US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Inspection of Select Vet Centers in Continental District 4 Zone 1

VCIP Report	22-04107-236	August 27, 2024

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Report Overview

The VA Office of Inspector General (OIG) Vet Center Inspection Program's (VCIP) purpose is to provide 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.

VCIP inspections are one element of the OIG's oversight to ensure that the nation's veterans receive high-quality and timely mental health care and VA services. Inspections are conducted to evaluate key clinical and administrative processes associated with promoting quality care and service delivery at vet centers.[1]

The OIG inspected six randomly selected vet centers throughout Continental District 4 zone 1: Fort Collins, Colorado; Kalispell, Montana; Tulsa, Oklahoma; Abilene, Texas; Salt Lake City, Utah; and Cheyenne, Wyoming.[2]

This VCIP inspection included 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 are intended to help vet centers to identify areas of vulnerability or conditions that, if addressed, could improve safety, accessibility, 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*, January 26, 2021, 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 for readjustment concerns related to specific types of military deployment stressors. Readjustment counseling services (RCS) are "designed by law to be provided without a medical diagnosis." Therefore, individuals 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] Readjustment Counseling Service is divided into five districts. Each district consists of two to four zones. Each zone consists of 18–25 vet centers.

Review Topics and Inspection Results

Suicide Prevention

The OIG found five of six Vet Center Directors (VCDs) did not ensure the attendance of a licensed provider at the VA medical facility's mental health executive council meetings as required.[3] The OIG was unable to conduct the High Risk Suicide Flag (HRSF) SharePoint site review due to concerns with data accuracy as a result of duplication, inaccuracies, or missing data values.[4]

The OIG issued one recommendation to select vet centers specific to suicide prevention activities. In April 2024, the OIG made a recommendation to the Readjustment Counseling Service (RCS) Chief Officer related to HRSF SharePoint site functionality. As of May 9, 2024, this recommendation remains open; therefore, the OIG will not make a new recommendation.[5]

Consultation, Supervision, and Training

The OIG found the six vet centers had assigned clinical liaisons and independently licensed mental health external clinical consultants from a support VA medical facility; however, five of the six VCDs did not ensure at least four hours of external clinical consultation per month for clinically complex cases.[6] Three of the six VCDs did not review the mandated 10 percent of each counselor's client records.[7] Additionally, staff at all six vet centers did not complete select

[3] VHA Directive 1500(2). Readjustment Counseling Service (RCS) requires a licensed vet center staff member attend all support VA medical facility mental health executive council meetings to assist with care coordination and collaboration for clients. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* November 15, 2016. VA medical centers are required to establish a mental health executive council that supports strategies, communication, and policies to improve mental health care and suicide prevention.

[4] On May 11, 2020, RCS implemented a HRSF SharePoint site containing names of RCS clients who also receive services at a VA medical facility and have a high risk for suicide flag. In June 2021, the SharePoint site was expanded to include Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) data. VA's REACH VET is a predictive analytics program developed to determine veterans who have a higher risk for suicide; The underlined terms are hyperlinks to another section of the report. To return to the point of origin, press and hold the "alt" and "left arrow" keys together.

[5] VA OIG, *Inspection of Southeast District 2 Vet Center Operations*, Report No. 22-03941-144, April 18, 2024.

[6] VHA Directive 1500(2). Each vet center aligns with a VA medical facility to ensure access to clinical services and coordination of care for shared clients.

[7] VHA Directive 1500(2).

required trainings related to suicide prevention, lethal means safety, military sexual trauma, and basic life support.[8]

The OIG issued three recommendations to select vet centers specific to consultation, supervision, and training.

Outreach

The OIG found all six vet enters had outreach plans.[9] However, the outreach plans at the six vet centers did not include one or more required strategic components.[10] The OIG was unable to evaluate if outreach activities were tailored to specific cultural orientations for three of the six plans because cultural orientations were not included in the plans. [11]

The OIG issued one recommendation to select vet centers specific to outreach.

Environment of Care

The OIG found the six vet centers in compliance with the following requirements: automated external defibrillator (AED) located on-site, and emergency and crisis plans.[12] Of the six vet centers,

- one was not compliant with an annual fire or safety inspection,
- two did not have an annual risk and vulnerability assessment completed by VA police or local law enforcement,
- two did not have monthly fire extinguisher inspections,
- one was not compliant with annual servicing of fire extinguishers,

[8] 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; VA Secretary, Agency-Wide Required Suicide Prevention Training; VHA memorandum, *Lethal Means Safety (LMS) Education and Counseling (VIEWS 7118915)*, March 17, 2022; 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; VHA Directive 1177, *Cardiopulmonary Resuscitation,* January 4, 2021.

[9] VHA Directive 1500(2).

[10] VHA Directive 1500(2). Required strategic components include: a strategic map of the vet center veteran service area identifying local eligible population concentrations, background information regarding cultural orientations of the local eligible communities, personal points of contact for non-VA medical facility community service providers, 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 behavior coordinator.

[11] VHA Directive 1500(2). RCS requires outreach activities are tailored to cultural orientations defined as identified ethnic, gender, occupational and generational in the outreach plan.

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

- five were noncompliant with having the on-site AED inspected monthly,
- one did not have annual AED servicing by VA medical center biomedical engineering,
- one did not have a building evacuation plan for staff and visitors to reference posted in a communal area, and
- one did not have a desktop reference sheet for ancillary office staff to follow in case of a suicidal or homicidal client.[13]

The OIG issued eight recommendations to select vet centers specific to environment of care.

Conclusion

The OIG conducted a focused inspection in four review areas and made 13 recommendations to district leaders and applicable VCDs. The number of recommendations should not be used as a gauge for the overall quality of care provided within the zone. These recommendations are intended to be used as a road map to help improve operations and clinical care. The recommendations address systems issues and site-specific findings that may compromise quality care and safety.

VA Comments and OIG Response

The 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 4, 6, 8, 9, 10, 11, 12, and 13 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

[13] RCS, *Administrative Site Visit (ASV) Protocol;* RCS, *Vet Center Clinical Site Visit (CSV) Report: Procedural Background Information*, accessed from internal RCS website on January 23, 2023. Vet center ancillary office staff include a veterans outreach program specialist and a program support assistant or office manager.

