Myers Vet Center veteran service area includes one National Guard unit based in Lee County and a US Coast Guard

⁶⁴ Southwest Florida Regional Planning Council, *Strategic Regional Policy Plan (Volume One)*, accessed February 27, 2023, <https://www.swfrpc.org>.

⁶⁵ VA, *VA Locations*, accessed February 27, 2023, <https://www.va.gov/bay-pines-health-care/locations>.

station in Ft. Myers Beach.⁶⁶ Florida South Western State College and Florida Gulf Coast University are two of the higher education systems within the veteran service area.⁶⁷

According to the VCD, the Fort Myers Vet Center was temporarily assigned an MVC from the Clermont Vet Center in December 2021 and, during the review period, used the MVC for six outreach events. The vet center conducted 306 outreach events during the review period.

The Fort Myers VCD reported being in the position since August 2018, and additional staff included four readjustment counselors, a veteran outreach program specialist, and an office manager. At the time of the inspection, two of the four counselor positions were vacant, one for two months, and the other was an additional full-time position recently obtained by the vet center. The readjustment counseling staff were comprised of licensed clinical social workers.

On September 28, 2022, Hurricane Ian, a category 4 storm, made landfall west of Ft. Myers, Florida.⁶⁸ According to the VCD, the vet center was closed for a week due to power outages. The VCD was able to work from home and with the help of staff, ensured attempts were made to contact all clients to check on their well-being and offer resources. The MVC was not used as a resource during the aftermath of Hurricane Ian and was driven to the other side of Florida prior to the storm for safe keeping. The VCD noted the MVC was not utilized because the roads were unsafe and there were limited staff to man it due to power outages.

Findings

Suicide Prevention

The OIG determined the VCD entered an outcome for all clients listed on the HRSF SharePoint site.

The OIG identified the following deficiency:

Mental health executive council participation: The VCD stated the mental health executive council meetings were held monthly and various VCDs rotate attendance; however, the VCD was unable to provide documentation of any VCD attendance for 11 of 12 months.

⁶⁶ “Florida Military Bases,” University of South Florida, accessed February 27, 2023, https://sss.usf.edu/resources/format/pdf/Military_Bases.pdf; US Department of Homeland Security, *United States Coast Guard Auxiliary*, accessed February 27, 2023, <https://www.aux91fmb.org/>.

⁶⁷ “Our Colleges,” Florida Department of Education, accessed February 27, 2023, <https://www.fldoe.org/schools/higher-ed/fl-college-system/about-us/colleges.stml>; “About FGCU,” Florida Gulf Coast University, accessed February 27, 2023, <https://www.fgcu.edu/about/>.

⁶⁸ The storm tied the record for the fifth-strongest storm to make landfall in the United States.

Consultation, Supervision, and Training

Consultation

The OIG determined support VA medical facility leaders assigned a clinical liaison and an external clinical consultant licensed in mental health to the vet center.

The OIG identified the following deficiency:

External clinical consultation hours: Counselors did not receive four hours of external clinical consultation for 8 of 12 months reviewed. The VCD provided a spreadsheet that lacked dates or duration of meetings and the consultant's name. The VCD stated that the missing information was an oversight and meetings scheduled on holidays were not rescheduled.

Supervision

The OIG determined the vet center was compliant in all elements of the supervision review.

Training

The OIG determined that vet center staff completed Skills Training for Evaluation and Management of Suicide, lethal means safety education and counseling, military sexual trauma, and BLS trainings as required.

The OIG identified the following deficiency:

- One of two completed S.A.V.E. training for nonclinical staff.

Outreach

The OIG determined vet center staff completed an outreach plan for fiscal year 2022.

The OIG identified the following deficiencies:

Outreach plan: The outreach plan did not include the following required strategic components: map of the veteran service area, background regarding cultural orientations, or personal points of contact for non-VA service providers or VA medical facility partners.

Tailored outreach activities: Since the plan did not identify cultural orientations, outreach activities were not tailored to the cultural background information identified in the plan.

Environment of Care

The OIG determined completion of an annual fire and/or safety inspection and a risk and vulnerability assessment. The local fire department completed annual servicing for on-site fire extinguishers and AED. Monthly inspections were completed for fire extinguishers. The vet center also had the building evacuation plan posted in communal areas, as well as a critical event plan that included a desktop reference sheet outlining basic steps staff would follow in the event of a mental health crisis.

The OIG identified the following deficiencies:

AED inspection: Of the three months the OIG reviewed, monthly AED inspections were not completed for any month. The VCD did not inspect the AED monthly as staff had been misinformed that if the AED door was opened, an alarm would sound, and emergency services would be contacted.

Emergency and crisis plan: The OIG found a complete emergency and crisis plan, with all required components documented; however, the plan was not current. The VCD reported no regular updates or reviews were made to the plan.