Contents

Abbreviations

AED	automated external defibrillator
BLS	basic life support
HRSF	high risk suicide flag
OIG	Office of Inspector General
RCS	Readjustment Counseling Service
VCD	Vet Center Director
VCIP	Vet Center Inspection Program
VHA	Veterans Health Administration

Introduction

The VA Office of Inspector General (OIG) Vet Center Inspection Program's (VCIP) purpose is to conduct 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.

RCS is an autonomous organizational element in the Veterans Health Administration (VHA) with authority for and oversight of vet centers and the provision of readjustment counseling services. Vet centers are community-based clinics that provide a wide range of psychosocial services to clients to support a successful transition from military to civilian life.[2]

Scope and Methodology

The OIG randomly selected district 4 and the following six vet centers in zone 1 for review: Fort Collins, Colorado; Kalispell, Montana; Tulsa, Oklahoma; Abilene, Texas; Salt Lake City, Utah; and Cheyenne, Wyoming (see figure 1).[3]

[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*, January 26, 2021, 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 for readjustment concerns related to specific types of military deployment stressors. "Readjustment counseling services are designed by law to be provided without a medical diagnosis." Therefore, individuals receiving readjustment services are not viewed as patients. To be consistent with RCS policy and terminology, the OIG refers to veterans receiving readjustment services as clients in this report.

[2] VHA Directive 1500(2). Vet center counselors provide readjustment counseling to assist clients with psychological and psychosocial readjustment.

[3] RCS is divided into five districts. Each district consists of two to four zones. Each zone consists of 18–25 vet centers.

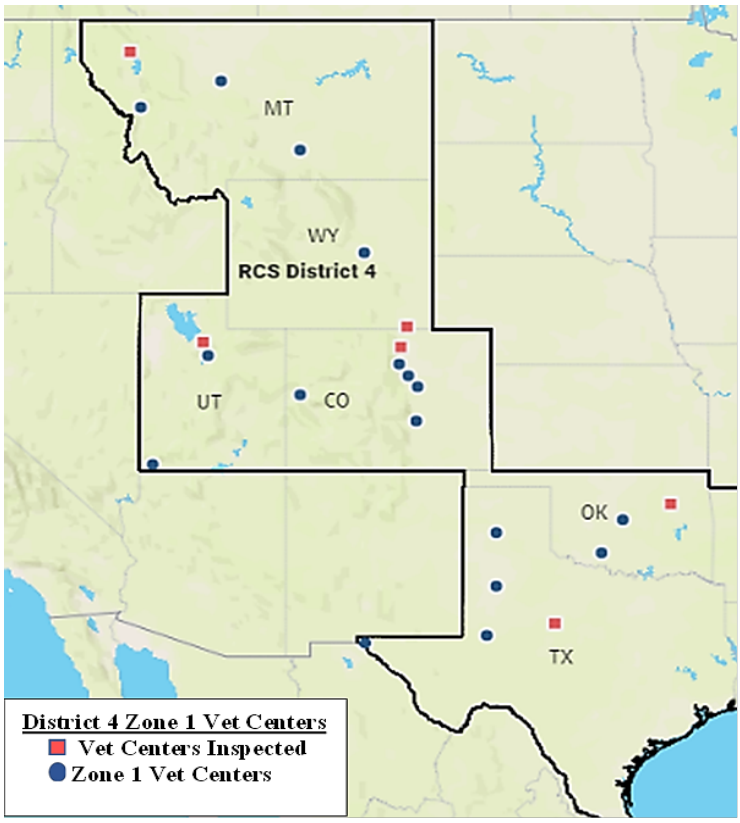

Figure 1. *Map of Continental District 4 zone 1 vet centers, including sites visited by the OIG. Source: OIG using RCS vet center data.*

The OIG review included vet center operations from October 1, 2021, through September 30, 2022, in the following categories:[4]

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

The OIG announced the inspection to district leaders on June 5, 2023, and conducted on-site and virtual visits from June 6 through July 6, 2023.[5] The OIG notified each selected vet center director (VCD) one day prior to the vet center site visit. During the site visits, the OIG

[4] The OIG review period was from October 1, 2021, through September 30, 2022, (fiscal year 2022) unless otherwise noted.

[5] 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.

interviewed VCDs and key staff, reviewed RCS practices and policies, and conducted client record reviews.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leadership if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted 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.

Overall Findings

The OIG reviewed VHA and RCS requirements and below are the inspection findings for the six selected vet centers. For additional details related to specific site findings, select the vet center in the respective review table.

Suicide Prevention

Early identification of clients at high risk for suicide allows for the provision of enhanced services and may prevent ongoing suicidality.[6] In an effort to reduce client risk for suicide, VHA and RCS staff members participate in local VA's (support VA medical facility) mental health executive council meetings to coordinate the care of shared clients.[7]

The High Risk Suicide Flag (HRSF) SharePoint site is part of an RCS national process intended to increase communication and coordination with VHA to ensure identification of clients at risk for suicide and provide resources that may reduce client risk.[8]

In early 2023, the OIG identified problems with the HRSF SharePoint site and issued the following recommendation to the RCS Chief Officer:

> The Readjustment Counseling Service Chief Officer ensures the HRSF SharePoint site functions as intended and includes accurate data.[9]

Despite continued communication with RCS, data concerns persisted because of duplication, inaccuracies, or missing data; therefore, the OIG was unable to evaluate the HRSF SharePoint site dispositions in this review. As of January 5, 2024, RCS leaders reported that an HRSF SharePoint site redesign was in process to address the identified issues.

[6] VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide,* November 1, 2020.

[7] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* November 16, 2015. Each vet center aligns with a support VA medical facility to ensure access to clinical services and coordination of care for shared clients. VA medical centers are required to establish a mental health executive council that supports strategies, communication, and policies to improve mental health care and suicide prevention. VHA Directive 1500(2). RCS requires a licensed vet center staff member attend all support VA medical facility mental health executive council meetings to assist with care coordination and collaboration for clients.

[8] The underlined terms are hyperlinks to another section of the report. To return to the point of origin, press and hold the "alt" and "left arrow" keys together. On May 11, 2020, RCS implemented an HRSF SharePoint site containing names of RCS clients who also receive services at a VA medical facility and have a high risk for suicide flag. In June 2021, the SharePoint site was expanded to include Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) data. VA's REACH VET is a predictive analytics program developed to determine veterans who have a higher risk for suicide.