Gainesville Vet Center

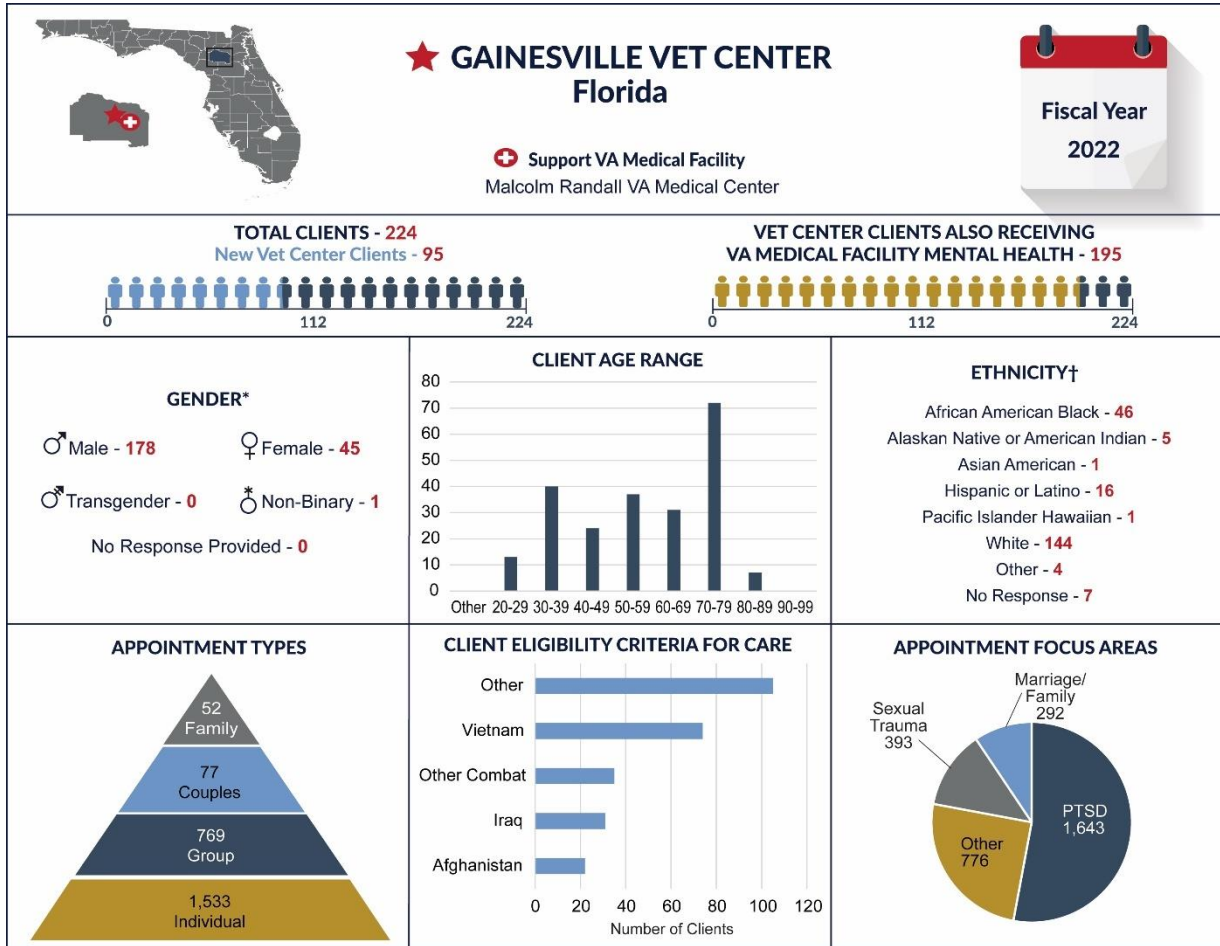


Figure 8. Client demographics across Gainesville Vet Center during fiscal year 2022.

Source: OIG created graphic utilizing RCS demographic data. Figures may not be exact replications of approximate percentages.

*Gender is self-reported by RCS clients according to an RCS leader.

†RCSNet functionality allows for the selection of one ethnicity category per client according to an RCS leader.

‡Age represents “age at date of last visit” according to an RCS leader.

The Gainesville Vet Center serves clients throughout Alachua, Bradford, Columbia, Dixie, Gilchrist, Levy, Putnam, Suwannee, and Union counties in north central Florida. The Malcolm Randall VA Medical Center provides supportive services to the vet center. The two military installations in the service area are Camp Blanding Joint Training Center in Starke, Florida, and the Naval Air Station located in Jacksonville, Florida.⁶⁹ The Gainesville Vet Center

⁶⁹ Training Group Southeast 01, Camp Blanding Joint Training Center, Brian Jennings, Kevin Grams, and Keith Quiles, accessed February 27, 2023, <http://www.nefltrainingcommand.org/camp-blanding>.

veteran service area includes Florida’s largest and oldest university, the University of Florida, and the University of Florida Health Hospital.⁷⁰

The Gainesville Vet Center coordinated with the Jacksonville Vet Center to utilize the MVC. During the review period, the Gainesville Vet Center utilized the MVC for six outreach events. The vet center conducted 62 outreach events during the review period.

The VCD reported being in the position since November 2017; additional staff included two readjustment counselors, a veteran outreach program specialist, and an office manager. The readjustment counseling staff were comprised of one licensed professional mental health counselor and two licensed clinical social workers.

Findings

Suicide Prevention

The OIG determined the VCD entered an outcome for all clients listed on the HRSF SharePoint site.

The OIG identified the following deficiency:

Mental health executive council participation: Vet center staff did not participate in the support VA medical facility’s mental health executive council. The VCD reported VA medical facility mental health executive council meetings were discontinued due to the COVID-19 pandemic and had not resumed during the review period but was unable to provide evidence of meeting cancellations.⁷¹

Consultation, Supervision, and Training

Consultation

The OIG determined support VA medical facility leaders assigned a clinical liaison and an external clinical consultant licensed in mental health to the vet center.

The OIG identified the following deficiency:

External clinical consultation hours: The OIG was unable to determine compliance with counselors receiving four hours of external clinical consultation for all months reviewed. Although, external clinical consultation was provided for 10 of 12 months, the submitted

⁷⁰ City of Gainesville, *City of Gainesville Facts*, accessed February 27, 2023, <https://www.gainesvillefl.gov/Community-Pages/Community/About-Gainesville/City-of-Gainesville-Facts>.

⁷¹ “A pneumonia of unknown cause detected in Wuhan, China, was first reported to the World Health Organization (WHO) Country Office in China on 31 December 2019. The virus was later named ‘SARS-CoV-2’ and the disease it causes named ‘coronavirus disease 2019’ (abbreviated ‘COVID-19’).” VHA Office of Emergency Management, *COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan, Version 1.6*, March 23, 2020.

documentation did not list duration for any of the meetings. For the two remaining months, the meetings were canceled. The VCD stated priority was given to capturing meeting notes and duration times were not documented.

Supervision

The OIG identified the following deficiency:

Record reviews: Of the three-month OIG review period, the VCD performed record reviews for all counselors but fell below the required 10 percent for two of three months. The VCD reported an error in calculating the total number of records for review, which caused the percentage of records reviewed to fall below 10 percent.

Training

The OIG determined that vet center staff completed S.A.V.E., Skills Training for Evaluation and Management of Suicide, lethal means safety education and counseling, and military sexual trauma trainings as required.

The OIG identified the following deficiency:

- Four out of five staff members completed training for BLS.

The VCD reported one staff member started but did not complete the BLS training.

Outreach

The OIG identified the following deficiencies:

Outreach plan: The veteran's outreach program specialist and the VCD did not develop an outreach plan for fiscal year 2022; therefore, the OIG could not evaluate the required elements. The VCD stated the outreach plan was last updated in 2018 and had not been updated since due to heavy workload and intermittent staff absences, during which time outreach was a team effort.

Environment of Care

The OIG determined vet center staff completed annual servicing of on-site fire extinguishers and monthly inspections of fire extinguishers and the AED. A building evacuation plan was posted in communal areas and there was an updated emergency and crisis plan, and critical event plan, including a desktop reference sheet, outlining basic steps staff would follow in the event of a mental health crisis.

The OIG identified the following deficiencies:

Fire and/or safety inspection: The vet center did not have an annual fire or safety inspection. The VCD reported the last assessment was in 2019 and the 2020 and 2021 assessments were on hold due to the COVID-19 pandemic. The VCD provided evidence that an inquiry was

made to the support VA medical facility to schedule an inspection three months before the OIG on-site visit but was pending at the time of the inspection.

AED servicing: Annual AED servicing had not been completed by the support VA medical facility. The VCD reported the AED had not undergone servicing since 2019 due to the COVID-19 pandemic.

Risk and vulnerability assessment: The support VA medical facility police service or local law enforcement did not complete an annual risk and vulnerability assessment during the review period. The VCD reported the last risk and vulnerability assessment was in 2019 and noted that all offsite visits were canceled due to the COVID-19 pandemic.