[9] VA OIG, *Inspection of Southeast District 2 Vet Center Operations*, Report No. 22-03941-144, April 18, 2024.

Table 1. Suicide Prevention Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	Fort Collins Vet Center	Kalispell Vet Center	Tulsa Vet Center	Abilene Vet Center	Salt Lake City Vet Center	Cheyenne Vet Center
A licensed vet center staff member participates in all support VA medical facility mental health executive council meetings.*	✗	✗	✓	✗	✗	✗
VCD ensures client contacts and outcomes are documented in the electronic record and the HRSF SharePoint site within five business days.	NA‡	NA‡	NA‡	NA‡	NA‡	NA‡

Sources: VHA Directive 1500(2); VA Chief Officer, Readjustment Counseling Service (10RCS), "High Risk Suicide Flag Outreach," memorandum to all vet center staff, April 27, 2020; OIG analysis of vet center data.
**The OIG reviewed mental health executive council meeting documentation to evaluate if required vet center staff met the overall compliance rate of 90 percent.*
‡The OIG did not review the HRSF SharePoint site due to concerns with data accuracy.

The VCDs reported the following reasons for noncompliance:

- *Mental health executive council participation:* The Fort Collins, Kalispell, and Abilene VCDs reported being unaware of the reasons the previous VCDs did not attend meetings. The VCDs also spoke to issues with arranging coverage when unable to attend. The Salt Lake City VCD reported attending meetings once per month; however, meetings were held twice per month. The Cheyenne VCD stated the VCD position was vacant for three months with no acting VCD assigned and counseling staff were not aware of the requirement to attend.

The HRSF SharePoint site functionality recommendation directed to the RCS Chief Officer remains open; therefore, the OIG will continue to monitor the progress to closure and not make a new recommendation.

The OIG made one recommendation related to suicide prevention.

Suicide Prevention Recommendation

Recommendation 1

District leaders and the Fort Collins, Kalispell, Abilene, Salt Lake City, and Cheyenne Vet Center Directors collaborate with the support VA medical facility to determine reasons for noncompliance with staff participation on the mental health executive council, take action as indicated, and monitor compliance.

Consultation, Supervision, and Training

Consultation with an independently licensed mental health external clinical consultant increases client access to VA health care and supports vet center counselors with clinically complex or high-risk cases. Supervision provides opportunities for ongoing feedback regarding counselor documentation, case planning, and compliance with RCS guidance and procedures.[10] Mandatory training completion supports a competent and skilled staff to provide services to clients.[11]

Reviewed trainings included:

- Nonclinical staff:
  - Initial or annual S.A.V.E. training[12]
- Clinical Staff:
  - Initial or annual suicide risk management training[13]
  - One-time lethal means safety education and counseling[14]
  - One-time military sexual trauma training[15]
- All staff:
  - Bi-annual basic life support (BLS) certification[16]

[10] VHA Directive 1500(2).

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

[12] 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 a veterans outreach program specialist and program support assistant or office manager.

[13] VA Secretary, Agency-Wide Required Suicide Prevention Training, *memorandum to Under Secretaries, Assistant Secretaries and Other Key Officials*, October 15, 2020; VHA Directive 1071. Suicide risk management training completion 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.

[14] VHA memorandum, *Lethal Means Safety (LMS) Education and Counseling*, March 17, 2022. Lethal Means Safety 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.

[15] VHA Directive 1115.01 (1), *Military Sexual Trauma Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017, amended May 8, 2020. Military sexual trauma training completion is required within 90 days of entering the position for clinical providers or "a provider must have completed the assigned training program (or passed the test-out, if applicable) in TMS, [Talent Management System], or have time remaining until the assignment due date."

[16] VHA Directive 1177, *Cardiopulmonary Resuscitation,* January 4, 2021. Any VA healthcare provider actively participating in direct patient care must maintain BLS certification.

Table 2. Consultation, Supervision, and Training Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	Fort Collins Vet Center	Kalispell Vet Center	Tulsa Vet Center	Abilene Vet Center	Salt Lake City Vet Center	Cheyenne Vet Center
Consultation: Assignment of a clinical liaison.	✓	✓	✓	✓	✓	✓
Consultation: Assignment of an independently licensed mental health external clinical consultant.	✓	✓	✓	✓	✓	✓
Consultation: Completion of four hours of monthly external clinical consultation for clinically complex cases.	✗	✓	✗	✗	✗	✗
Supervision: VCD monthly review of 10 percent of active client records for each counselor's caseload.	✗	✓	✓	✗	✗	✓
Training: Staff completion of select trainings in the required time frame.*	✗	✗	✗	✗	✗	✗

Sources: VHA Directive 1500(2); VHA Directive 1052; VHA Directive 1115.01(1); VHA Memorandum, Lethal Means Safety Education and Counseling; VA Memorandum, Agency-Wide Required SP Training; VHA Directive 1071; OIG analysis of vet center results.
**The OIG reviewed training records or BLS card copies and had findings with recommendations if one or more training elements were noncompliant.*

The OIG found the six vet centers had an assigned clinical liaison and independently licensed mental health external clinical consultant.

The VCDs reported the following reasons for noncompliance:

- *Completion of required four hours of monthly external clinical consultation:* The Fort Collins and Cheyenne VCDs reported external clinical consultation occurred; however, because the VCD positions were vacant, encounters were not documented. The Tulsa, Abilene, and Salt Lake City VCDs reported the requirement was met but the VCDs were unable to provide documentation.
- *Completion of monthly 10 percent record review:* The Fort Collins VCD reported obtaining counselor caseload data the month prior to conducting audits; therefore, the OIG was unable to validate 10 percent of the counselor caseloads for one of three months reviewed. The Abilene VCD was unable to provide evidence of completed chart reviews and reported that the tracking document had been inadvertently deleted. The Salt Lake City VCD reported not completing one month of reviews due to a client crisis event.

- *Completion of select staff trainings:* The Tulsa and Cheyenne VCDs reported not ensuring completion of required training was an oversight. The Kalispell, Abilene, and Salt Lake City VCDs reported not being aware of required trainings and that trainings were not entered into the VA training application. The Fort Collins VCD reported belief that the completed incorrect military sexual trauma training met the requirement.

The OIG made three recommendations related to consultation, supervision, and training.

Consultation, Supervision, and Training Recommendations

Recommendation 2

District leaders and the Fort Collins, Tulsa, Abilene, Salt Lake City, and Cheyenne Vet Center Directors determine reasons for noncompliance with completing four hours of external clinical consultation for clinically complex cases per month, ensure a process is implemented, and monitor compliance.

Recommendation 3

District leaders and the Fort Collins, Abilene, and Salt Lake City Vet Centers Directors determine reasons for noncompliance with Vet Center Directors review of 10 percent of active client records monthly for each counselor's caseload, ensure completion, and monitor compliance.

Recommendation 4

District leaders and the Fort Collins, Kalispell, Tulsa, Abilene, Salt Lake City, and Cheyenne Vet Center Directors determine reasons for noncompliance with employees completing select trainings in the required time frame, ensure completion, and monitor compliance.

Outreach

A tailored written outreach plan addresses the unique demographics and needs of veterans in the specific service area. The outreach plan identifies events to engage eligible clients and their families and distinguishes relevant community partners and stakeholders.[17]

[17] VHA Directive 1500(2).

Table 3. Outreach Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	Fort Collins Vet Center	Kalispell Vet Center	Tulsa Vet Center	Abilene Vet Center	Salt Lake City Vet Center	Cheyenne Vet Center
Presence of a written outreach plan.	✓	✓	✓	✓	✓	✓
Inclusion of required outreach plan strategic components.*	✗	✗	✗	✗	✗	✗
Outreach activities tailored to cultural orientations.	✓	✓	NA‡	NA‡	NA‡	✓

Sources: VHA Directive 1500(2); OIG analysis of vet center results.
**The OIG reviewed outreach plan requirements including a strategic map of the vet center service area identifying local eligible population concentrations, strategic coordination with mobile vet center operations, background information regarding cultural orientation of local communities, personal points of contact for non-VA and VA service providers, and identification of all strategic VA medical facility partners.*
‡NA indicates the OIG did not evaluate whether outreach activities were tailored to community demographics because the cultural orientations component was not included in the plan.

The OIG found the six vet centers had an outreach plan.

The VCDs reported the following reasons for noncompliance:

- *Inclusion of required strategic components:* The VCDs of all six selected vet centers reported being unaware of the requirement for strategic components to be included in the outreach plan.

The OIG made one recommendation related to outreach.

Outreach Recommendation

Recommendation 5

District leaders and the Fort Collins, Kalispell, Tulsa, Abilene, Salt Lake City, and Cheyenne Vet Center Directors determine reasons for noncompliance with completion of an outreach plan with all required strategic components, ensure completion, and monitor compliance.

Environment of Care

Safety in the physical environment is essential for promoting effective therapeutic work and requires adherence to general safety and emergency preparedness standards.[18]

Table 4. Environment of Care Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	Fort Collins Vet Center	Kalispell Vet Center	Tulsa Vet Center	Abilene Vet Center	Salt Lake City Vet Center	Cheyenne Vet Center
Fire or safety inspection completed annually.	NA*	✓	✓	✓	✓	✗
Risk and vulnerability assessment completed annually by VA police or local law enforcement.	NA*	✓	NA‡	✗	✓	✗
Fire extinguishers inspected monthly.	✗	✗	✓	✓	✓	✓
Fire extinguishers serviced annually.	✓	✓	✓	✓	✗	✓
Automated external defibrillator (AED) located on-site.	✓	✓	✓	✓	✓	✓
AED inspected monthly.	✗	✗	✓	✗	✗	✗
AED serviced annually by VA medical center biomedical engineering.	✓	✓	✓	✓	✗	✓
Building evacuation plan posted in a communal area for staff and visitors to reference.	✓	✓	✓	✓	✓	✗

[18] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

✓ Compliant ✗ Noncompliant **RCS Requirement**	Fort Collins Vet Center	Kalispell Vet Center	Tulsa Vet Center	Abilene Vet Center	Salt Lake City Vet Center	Cheyenne Vet Center
Emergency and crisis plan with required components.[§]	✓	✓	✓	✓	✓	✓
Desktop reference sheet outlining steps for ancillary office staff to follow in case of a suicidal or homicidal client.[‖]	✗	✓	✓	✓	✓	✓

Sources: RCS, Administrative Site Visit Protocol; RCS, *Vet Center Clinical Site Visit (CSV) Report: Procedural Background Information; OIG analysis of vet center results.*

[*]*The Fort Collins Vet Center had ongoing construction; therefore, the VCD was unable to schedule the annual fire or safety inspection and risk and vulnerability assessment.*

[‡]*The Tulsa Vet Center relocated to a new building on April 1, 2023, and had not completed an annual risk and vulnerability assessment at the time of the OIG inspection.*

[§]*The OIG evaluated that the plan had been reviewed or updated within two years of the date of inspection. The emergency and crisis plan includes the following components: contingencies for phone and computer disruptions; weather or natural disaster emergency plan; site, facility, or building temporary relocation plan; management of disruptive behavior plan; violence in the workplace plan (including active shooter plan); and handling of suspicious mail and bomb threats.*

[‖]*Vet center ancillary office staff includes a veterans outreach program specialist and program support assistant or office manager.*

The OIG found the six vet centers had AEDs on-site and emergency and crisis plans.

The VCDs reported the following reasons for noncompliance:

- *Fire or safety inspection completed annually:* The Cheyenne VCD reported the last inspection was completed in June 2021 and was unaware of the annual inspection requirement.
- *Risk and vulnerability assessment completed annually:* The Abilene VCD reported making multiple requests to schedule the assessment and the VA medical facility did not respond. The Cheyenne VCD reported contacting the VA police department to schedule an assessment and was erroneously informed an assessment had been completed.
- *Fire extinguisher inspected monthly:* The Fort Collins VCD reported the VCD position was vacant in March 2023 and was unaware of why there was no fire extinguisher documentation. The Kalispell VCD reported prioritizing tasks, other than the monthly fire extinguisher inspections, until the month prior to the OIG inspection.
- *Fire extinguishers serviced annually:* The Salt Lake City VCD reported being unaware of the requirement to service fire extinguishers annually.