Lakeland Vet Center

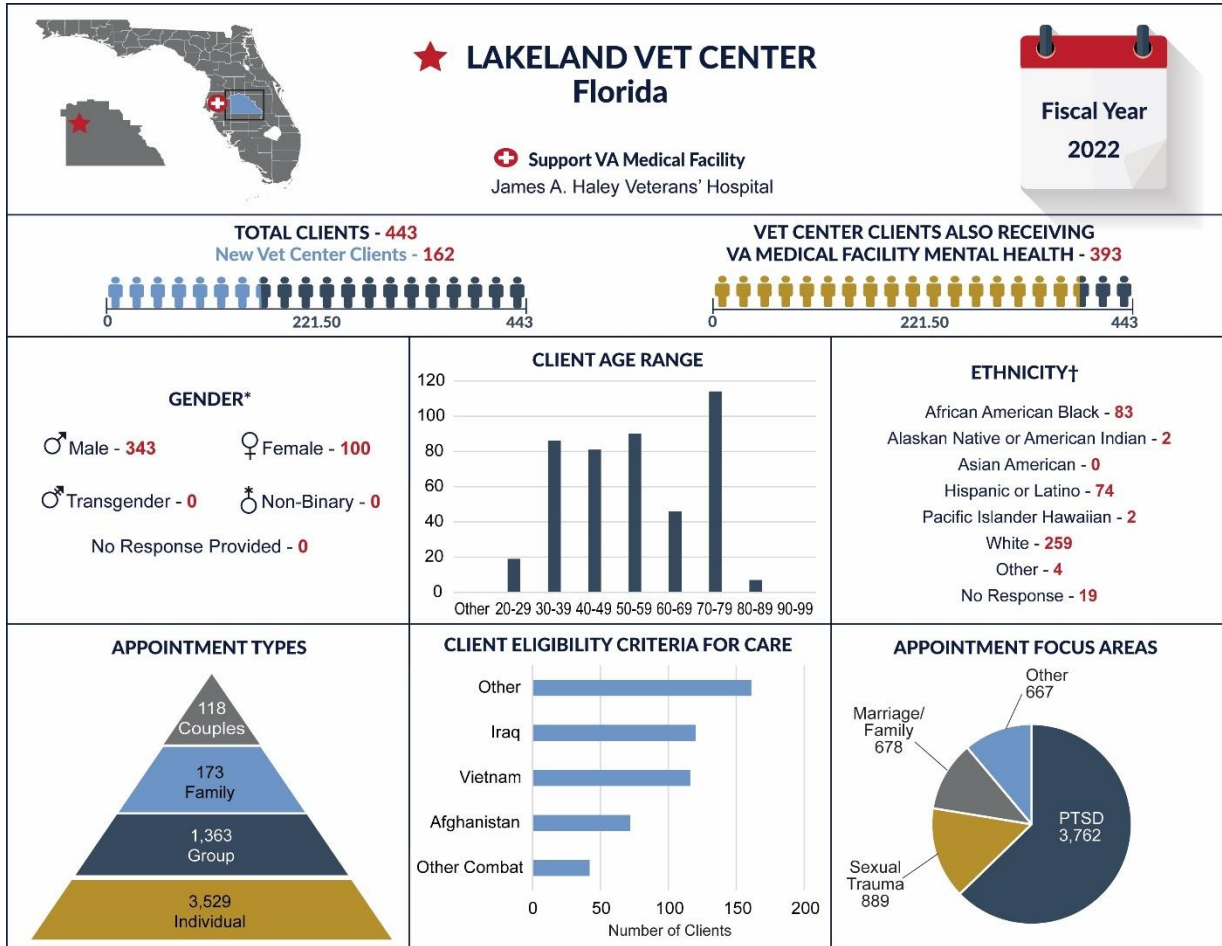


Figure 9. Client demographics across Lakeland Vet Center during fiscal year 2022.
Source: OIG created graphic utilizing RCS demographic data. Figures may not be exact replications of approximate percentages.

*Gender is self-reported by RCS clients according to an RCS leader.

†RCSNet functionality allows for the selection of one ethnicity category per client according to an RCS leader.

‡Age represents “age at date of last visit” according to an RCS leader.

The Lakeland Vet Center serves clients throughout Polk County. The James A. Haley VA Medical Center provides supportive services to the vet center. The vet center has a community partnership with the MacDill Air Force Base Exchange and Clinics. The Lakeland Vet Center also partners with Florida Southern University, Polk State College, Southeastern University, and several other colleges.

During the review period, the Lakeland Vet Center did not utilize an MVC for outreach events. The vet center conducted 60 outreach events during the review period.

The Lakeland VCD reported being in the position since October 2022, and additional staff included four readjustment counselors, a veteran outreach program specialist, and an office manager.⁷² Clinical staff were comprised of one licensed mental health counselor and four licensed clinical social workers. The veteran outreach program specialist started approximately five months preceding the OIG inspection, prior to which the position was vacant and without coverage for approximately five months. The VCD reported that the vacancy consistently affected the vet center's ability to conduct outreach throughout fiscal year 2022.

Findings

Suicide Prevention

The OIG identified the following deficiencies:

Mental health executive council participation: Vet center staff did not participate in three meetings of the support VA medical facility's mental health executive council during fiscal year 2022. The VCD and former acting VCD were unable to provide a reason for the lack of attendance.⁷³

HRSF SharePoint site: The OIG determined the VCD did not enter an outcome for one client on the HRSF SharePoint site. The VCD reported entering the outcome on the site; however, the updated information did not save.

Consultation, Supervision, and Training

Consultation

The OIG identified the following deficiencies:

Clinical liaison: The support VA medical facility leaders did not assign a clinical liaison to the vet center during the review period. The VCD and the former acting VCD were unable to provide a reason a clinical liaison was not assigned or provide information about how long the role was vacant.

External clinical consultant: The VCD reported that support VA medical facility leaders did not assign an external clinical consultant to the vet center; therefore, the OIG did not assess if the vet center received four clinical consultation hours a month. The former acting VCD

⁷² The Lakeland VCD reported being hired on October 9, 2022, approximately seven weeks prior to the OIG inspection and, therefore, had limited knowledge of the prior processes. The VCD also reported the previous VCD departed on July 17, 2022, and an acting VCD was in place from July 18 through October 11, 2022. The OIG included the former acting VCD in inspection interviews to obtain a more complete understanding of the vet center's processes.

⁷³ The review period was from October 1, 2021, through September 30, 2022. The VCD and former acting VCD were unable to provide reasons for noncompliance for some review elements since neither were functioning in the VCD role for the entirety of the review period.

reported that since the external clinical consultant retired in June 2022, no one had been assigned. The VCD and former acting VCD were unable to provide information about why the role went unfilled.

Supervision

The OIG identified the following deficiency:

Record reviews: During the three months reviewed, supervisors did not complete record reviews for all counselors. The former acting VCD believed the previous VCD completed the July chart reviews. The former acting VCD did not complete the August and September reviews due to competing priorities.

Training

The OIG identified the following deficiencies:

- One of two completed S.A.V.E. training for nonclinical staff.
- Two of five completed Skills Training for Evaluation and Management of Suicide training for clinical staff.
- Three of five completed military sexual trauma training for clinical staff.
- One of seven completed training for BLS.

The VCD was unable to provide a reason for incomplete training.

Outreach

The OIG identified the following deficiency:

Outreach plan: The veteran outreach program specialist and the VCD did not develop an outreach plan for fiscal year 2022 and, therefore, the OIG could not evaluate required elements. The VCD was unable to provide a reason an outreach plan was not developed.

Environment of Care

The OIG determined completion of an annual fire and/or safety inspection, annual risk and vulnerability assessment, and annual servicing and monthly inspections of fire extinguishers and the AED. The vet center also had building evacuation plans posted in communal areas and a critical event plan that included a desktop reference sheet outlining basic steps staff would follow in the event of a mental health crisis.

The OIG identified the following deficiency:

Emergency and crisis plan: The vet center had an emergency and crisis plan but the components addressing management of disruptive behavior and violence in the workplace had not been updated since November 6, 2020. The VCD was unable to provide a reason all emergency and crisis information was not updated.

Naples Vet Center

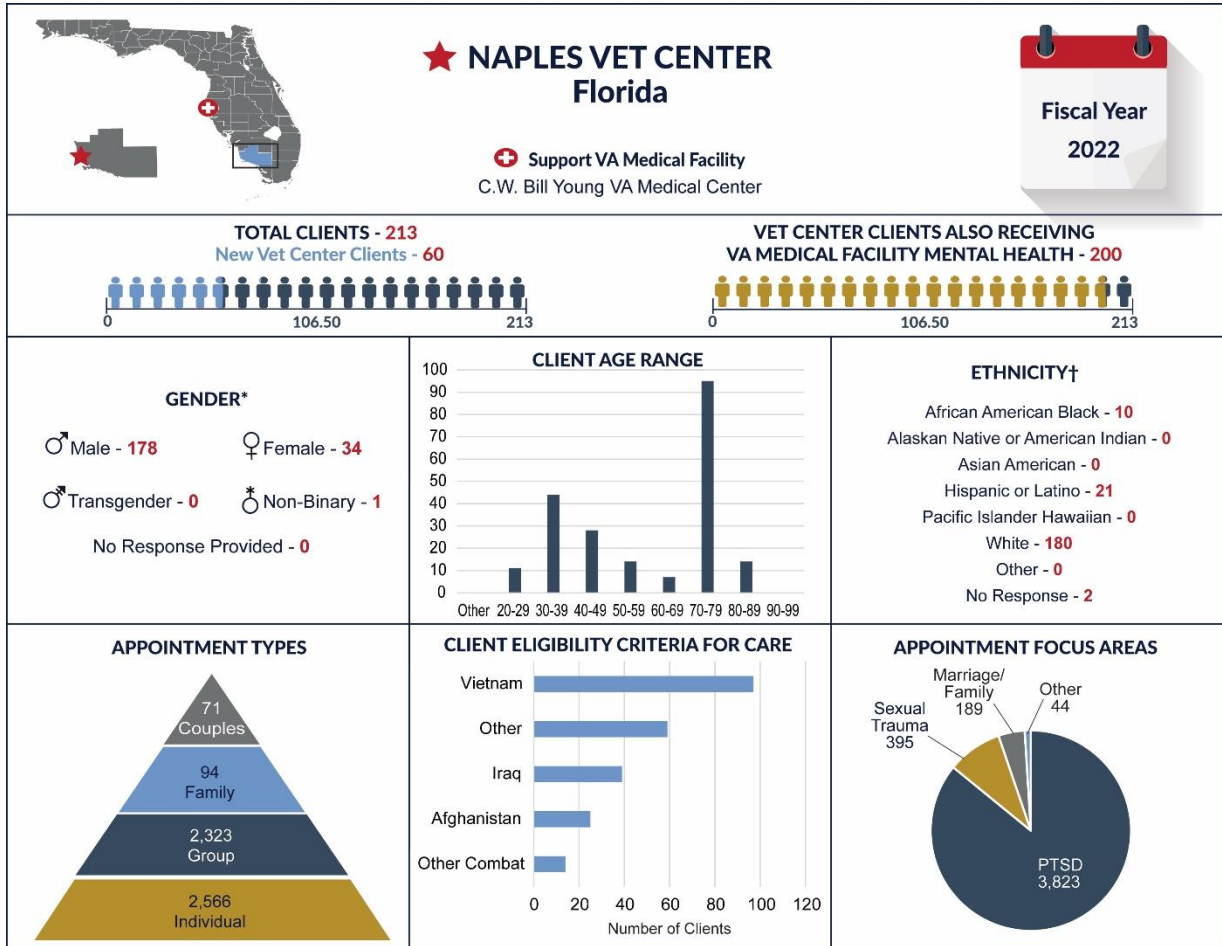


Figure 10. Client demographics across Naples Vet Center during fiscal year 2022.

Source: OIG created graphic utilizing RCS demographic data. Figures may not be exact replications of approximate percentages.

*Gender is self-reported by RCS clients according to an RCS leader.

†RCSNet functionality allows for the selection of one ethnicity category per client according to an RCS leader.

‡Age represents “age at date of last visit” according to an RCS leader.

C.W. Bill Young VA Medical Center, specifically the Naples VA Clinic, provides supportive services to the vet center.⁷⁴ The VCD reported, the Naples Vet Center coordinates with the Fort Myers Vet Center to utilize the MVC. The VCD also reported the vet center participated in 39 outreach events during the review period.

⁷⁴ VA, *VA Locations*, accessed February 27, 2023, <https://www.va.gov/bay-pines-health-care/locations>.

The VCD reported being in position since April 2022, and additional staff included two readjustment counselors, and a veteran outreach program specialist.⁷⁵ The VCD reported the office manager position had been vacant since April 2022. The readjustment counseling staff were comprised of one licensed mental health counselor and two licensed clinical social workers.

During the time of Hurricane Ian, the VCD reported the vet center was affected and was temporarily closed. While the building was closed, the VCD reported staff continued to meet client counseling needs through telehealth services.

Findings

Suicide Prevention

The OIG determined the VCD entered an outcome for all clients listed on the HRSF SharePoint site.

The OIG identified the following deficiency:

Mental health executive council participation: The VCD stated that mental health executive council meetings were held monthly and various VCDs rotated attendance; however, the VCD was unable to provide documentation of any VCD attendance for 11 of the 12 meetings held.

Consultation, Supervision, and Training

Consultation

The OIG determined support VA medical facility leaders assigned a clinical liaison and an external clinical consultant licensed in mental health to the vet center.

The OIG identified the following deficiency:

External clinical consultation hours: The OIG was unable to determine compliance with counselors receiving four hours of external consultation for all months reviewed based on submitted documentation.

Supervision

The OIG determined all elements in the supervision review were compliant.

Training

The OIG determined all elements in the training review were compliant.

⁷⁵ The VCD reported starting the role in April 2022 and was only in the position for the months of August and September during the review period (fiscal year 2022). Prior to the VCD's start of employment and while the VCD was absent, the VCD reported coverage for the Naples Vet Center was assigned to the Fort Myers VCD with an effective date of January 31, 2022.

Outreach

The OIG determined the vet center had an outreach plan for fiscal year 2022.

The OIG identified the following deficiencies:

Outreach plan: The outreach plan was missing the following required strategic components: a map of the veteran service area, background information regarding cultural orientations, personal points of contact for non-VA service providers or VA medical facility partners, and strategic coordination with MVC operations.

Tailored outreach activities: Since the plan did not identify cultural orientations, outreach activities were not tailored to the cultural background information identified in the plan.

Environment of Care

The OIG determined an annual fire and/or safety inspection, annual risk and vulnerability assessment, annual fire extinguisher servicing, and monthly AED inspections were completed. The vet center also had a critical event plan that included a desktop reference sheet outlining basic steps staff would follow in the event of a mental health crisis.

The OIG identified the following deficiencies:

Fire extinguisher inspection: Of the three months the OIG reviewed, vet center staff did not complete monthly fire extinguisher inspections on two extinguishers for one month. The VCD stated the missed inspections were an oversight.

AED servicing: Annual AED servicing had not been completed by the support VA medical facility since August of 2021. According to staff at the support facility, AEDs are only serviced biannually and, therefore, an inspection in 2022 was not completed.