- *AED inspected monthly:* The Fort Collins, Kalispell, Abilene, Salt Lake City, and Cheyenne VCDs reported being unaware of the requirement to inspect AEDs monthly.
- *AED serviced annually:* The Salt Lake City VCD reported being unaware of annual AED servicing requirements.
- *Evacuation plan*: The Cheyenne VCD reported being unaware that a plan was required.
- *Desktop reference sheet:* The Fort Collins VCD reported vet center staff were provided desktop reference sheets; however, during the on-site inspection, an ancillary staff member could not produce the document.

The OIG made eight recommendations related to environment of care.

Environment of Care Recommendations

Recommendation 6

District leaders and the Cheyenne Vet Center Director determine reasons for noncompliance with completion of an annual fire or safety inspection, ensure completion, and monitor compliance.

Recommendation 7

District leaders and the Abilene and Cheyenne Vet Center Directors determine reasons for noncompliance with having an annual risk and vulnerability assessment completed by VA police or local law enforcement, ensure completion, and monitor compliance.

Recommendation 8

District leaders and the Fort Collins and Kalispell Vet Center Directors determine reasons for noncompliance with monthly fire extinguisher inspections, ensure completion, and monitor compliance.

Recommendation 9

District leaders and the Salt Lake City Vet Center Director determine reasons for noncompliance with annual fire extinguisher servicing, ensure completion, and monitor compliance.

Recommendation 10

District leaders and the Fort Collins, Kalispell, Abilene, Salt Lake City, and Cheyenne Vet Center Directors determine reasons for noncompliance with monthly automated external defibrillator inspections, ensure completion, and monitor compliance.

Recommendation 11

District leaders and the Salt Lake City Vet Center Director determine reasons for noncompliance with annual automated external defibrillator servicing by VA medical center biomedical engineering, ensure completion, and monitor compliance.

Recommendation 12

District leaders and the Cheyenne Vet Center Director determine reasons for noncompliance with building evacuation plans posted in a communal area for staff and visitors, ensure completion, and monitor compliance.

Recommendation 13

District leaders and the Fort Collins Vet Center Director determine reasons for noncompliance with a desktop reference sheet outlining steps for ancillary office staff to follow in case of a suicidal or homicidal client, ensure completion, and monitor compliance.

Appendix A

This section presents an overview of each selected vet center along with inspection results. For an overview of all results see Overall Findings.

Fort Collins Vet Center

The Fort Collins Vet Center serves clients throughout Colorado, Nebraska, and Wyoming and is supported by the Cheyenne VA Medical Center. The vet center's outreach plan indicated approximately 419,199 veterans reside in the veteran service area, which includes the F.E. Warren Air Force Base. The VCD highlighted the availability of year-round care via telehealth to a large number of clients who spend the winter months in Arizona.

For compliant element findings, please see findings related to Suicide Prevention; Consultation, Supervision, and Training; Outreach; and Environment of Care.

Table A.1. Fiscal Year 2022 Vet Center Profile

Profile	Fort Collins Vet Center
Budget	$743,589.96
Total Unique Clients	319
New Clients	56
Active Duty Clients	1
Bereavement Clients	7
Family Clients	37
Total Number of Positions	
Total Authorized Full-time Positions	7
Total Filled Positions	4
Total Vacancies	3

Source: RCS data.

Identified Deficiencies

Suicide Prevention

Mental health executive council participation: Vet center staff did not participate in the support VA medical facility's mental health executive council for 2 of 10 monthly meetings held during the review period.

Consultation, Supervision, and Training

External clinical consultation hours: Counselors did not receive four hours of external clinical consultation for 5 of the 12 months reviewed.

Completion of monthly 10 percent record review: The VCD did not perform record reviews for the last three months of the review period for one counselor and fell below the required 10 percent for two of three counselor record reviews.

Staff training:

- One of two clinical staff did not complete military sexual trauma training.

Outreach

Outreach plan: The outreach plan was missing one required strategic component: identification of VA medical facility partners.

Environment of Care

Fire extinguisher inspection: Of the three months reviewed, two fire extinguishers were missing one monthly inspection.[19]

AED inspection: AED inspections were not completed for all three months reviewed.

Desktop reference sheet: During the on-site inspection, one ancillary staff member could not produce the desktop reference sheet.

[19] The vet center had a total of four fire extinguishers, two fire extinguishers were new at the time of inspection (June 2023) and did not have prior monthly inspections and therefore were not included in the review.

Kalispell Vet Center

The Kalispell Vet Center serves clients throughout Northwest Montana and is supported by the Fort Harrison VA Medical Center. The vet center's outreach plan indicated approximately 18,500 veterans reside in the veteran service area, which includes local National Guard and reserve units. The VCD highlighted the vet center staff's hard work in providing minimal disruption to client care despite vacant counselor positions.

For compliant element findings, please see findings related to Suicide Prevention; Consultation, Supervision, and Training; Outreach; and Environment of Care.

Table A.2. Fiscal Year 2022 Vet Center Profile

Profile	Kalispell Vet Center
Budget	$727,566.67
Total Unique Clients	427
New Clients	113
Active Duty Clients	5
Bereavement Clients	44
Family Clients	70
Total Number of Positions	
Total Authorized Full-time Positions	7
Total Filled Positions	6
Total Vacancies	1

Source: RCS data.

Identified Deficiencies

Suicide Prevention

Mental health executive council participation: Of the nine meetings held during the 12 months, vet center staff attended eight.

Consultation, Supervision, and Training

Staff training:

- One of two clinical staff did not complete military sexual trauma training.

Outreach

Outreach plan: The outreach plan was missing two required strategic components: personal points of contact for non-VA service providers and identification of VA medical facility partners.

Environment of Care

Fire extinguisher inspection: Of the three months reviewed, all four fire extinguishers were missing two monthly inspections.

AED inspection: AED inspections were missing for two of the three months reviewed.