Evacuation plan: The vet center had an evacuation plan posted in the staff breakroom but not in a communal area. The VCD stated that clients are not allowed in the staff breakroom.

Emergency and crisis plan: The vet center had a complete emergency and crisis plan with all required components documented; however, the emergency portion of the plan was not current. The VCD was unaware of the expired plan and was not able to provide an updated version.

San Juan Vet Center

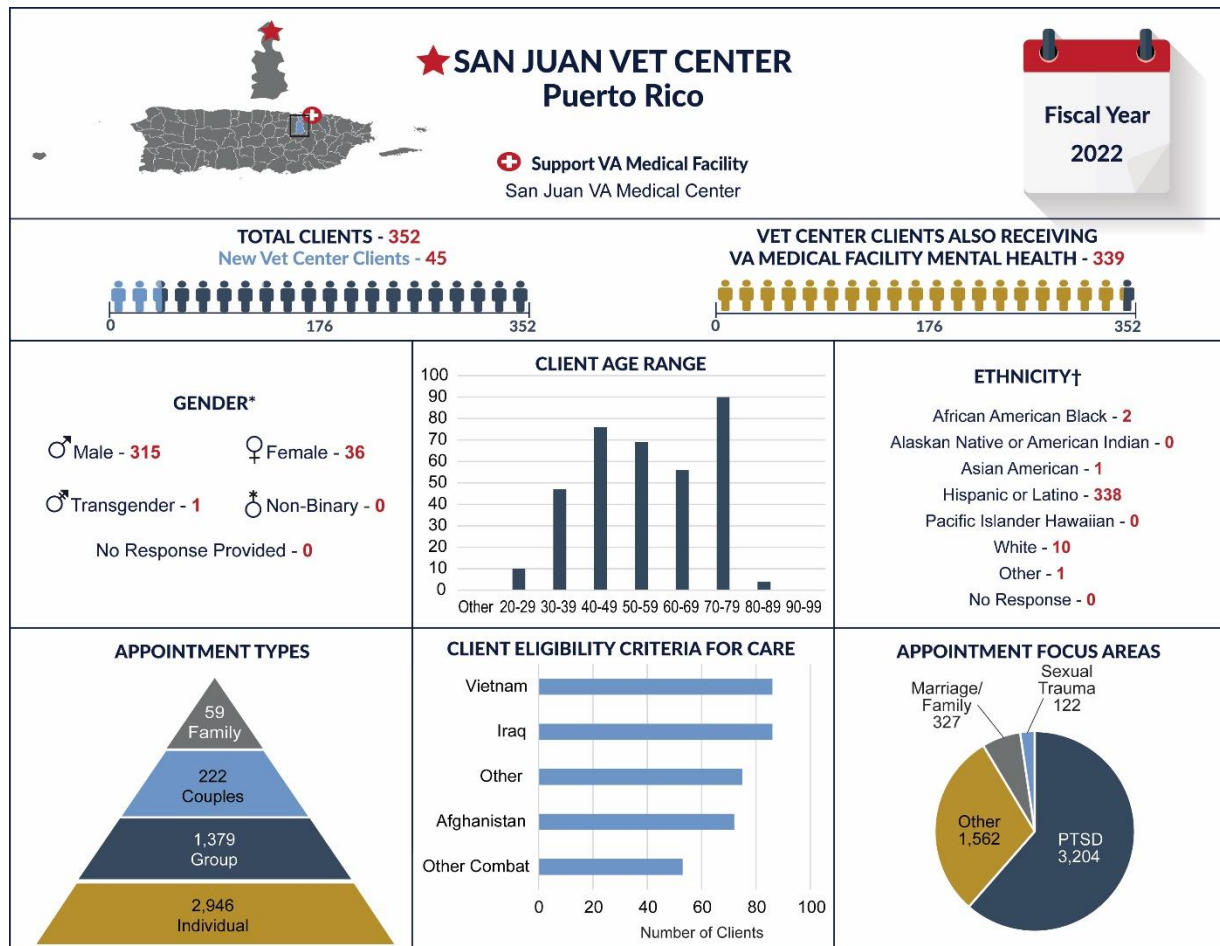


Figure 11. Client demographics across San Juan Vet Center during fiscal year 2022.

Source: OIG created graphic utilizing RCS demographic data. Figures may not be exact replications of approximate percentages.

*Gender is self-reported by RCS clients according to an RCS leader.

†RCSNet functionality allows for the selection of one ethnicity category per client according to an RCS leader.

‡Age represents “age at date of last visit” according to an RCS leader.

The San Juan Vet Center serves clients throughout 33 municipalities and two islands in the eastern parts of Puerto Rico. The San Juan VA Medical Center provides supportive services to the vet center. The closest military installation is Fort Buchanan in Guaynabo.⁷⁶ The San Juan Vet Center is located near the University of Puerto Rico, the largest and oldest institution of higher education in the Caribbean.⁷⁷

⁷⁶ “Welcome to Puerto Rico,” Government of Puerto Rico, accessed March 6, 2023, <https://welcome.topuertorico.org/government>.

⁷⁷ Universidad de Puerto Rico, “About Us,” accessed March 6, 2023, <https://www.uprrp.edu>.

The San Juan Vet Center was assigned an MVC that was received on December 3, 2021. During the review period, the MVC was utilized for 36 outreach events. The Vet center staff conducted 84 outreach events during the review period.

The San Juan VCD, a licensed master's level social worker, reported being in the position since February 2022, and additional staff included three readjustment counselors (a clinical psychologist, a licensed clinical social worker, and a master's level social worker), a veteran outreach program specialist, and an office manager. A fourth readjustment counseling position was vacant for three months at the time of inspection. Additionally, the VCD and two readjustment counselors were in their roles for less than one year.

On September 18, 2022, Hurricane Fiona hit the southwestern coast of Puerto Rico, causing an electricity outage to the entire island and leaving most residents without running water. The San Juan VCD reported that the Ponce Vet Center building, located an hour and a half away on the southern side of Puerto Rico, was significantly damaged in the hurricane. The San Juan VCD reported the MVC was deployed to the Ponce Vet Center to provide direct counseling and other supportive services from September 26 through November 22, 2022. The San Juan veteran outreach program specialist also assisted the Ponce Vet Center one day a week. Through the use of the MVC and partnership with the Ponce Vet Center, 744 contacts were made to veterans and families. In addition, the VCD reported increased collaboration with VA's emergency management and response team and the district office during Hurricane Fiona.

Findings

Suicide Prevention

The OIG determined the VCD entered an outcome for all clients listed in the HRSF SharePoint site.

The OIG identified the following deficiency:

Mental health executive council participation: Vet center staff either participated or were excused from 10 of 12 monthly meetings. The VCD reported not being in the role at the time of the missed meetings and was unable to provide a reason for not attending.

Consultation, Supervision, and Training

Consultation

The OIG determined the support VA medical facility leaders assigned a clinical liaison and an external clinical consultant licensed in mental health to the vet center.

The OIG determined the following deficiency:

External clinical consultation hours: Counselors did not receive four hours of external clinical consultation a month for any of the months reviewed. The VCD was unable to provide reasons minimum clinical consultation hours were not completed prior to the VCD transitioning into the director role on February 14, 2022. For the first three months of filling the role, the VCD reported being unaware that the requirement was not being met. The VCD began coordinating with the support VA medical facility to increase consultation hours, but the increase did not occur during the review period.

Supervision

The OIG determined all elements in the supervision review were compliant.

Training

The OIG determined vet center staff completed S.A.V.E., military sexual trauma, and BLS trainings as required.

The OIG identified the following deficiencies:

- Two of four completed Skills Training for Evaluation and Management of Suicide training for clinical staff.
- Three of four completed lethal means safety education and counseling training for clinical staff.

The VCD reported that lack of coordination and structure to track training completion contributed to the noncompliance.

Outreach

The OIG determined the vet center had an outreach plan for fiscal year 2022.

The OIG identified the following deficiencies:

Outreach plan: The outreach plan was missing the following required strategic components: a map of the veteran service area, background information regarding cultural orientations, personal points of contact for non-VA service providers, and VA medical facility partners.

Tailored outreach activities: Since the plan did not identify cultural orientations, outreach activities were not tailored to the cultural background information in the plan. The VCD was unaware of the outreach plan components requirements.

Environment of Care

The OIG determined all elements in the environment of care review were compliant.

Results and Recommendations Summary

The following section is an overview of results for the six reviewed vet centers and resulting recommendations. Recommendations target deficiencies that, if improved, would positively influence the quality of client care. These recommendations are intended to be used as a road map to help improve operations and clinical care.

Suicide Prevention Results

For details on the review topic requirements and methodology see [Suicide Prevention](#).

Requirement	Impact	Noncompliant Vet Center(s)
1. A licensed vet center staff attends all support VA medical facility mental health executive council meetings	Lack of vet center participation on the support VA mental health executive council may decrease collaboration between the vet center and support VA facility, which could result in a lack of services offered to clients.	Ft. Lauderdale Ft. Myers Gainesville Lakeland Naples San Juan
2. An outcome is dispositioned in the HRSF SharePoint site within five business days of receiving the HRSF list	Failure to perform timely dispositions may result in high-risk clients not receiving timely interventions.	Lakeland

Suicide Prevention Recommendations

Recommendation 1

District leaders and the Ft. Lauderdale, Ft. Myers, Gainesville, Lakeland, Naples, and San Juan Vet Center Directors, collaborate with the support VA medical facility clinical liaison to determine the reasons for noncompliance, take action as indicated, and monitor to ensure compliance with staff participation on the mental health executive council.

Recommendation 2

District leaders and the Lakeland Vet Center Director, determine reasons for noncompliance with High Risk Suicide Flag SharePoint site requirements and the tracking of continuity of care for at-risk clients, take action to ensure requirements are met, and monitor compliance.

Consultation, Supervision, and Training Results

For details on review topic requirements and methodology see [Consultation, Supervision, and Training](#).

Requirement	Impact	Noncompliant Vet Center(s)
3. Vet Center has an assigned clinical liaison from the support VA medical facility that is a mental health professional	Lack of an assigned clinical liaison may result in decreased client access to health care beyond what is provided by the vet center.	Lakeland
4. Vet center has an assigned external clinical consultant from the support VA medical facility that is an independently licensed mental health professional	The absence of an independently licensed mental health professional serving as the vet center external clinical consultant may lead to a lack of support for mental health care and services.	Lakeland
5. External clinical consultant provides at least four hours of consultation monthly	Vet center may lack enough support for readjustment of clients with clinically complex cases.	Ft. Lauderdale Ft. Myers San Juan Gainesville–unable to determine Lakeland–not assessed Naples–unable to determine
6. VCDs review 10 percent of active counseling records monthly for each staff member	Lack of record reviews may lead to missed opportunities to provide immediate feedback regarding improvements for quality patient care, counselor documentation, and compliance with RCS guidance and procedures.	Ft. Lauderdale Gainesville Lakeland
7. Staff members complete required trainings in the allotted time frame	Lack of completion of required training may result in inappropriate staff response and interventions when providing services to clients.	Ft. Lauderdale Ft. Myers Gainesville Lakeland San Juan

Consultation, Supervision, and Training Recommendations

Recommendation 3

District leaders and the Lakeland Vet Center Director determine reasons for noncompliance and ensure assignment of a liaison.

Recommendation 4

District leaders and the Lakeland Vet Center Director determine reasons for noncompliance and ensure assignment of an external clinical consultant.

Recommendation 5

District leaders and the Ft. Lauderdale, Ft. Myers, Gainesville, Naples, and San Juan Vet Center Directors determine reasons for noncompliance, ensure a process is implemented for completing and tracking four hours of external clinical consultation per month, and monitor compliance.

Recommendation 6

District leaders and the Ft. Lauderdale, Gainesville, and Lakeland Vet Center Directors determine reasons for noncompliance with monthly active counseling records, ensure chart audits are completed as required, and monitor compliance.

Recommendation 7

District leaders and the Ft. Lauderdale, Ft. Myers, Gainesville, Lakeland, and San Juan Vet Center Directors determine reasons for noncompliance, develop processes to ensure all staff complete mandatory trainings, and monitor compliance.

Outreach Results

For details on review topic requirements and methodology see [Outreach](#).

Requirement	Impact	Noncompliant Vet Centers(s)
8. Vet center has a written outreach plan	The absence of an outreach plan may lead to a lack of focus on engagement of eligible clients, decreased visibility and utilization of vet centers, and a less robust referral network.	Gainesville Lakeland

Requirement	Impact	Noncompliant Vet Centers(s)
9. Outreach plan includes required strategic components	The absence of strategic outreach plan components may lead to missed opportunities to target outreach services accurately and establish personal relationships with relevant providers.	Ft. Lauderdale Ft. Myers Naples San Juan
10. Outreach activities are tailored to cultural background information identified in the outreach plan	Failure to tailor outreach activities may lead to decreased outcomes and quality of care and contribute to sustained health disparities, specifically related to race and ethnicity.	Ft. Myers Naples San Juan

Outreach Recommendations

Recommendation 8

District leaders and the Gainesville and Lakeland Vet Center Directors determine reasons for noncompliance and ensure outreach plans are completed.

Recommendation 9

District leaders and the Ft Lauderdale, Ft. Myers, Naples, and San Juan Vet Center Directors determine reasons for noncompliance and ensure outreach plans include all required strategic components.

Recommendation 10

District leaders and the Ft. Myers, Naples, and San Juan Vet Center Directors determine reasons for noncompliance, ensure outreach activities are tailored to the cultural demographics of the vet center’s veteran service area, and monitor compliance.

Environment of Care Results

For details on review topic requirements and methodology see [Environment of Care](#).

Requirement	Impact	Noncompliant Vet Centers(s)
11. Fire and/or safety inspection completed annually	Failure to complete annual fire and/or safety inspection could cause key safety items to be missed, which could result in a significant safety issue.	Gainesville
12. Risk and vulnerability assessment updated annually	Lack of current risk and vulnerability assessment may cause staff to be uninformed and unprepared for emergencies.	Gainesville
13. AED serviced annually by VA medical facility	Failure to complete annual servicing of AED could affect reliability and effectiveness in an emergency.	Gainesville Naples
14. Fire extinguishers inspected monthly	Failure to complete monthly inspections of portable fire extinguishers could affect reliability and effectiveness in an emergency.	Ft. Lauderdale Naples
15. AEDs inspected monthly	Failure to complete monthly inspections of AEDs could affect reliability and effectiveness in an emergency.	Ft. Myers
16. Building evacuation plan posted in communal area for staff and visitors to reference	Lack of emergency evacuation plan posted in communal area may result in difficulty evacuating the building during an emergency.	Naples
17. Current emergency and crisis plan that includes required components	Lack of current emergency and crisis plan may cause staff to be unsafe and unprepared in the event of an emergency.	Ft. Lauderdale Ft. Myers Lakeland Naples

Environment of Care Recommendations

Recommendation 11

District leaders and the Gainesville Vet Center Director determine reasons for noncompliance, ensure completion of fire and/or safety inspections, and monitor compliance.