Tulsa Vet Center

The Tulsa Vet Center serves clients throughout 30 counties in Northern and Southern Oklahoma and is supported by the Eastern Oklahoma VA Health Care System also known as Jack C. Montgomery VA Medical Center. The vet center's outreach plan indicated approximately 108,322 veterans reside in the veteran service area, which includes the Broken Arrow Armed Forces Reserve Center, 138th Fighter Wing – Tulsa, and Camp Gruber. The VCD highlighted the vet center's relationship with a local quilting organization that makes quilts for each client the vet center connects with. For compliant element findings, please see findings related to Suicide Prevention; Consultation, Supervision, and Training; Outreach; and Environment of Care.

Table A.3. Fiscal Year 2022 Vet Center Profile

Profile	Tulsa Vet Center
Budget	$710,095.92
Total Unique Clients	348
New Clients	110
Active Duty Clients	8
Bereavement Clients	9
Family Clients	58
Total Number of Positions	
Total Authorized Full-time Positions	7
Total Filled Positions	6
Total Vacancies	1

Source: RCS data.

Identified Deficiencies

Consultation, Supervision, and Training

External clinical consultation hours: The VCD was unable to provide documentation to support four hours of consultation for 2 of the 12 months reviewed.

Staff training:

- One of four clinical staff did not complete suicide risk management training.
- One of four clinical staff did not complete military sexual trauma training.

Outreach

Outreach plan: The outreach plan was missing five required strategic components: a strategic map identifying local eligible population concentrations (provided only a geographic map of the veteran service area), background information regarding cultural orientations, personal points of contact for non-VA community service providers (although provided in a separate document), VA medical facility partners (although provided as a separate document), and strategic coordination with mobile vet center operations.

Abilene Vet Center

The Abilene Vet Center serves clients throughout 26 counties in Texas but served 28 counties previously and is supported by the George H. O'Brien, Jr. VA Medical Center. The vet center's fiscal year 2022 outreach plan indicated approximately 43,916 veterans reside in the veteran service area, which includes Dyess Air Force base and local reserve units. The VCD highlighted the vet center's relationships with the Chamber of Commerce, Military Affairs Committee, and Dyess Air Force Base with the latter leading to approximately 25 percent of vet center clients being on active duty.

Table A.4. Fiscal Year 2022 Vet Center Profile

Profile	Abilene Vet Center
Budget	$616,505.31
Total Unique Clients	238
New Clients	113
Active Duty Clients	76
Bereavement Clients	6
Family Clients	36
Total Number of Positions	
Total Authorized Full-time Positions	5
Total Filled Positions	5
Total Vacancies	0

Source: RCS data.

For compliant element findings, please see findings related to Suicide Prevention; Consultation, Supervision, and Training; Outreach; and Environment of Care.

Identified Deficiencies

Suicide Prevention

Mental health executive council participation: Vet center staff did not participate in the support VA medical facility's mental health executive council for two of four quarterly meetings during the review period.

Consultation, Supervision, and Training

External clinical consultation hours: Counselors did not receive four hours of external clinical consultation for 10 of the 12 months reviewed.

Completion of monthly 10 percent record review: Of the three months reviewed, the VCD had no evidence of one month's record review for a clinical staff member.

Staff training:

- All three clinical staff did not complete suicide risk management training.
- One of three clinical staff did not complete lethal means safety education and counseling.
- Two of three clinical staff did not complete military sexual trauma training.
- One of five staff did not complete BLS training.

Outreach

Outreach plan: The outreach plan was missing three required strategic components: background information regarding cultural orientations, personal points of contact for non-VA community service providers, and identification of VA medical facility partners.

Environment of Care

Risk and vulnerability assessment: The support VA medical facility police service or local law enforcement had not completed an annual risk and vulnerability assessment since January 2019.

AED inspection: AED inspections were not completed for all three months reviewed.

Salt Lake City Vet Center

The Salt Lake City Vet Center serves clients in Salt Lake County up through Northern Utah and parts of Nevada and Wyoming and is supported by the George E. Wahlen VA Medical Center. The vet center's outreach plan indicated approximately 79,000 veterans reside in veteran service area, which includes Hill Airforce Base. The VCD highlighted the counseling staff's ability to manage high caseloads by taking a team approach in providing client care.

Table A.5. Fiscal Year 2022 Vet Center Profile

Profile	Salt Lake City Vet Center
Budget	$771,941.69
Total Unique Clients	733
New Clients	226
Active Duty Clients	26
Bereavement Clients	19
Family Clients	157
Total Number of Positions	
Total Authorized Full-time Positions	10
Total Filled Positions	9
Total Vacancies	1

Source: RCS data.

For compliant element findings, please see findings related to Suicide Prevention; Consultation, Supervision, and Training; Outreach; and Environment of Care.

Identified Deficiencies

Suicide Prevention

Mental health executive council participation: The VCD reported participating in the support VA medical facility's mental health executive council monthly meetings but was unable to provide evidence of attendance for 7 of the 12 months reviewed.

Consultation, Supervision, and Training

External clinical consultation hours: Counselors did not receive four hours of external clinical consultation for 4 of the 12 months reviewed.

Completion of monthly 10 percent record review: The VCD did not perform record reviews for at least 10 percent of the cases for one of the three months reviewed.

Staff training:

- None of the three staff completed BLS training.

Outreach

Outreach plan: The outreach plan was missing four required strategic components: a strategic map identifying local eligible population concentrations, background information regarding

cultural orientation of local communities, personal points of contact for non-VA service providers, and identification of VA medical facility partners.

Environment of Care

Fire extinguisher servicing: Fire extinguishers were not serviced annually.

AED inspection and servicing: Monthly AED inspections and annual servicing were not completed.

Cheyenne Vet Center

The Cheyenne Vet Center serves clients throughout nine counties in Wyoming and is supported by the Cheyenne VA Medical Center. The vet center's outreach plan indicated approximately 21,000 veterans reside in the veteran service area, which includes the F.E. Warren Air Force Base. The VCD highlighted assisting the Ogden and Fort Collins Vet Centers and the Casper Outstation to provide client care related to staffing shortages.

Table A.6. Fiscal Year 2022 Vet Center Profile

Profile	Cheyenne Vet Center
Budget	$522,211.52
Total Unique Clients	163
New Clients	42
Active Duty Clients	18
Bereavement Clients	19
Family Clients	21
Total Number of Positions	
Total Authorized Full-time Positions	5
Total Filled Positions	5
Total Vacancies	0

Source: RCS data.