Recommendation 12

District leaders and the Gainesville Vet Center Director determine reasons for noncompliance, ensure the risk and vulnerability assessment is completed by VA police or local law enforcement, and monitor compliance.

Recommendation 13

District leaders and the Gainesville and Naples Vet Center Director determine reasons for noncompliance, ensure automated external defibrillators are serviced annually, and monitor compliance.

Recommendation 14

District leaders and the Ft. Lauderdale and Naples Vet Center Directors determine reasons for noncompliance, ensure fire extinguishers are inspected monthly, and monitor compliance.

Recommendation 15

District leaders and the Ft. Myers Vet Center Director determine reasons for noncompliance, ensure automated external defibrillators are inspected monthly, and monitor compliance.

Recommendation 16

District leaders, and the Naples Vet Center Director, determine reasons for noncompliance and ensure evacuation plans are posted in a communal area.

Recommendation 17

District leaders and the Ft. Lauderdale, Ft. Myers, Lakeland, and Naples Vet Center Directors determine reasons for noncompliance, ensure completion of a current and comprehensive emergency and crisis plan, and monitor compliance.

Appendix A: District 2 Zone 2 Profile

Table A.1. Fiscal Year 2022 Vet Center Profiles

Profile	Ft. Lauderdale Vet Center	Ft. Myers Vet Center	Gainesville Vet Center	Lakeland Vet Center	Naples Vet Center	San Juan Vet Center
Budget	\$685,805.23	\$668,602.04	\$495,232.66	\$563,672.01	\$420,604.88	\$747,759.57
Total Unique Clients	468	433	223	437	208	352
New Clients	92	163	94	162	59	135
Active-Duty Clients	15	47	18	31	49	16
Bereavement Clients	4	29	4	28	1	11
Family Clients	36	42	25	55	28	72
Total Number of Positions						
Total Authorized Full-time Positions	7	7	5	7	5	9
Total Filled Positions	6	6	5	6	4	7
Total Vacancies	1	1	0	1	1	2

Source: RCS District 2 demographic and position data.

Appendix B: RCS Chief Readjustment Counseling Officer Memorandum

Department of Veterans Affairs Memorandum

Date: February 9, 2024

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

Subj: Inspection of Selected Vet Centers in Southeast District 2 Zone 2

To: Office of the Under Secretary for Health (10N)
Director, GAO/OIG Accountability Liaison (VHA 10B GOAL Action)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Inspection of Select Vet Centers in Southeast District 2 Zone 2. I have reviewed the recommendations and submit action plans to address all findings in the report.

(Original signed by:)

Michael Fisher
Chief Officer, Readjustment Counseling Service

Appendix C: RCS Southeast District 2 Director Memorandum

Department of Veterans Affairs Memorandum

Date: February 4, 2024

From: Joseph Dudley, Southeast District 2 (RCS2)

Subj: Inspection of Selected Vet Centers in Southeast District 2 Zone 2

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 2 Zone 2.
2. I reviewed the draft report and request closure of recommendations 1 through 10 and 13 through 17. District leaders and Vet Center Directors took action to resolve concerns identified during the District 2 Zone 2 inspection. Specific actions taken are in the attachments including evidence of compliance over at least a ninety-day period. District leaders also made it a point of emphasis to confirm and validate compliance during annual clinical and administrative site visits.
3. Please express my thanks to the team for their professionalism and assistance to us in our continuing efforts to improve the care we provide to our Veterans.

(Original signed by:)

Joseph Dudley
District Director

District Director Response

Recommendation 1

District leaders and the Ft. Lauderdale, Ft. Myers, Gainesville, Lakeland, Naples, and San Juan Vet Center Directors collaborate with the support VA medical facility clinical liaison to determine the reasons for noncompliance, take action as indicated, and monitor to ensure compliance with staff participation on the mental health executive council.

Enter text here

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

Vet Center Directors (VCD) were not consistently documenting participation in the Mental Health Executive Council (MHEC) meetings. District 2 Zone 2 leadership provided education to VCDs and ongoing reminders to meet this requirement. The VCDs track compliance locally and the district confirms compliance during the annual clinical site visit. These Vet Centers coordinated with their support VA Medical Centers, and all now have representation on the local MHEC.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 2

District leaders and the Lakeland Vet Center Director determine reasons for noncompliance with High Risk Suicide Flag SharePoint site requirements and the tracking of continuity of care for at-risk clients, take action to ensure requirements are met, and monitor compliance.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The outcome for one client on the High-Risk Suicide Flag (HRSF) SharePoint site was not present. District 2 Zone 2 leadership immediately developed and implemented a process to track and monitor compliance. District leadership provides the HRSF notification link to VCDs

each time it is updated and monitors all actions until completed. The VCDs track compliance locally and district leadership tracks every individual on the HRSF and monitors each until completed and the outcome is documented. The district also confirms compliance during the annual clinical site visit. The Lakeland Vet Center is compliant with HRSF SharePoint requirements.

OIG Comments

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

Recommendation 3

District leaders and the Lakeland Vet Center Director determine reasons for noncompliance and ensure assignment of a liaison.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The local VAMC assigned a clinical liaison to the Lakeland Vet Center in March 2023. A Memorandum of Understanding (MOU) between Lakeland Vet Center and the local VAMC was signed in November 2023 to strengthen the relationship between the Vet Center and VAMC and to formalize the ongoing requirement for the assignment of a clinical liaison. The Lakeland Vet Center is compliant with the requirement for the assignment of a clinical liaison.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 4

District leaders and the Lakeland Vet Center Director determine reasons for noncompliance and ensure assignment of an external clinical consultant.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The local VAMC has assigned a licensed Psychologist to serve as the external clinical consultant for the Lakeland Vet Center In March 2023. An MOU between Lakeland Vet Center and the local VAMC was signed in November 2023 to strengthen the relationship between the Vet Center and VAMC and to formalize the ongoing requirement for the assignment of an external clinical consultant. The Lakeland Vet Center is compliant with the requirement for the assignment of an external clinical consultant.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 5

District leaders and the Ft. Lauderdale, Ft. Myers, Gainesville, Naples, and San Juan Vet Center Directors determine reasons for noncompliance, ensure a process is implemented for completing and tracking four hours of external clinical consultation per month, and monitor compliance.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The VCDs were not consistently completing and monitoring compliance for the four hours of monthly external consultation at these two Vet Centers. District 2 Zone 2 leadership provided education to VCDs and ongoing reminders to meet this requirement. The VCDs track compliance locally and the district confirms compliance during the annual clinical site visit. these Vet Centers have consistently completed four hours of external clinical consultation per month.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 6

District leaders and the Ft. Lauderdale, Gainesville, and Lakeland Vet Center Directors determine reasons for noncompliance with monthly active counseling records, ensure chart audits are completed as required, and monitor compliance.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The VCDs were not consistently auditing the correct number of charts. District 2 Zone 2 leadership provided education to VCDs regarding chart audit requirements including accurate calculation of the number of charts to audit. The VCDs track compliance locally and the district confirms compliance during the annual clinical site visit. These Vet Centers have consistently completed chart audits as required.