For compliant element findings, please see findings related to Suicide Prevention; Consultation, Supervision, and Training; Outreach; and Environment of Care.

Identified Deficiencies

Suicide Prevention

Mental health executive council participation: Vet center staff did not participate in the support VA medical facility's mental health executive council for 4 of the 10 monthly meetings.

Consultation, Supervision, and Training

External clinical consultation hours: Counselors did not receive four hours of external clinical consultation for 8 of the 12 months reviewed.

Staff training:

- The one nonclinical staff reviewed did not complete S.A.V.E. training.
- One of four staff did not complete BLS training.

Outreach

Outreach plan: The outreach plan was missing one required strategic component – identification of VA medical facility partners.[20]

Environment of Care

Fire or safety inspection: An annual fire or safety inspection was not completed since June 2021.

Risk and vulnerability assessment: VA police or local law enforcement did not complete an annual risk and vulnerability assessment.

AED inspection: Monthly AED inspections were not completed for the three months reviewed.

Building evacuation plan posted: Building evacuation plans were not posted in communal areas.

[20] Strategic VA medical facility partners did not include contact names, phone numbers, or email addresses identifying specific individuals.

Appendix B: RCS Chief Readjustment Counseling Officer Memorandum

Department of Veterans Affairs Memorandum

Date: June 27, 2024

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

Subj: Inspection of Select Vet Centers in Continental District 4 Zone 1

To: Director, Office of Healthcare Inspections, Vet Center Inspection Program (VC00)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL 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 Continental District 4 Zone 1. 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

[OIG comment: The OIG received the above memorandum from VHA on July 1, 2024.]

Appendix C: RCS Continental District 4 Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 27, 2024

From: Carrie Crownover, Continental District 4 (RCS4)

Subj: Inspection of Select Vet Centers in Continental District 4 Zone 1

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 4 Zone 1.

2. I reviewed the draft report and request closure of all recommendations. District leaders and Vet Center Directors took action to resolve concerns identified during the District 4 Zone 1 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*:)

Carrie Crownover
District Director

[OIG comment: The OIG received the above memorandum from VHA on July 1, 2024.]

District Director Response

Recommendation 1

District leaders and the Fort Collins, Kalispell, Abilene, Salt Lake City, and Cheyenne Vet Center Directors collaborate with the support VA medical facility to determine reasons for noncompliance with staff participation on the mental health executive council, take action as indicated, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Request Closure.

Director Comments

Vet Center Directors (VCD) were not consistent with staff participation on the Mental Health Executive Council (MHEC). District 4 Zone 1 leadership provided education to VCDs and ongoing reminders to meet this requirement. District 4 has developed a compliance tracker for all Vet Centers. The Fort Collins, Kalispell, Abilene, Salt Lake City, and Cheyenne Vet Centers have consistently participated and documented in the Oversight tracker. Leadership verified Oversight tracker entries monthly and logged the compliance into the tracker. The district confirms compliance during the annual clinical site visits. The district office has provided the last three months, demonstrating each of these Vet Centers maintained consistent participation.

OIG Comments

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

Recommendation 2

District leaders and the Fort Collins, Tulsa, Abilene, Salt Lake City, and Cheyenne Vet Center Directors determine reasons for noncompliance with completing four hours of external clinical consultation for clinically complex cases per month, ensure a process is implemented, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Request Closure.

Director Comments

VCDs were not consistently documenting external consultation hours. District 4 Zone 1 leadership provided education to VCDs and ongoing reminders to meet this requirement. These VCDs have completed four hours of external consultation and documented it in the Oversight Tracker. District 4 developed a compliance tracker for all Vet Centers, where leadership confirms entries in the Oversight Tracker and records the compliance monthly. The district confirms compliance during the annual clinical site visit. The district office has provided the last three months, and each of these Vet Centers were compliant.

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 Fort Collins, Abilene, and Salt Lake City Vet Centers Directors determine reasons for noncompliance with Vet Center Directors review of 10 percent of active client records monthly for each counselor's caseload, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Request Closure.

Director Comments

VCDs were not consistently reviewing the correct number of active client records. District 4 Zone 1 leadership provided education to VCDs on accurately calculating the number of client records to audit each month. District 4 established a compliance tracker for all Vet Centers, where leadership confirms monthly compliance. The district office has provided the last three months, and each of these Vet Centers were compliant.

OIG Comments

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

Recommendation 4

District leaders and the Fort Collins, Kalispell, Tulsa, Abilene, Salt Lake City, and Cheyenne Vet Center Directors determine reasons for noncompliance with employees completing select trainings in the required time frame, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Request Closure.

Director Comments

In fiscal year (FY) 2023, these Vet Centers did not meet full compliance with mandatory staff training. District leadership instructed VCDs to ensure completion of mandatory staff trainings. Vet Center staff training is documented in the Talent Management System (TMS) and tracked locally by Vet Center Directors. District 4 established a compliance tracker for all Vet Centers, where leadership continues to confirm compliance. All staff at these Vet Centers are compliant with mandatory training.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 5

District leaders and the Fort Collins, Kalispell, Tulsa, Abilene, Salt Lake City, and Cheyenne Vet Center Directors determine reasons for noncompliance with completion of an outreach plan with all required strategic components, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Request Closure.

Director Comments

In FY 2022, these Vet Centers did not include all required strategic components in the outreach plans. District 4 Zone 1 leadership provided instruction for creating an outreach plan to incorporate all components listed in VHA Directive 1500(4) Appendix B. On May 15, 2024, Readjustment Counseling Service promulgated an outreach plan template that aligns with the required strategic components. These Vet Centers have established an updated outreach plan in June 2024.The VCDs track compliance locally, and the district confirms compliance during the annual clinical site visit.

OIG Comments

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

Recommendation 6

District leaders and the Cheyenne Vet Center Director determine reasons for noncompliance with completion of an annual fire or safety inspection, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Request Closure.