OIG Comments

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

Recommendation 7

District leaders and the Ft. Lauderdale, Ft. Myers, Gainesville, Lakeland, and San Juan Vet Center Directors determine reasons for noncompliance, develop processes to ensure all staff complete mandatory trainings, and monitor compliance.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

In Fiscal Year (FY) 2022, these Vet Centers did not meet full compliance for mandatory staff trainings. District management provided instruction to VCDs to ensure completion of mandatory trainings. Vet Center staff training is documented in the Talent Management System (TMS) and tracked locally by Vet Center Directors. Compliance is confirmed by the district during the annual administrative site visit. All staff are compliant with mandatory training.

OIG Comments

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

Recommendation 8

District leaders and the Gainesville and Lakeland Vet Center Directors determine reasons for noncompliance and ensure outreach plans are completed.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The Gainesville and Lakeland Vet Centers did not complete a FY 2022 outreach plan. The FY 2023 outreach plan was completed by both Vet Centers and verified by the district during the annual clinical site visit. District management also confirmed these Vet Centers have an outreach plan for FY 2024 and will continue to monitor compliance moving forward.

OIG Comments

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

Recommendation 9

District leaders and the Ft Lauderdale, Ft. Myers, Naples, and San Juan Vet Center Directors determine reasons for noncompliance and ensure outreach plans include all required strategic components.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The FY 2022 outreach plans at these locations did not include all required strategic components. District 2 Zone 2 management provided instruction for creating an outreach plan that includes all strategic components listed in VHA Directive 1500(4) Appendix B. The VCDs track compliance locally and the district confirms compliance during the annual clinical site visit. These Vet Centers all have a current outreach plan that includes all required strategic components.

OIG Comments

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

Recommendation 10

District leaders and the Ft. Myers, Naples, and San Juan Vet Center Directors determine reasons for noncompliance, ensure outreach activities are tailored to the cultural demographics of the vet center’s veteran service area, and monitor compliance.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The FY 2022 outreach plans at these locations did not include activities tailored to the cultural demographics of the Vet Center’s Veteran service area. District 2 Zone 2 management provided instruction for creating an outreach plan that includes outreach activities are tailored to the cultural demographics of the local area. The VCDs track compliance locally and the district confirms compliance during the annual clinical site visit. These Vet Centers all have a current outreach plan that includes activities tailored to the local cultural demographics.

OIG Comments

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

Recommendation 11

District leaders and the Gainesville Vet Center Director determine reasons for noncompliance, ensure completion of fire and/or safety inspections, and monitor compliance.

Concur

Nonconcur

Target date for completion: Ongoing.

Director Comments

The Gainesville Vet Center did not have the required fire and/or safety inspections. The FY 2024 fire and safety inspection was completed in January 2024, but the Vet Center has not received the final report. The Vet Center Director and District leadership will receive the report and review any findings to confirm compliance with this requirement for FY 2024. The VCD will also track compliance locally and the district will confirm compliance during the annual administrative site visit.

Recommendation 12

District leaders and the Gainesville Vet Center Director determine reasons for noncompliance, ensure the risk and vulnerability assessment is completed by VA police or local law enforcement, and monitor compliance.

Concur

Nonconcur

Target date for completion: Ongoing.

Director Comments

The Gainesville Vet Center did not have a risk and vulnerability assessment in FY 2022. The VCD received guidance and instruction from district management and the Risk and Vulnerability Assessment was completed in October 2023, but the Vet Center has not received the final report. The Vet Center Director and District leadership will receive the report and review any findings to confirm compliance with this requirement for FY 2024. The VCD will track compliance locally and the district will confirm compliance during the annual administrative site visit.

Recommendation 13

District leaders and the Gainesville Vet Center Director determine reasons for noncompliance, ensure the risk and vulnerability assessment is completed by VA police or local law enforcement, and monitor compliance.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The automated external defibrillators (AED) in the Gainesville and Naples Vet Centers did not receive the required annual service in FY 2022. The VCDs received guidance and instruction from district management and the AEDs were serviced in FY 2023, (June 2023- Gainesville Vet Center and August 2023- Naples Vet Center). The VCDs tracks compliance locally and the district confirmed compliance during the annual administrative site visit.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 14

District leaders and the Ft. Lauderdale and Naples Vet Center Directors determine reasons for noncompliance, ensure fire extinguishers are inspected monthly, and monitor compliance.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The VCDs were not consistently inspecting fire extinguishers monthly. District 2 Zone 2 management provided instruction to VCDs and sends regular reminders of this requirement. The VCDs track compliance locally and the district confirms compliance during the annual administrative site visit. These Vet Centers are now consistently completing monthly inspection of fire extinguishers.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 15

District leaders and the Ft. Myers Vet Center Director determine reasons for noncompliance, ensure automated external defibrillators are inspected monthly, and monitor compliance.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The Ft. Myers Vet Center was not in compliance with monthly inspection and monitoring of the AED. District 2 Zone 2 management provided instruction to the VCD and sends regular reminders of this requirement. The VCD tracks compliance locally and the district confirmed compliance during the annual administrative site visit. Effective January 2023, Ft. Myers Vet Center has consistently completed monthly inspection the AED.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 16

District leaders and the Naples Vet Center Director determine reasons for noncompliance and ensure evacuation plans are posted in a communal area.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

Evacuation plans were not posted in a communal area. Evacuation plans are now posted in the lobby, two hallways and the group room. The VCD verified compliance locally and the district confirmed compliance during the annual administrative site visit. The Naples Vet Center is compliant with posted evacuation plans in four communal areas.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 17

District leaders and the Ft. Lauderdale, Ft. Myers, Lakeland, and Naples Vet Center Directors determine reasons for noncompliance, ensure completion of a current and comprehensive emergency and crisis plan, and monitor compliance.

Concur

Nonconcur

Target date for completion: Closed.

Director Comments

The VCDs at these Vet Centers did not maintain a current and comprehensive emergency and crisis plan. These Vet Centers updated their emergency and crisis plan for FY 2023 and again for FY 2024. The VCDs track compliance locally and the district confirmed compliance during the annual clinical and administrative site visits.

OIG Comments

The OIG considers this recommendation closed.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Inspection Team	Lindsay Gold, LCSW, Director Leakie Bell-Wilson, MSN, RN Shelevia Dawson, MSN, RN Mahshid Lee, LCSW Martynee Nelson, LCSW Bina Patel, PhD, LCSW
------------------------	--

Other Contributors	Elizabeth Bullock Felecia Burke Alicia Castillo-Flores, MBA, MPH Jennifer Christensen, DPM Limin Clegg, PhD Dawn Dudek, LCSW SoonHee Han Christopher D. Hoffman, LCSW, MBA Ryan Mairs, LICSW Barbara Mallory-Sampat, JD, MSN Lindsey Marano, LCSW Misty Mercer, MBA Maria Pini, MSN, RN Tiffany Price, LCSW April Terenzi, BA, BS
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Puerto Rico: Jenniffer González-Colón

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