Director Comments

In FY 2023, the Cheyenne Vet Center did not have the required fire or safety inspections. District 4 Zone 1 leadership provided instruction and confirmed this Vet Center had an inspection completed in FY 2023 and FY 2024. The VCD will track compliance locally and the district will confirm compliance during annual administrative site visits.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 7

District leaders and the Abilene and Cheyenne Vet Center Directors determine reasons for noncompliance with having an annual risk and vulnerability assessment completed by VA police or local law enforcement, ensure completion and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Request Closure.

Director Comments

The Abilene and Cheyenne Vet Centers did not have an annual risk and vulnerability assessment completed. District 4 Zone 1 leadership provided instruction to VCDs. District leadership confirmed Abilene Vet Center is current with their assessment. Cheyenne Vet Center received an assessment in FY 2023. The VCDs will track compliance locally and the district will confirm compliance during annual administrative site visits.

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 Fort Collins and Kalispell Vet Center Directors determine reasons for noncompliance with monthly fire extinguisher inspections, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Request Closure.

Director Comments

The Fort Collins and Kalispell Vet Centers were not consistently conducting monthly inspections of fire extinguishers. District 4 Zone 1 leadership provided instruction to VCDs on inspecting and documenting. District leadership has begun sending automatic reminders each month to complete fire extinguisher inspections. VCDs or designated staff member complete the inspection, and VCDs track compliance locally on the fire extinguisher tag. District leadership confirmed these Vet Centers have been inspecting monthly and will continue to monitor. Additionally, the district monitors during annual administrative site visits.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 9

District leaders and the Salt Lake City Vet Center Director determine reasons for noncompliance with annual fire extinguisher servicing, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Request Closure.

Director Comments

This Vet Center did not have their fire extinguisher serviced in FY23, at the time of the inspection. District 4 Zone 1 leadership provided instruction on servicing fire extinguishers

annually. Salt Lake City relocated in June 2024, and the VCD has ensured compliance at the new location. The district will continue to monitor during annual administrative site visits.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 10

District leaders and the Fort Collins, Kalispell, Abilene, Salt Lake City, and Cheyenne Vet Center Directors determine reasons for noncompliance with monthly automated external defibrillator inspections, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Request Closure.

Director Comments

In FY 2023, these Vet Centers were not consistently conducting monthly automated external defibrillator (AED) inspections. District 4 Zone 1 leadership provided instruction to VCDs on inspecting and documenting. The Salt Lake City Vet Center's VCD was provided instruction upon onboarding in March 2024 and has since been consistently inspecting their AED. District leadership has begun sending automatic reminders each month to complete AED inspections. VCDs or designated staff member complete the inspection, and VCDs are tracking compliance locally on the AED log. District leadership confirmed these Vet Centers have been inspecting monthly, and the district verifies monthly monitoring during the annual administrative site visit.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 11

District leaders and the Salt Lake City Vet Center Director determine reasons for noncompliance with annual automated external defibrillator servicing by VA medical center biomedical engineering, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Request Closure.

Director Comments

The Salt Lake City Vet Center did not receive an annual service in FY 2022 on the AED. They received guidance from Biomedical Engineering at the George E. Wahlen VA Medical Center indicating "maintenance testing is unnecessary," as the AED onsite conducts daily self-test to ensure its readiness for use. An initial inspection was conducted in FY 2020, prior to assigning the AED to its designated location. VCD will continue to verify annually with VA Medical Center, and the district will confirm compliance during the annual administrative site visit.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 12

District leaders and the Cheyenne Vet Center Director determine reasons for noncompliance with building evacuation plans posted in a communal area for staff and visitors, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Request Closure.

Director Comments

The Cheyenne Vet Center did not have building evacuation plans posted in communal areas during the Vet Center Inspection Program visit in June 2023. District 4 Zone 1 leadership provided instruction. The VCD has established and posted building evacuation plans in communal areas for staff and visitors. VCD will continue to ensure compliance locally, and district confirms compliance during the annual administrative site visit.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 13

District leaders and the Fort Collins Vet Center Director determine reasons for noncompliance with a desktop reference sheet outlining steps for ancillary office staff to follow in case of a suicidal or homicidal client, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Request Closure.

Director Comments

The Fort Collins Vet Center was not in compliance with ensuring all ancillary staff had a desktop reference sheet. District 4 Zone 1 leadership provided instruction. The VCD has made corrections to ensure all staff have the crisis desktop reference sheet available at their phones. The VCD monitors ongoing compliance locally, and the district confirms compliance during the annual clinical and administrative site visits.

OIG Comments

The OIG considers this recommendation closed.

Glossary

To go back, press "alt" and "left arrow" keys.

automated external defibrillator. Is "an electronic device that applies an electric shock to restore the rhythm of a fibrillating heart."[21] It is "a sophisticated, yet easy-to-use, medical device that can analyze the heart's rhythm and, if necessary, deliver an electrical shock, or defibrillation, to help the heart to re-establish an effective rhythm."[22]

clinical liaisons. Are mental health professionals assigned by the support VA medical facility who assist the VCD in coordinating care and suicide prevention activities and making referrals for support VA medical facility-shared clients.[23]

independently licensed mental health external clinical consultants. Are assigned by the support VA medical facility to provide vet center counseling staff with a minimum of four hours per month of consultation for clinically complex cases.[24]

High Risk Suicide Flag (HRSF) SharePoint site. Lists names of RCS clients identified by VA medical facilities as high risk. VCDs are required to review the HRSF SharePoint site monthly to identify clients who receive or have received vet center services in the past 12 months to determine whether client contact is needed, and if appropriate, complete follow-up.

outreach plan. A written strategic document developed for the unique demographic distributions of eligible individuals within that vet center's service area. The outreach plan identifies specific outreach locations and events that will allow vet center staff to directly provide eligible individuals and families with information about vet center services. Additionally, the outreach plan identifies local service providers, within the VA and non-VA, to establish referral networks for vet center clients. Outreach plans are updated annually.[25]

[21] *Merriam Webster.com Dictionary*, "defibrillator," accessed August 8, 2022, Defibrillator Definition & Meaning - Merriam-Webster.

[22] *American Red Cross*, "AED," accessed August 8, 2022, https://www.redcross.org/take-a-class/aed/using-an-aed/what-is-aed.

[23] VHA Directive 1500(2).

[24] VHA Directive 1500(2).

[25] VHA Directive 1500(2).

OIG Contact and Staff Acknowledgments

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