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 2

VCIP Report	22-04108-235	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 2: Fayetteville, Arkansas; New Orleans, Louisiana; Jackson, Mississippi; and Corpus Christi, Fort Worth, and San Antonio Northeast, Texas.[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 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 two of the 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. On April 18, 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]

Incidental Finding

During suicide prevention client record review, the OIG identified concerns related to accuracy, duplication, and lack of substantive content in progress notes.

The OIG issued one recommendation to a vet center specific to documentation.

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, none of the vet center leaders ensured at least four hours of external clinical consultation per month for clinically complex cases.[6] Two 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 centers 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. One of the three plans did not include outreach activities tailored to specific cultural orientations.[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: fire or safety inspection completed annually, fire extinguisher annual service, automated external defibrillator (AED) located on-site, AED serviced annually, and a building evacuation plan posted in a communal area.[12] Of the six vet centers,

- one did not have a risk and vulnerability assessment completed by VA police or local law enforcement;
- one was noncompliant with the monthly fire extinguisher inspection;
- three were noncompliant with monthly AED inspections;

[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.*

- one had an emergency and crisis plan; however, the plan did not have all the required components; and
- four did not have a desktop reference sheet for ancillary staff to follow in case of a suicidal or homicidal client.[13]

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

Conclusion

The OIG conducted a focused inspection in four review areas and made 11 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 5, 6, 7, 8, 9, and 11 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

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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
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

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.[2] 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.

Scope and Methodology

The OIG randomly selected district 4 and the following vet centers in zone 2 for review: Fayetteville, Arkansas; New Orleans, Louisiana; Jackson, Mississippi; and Corpus Christi, Fort Worth, and San Antonio Northeast, Texas (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 considered 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.

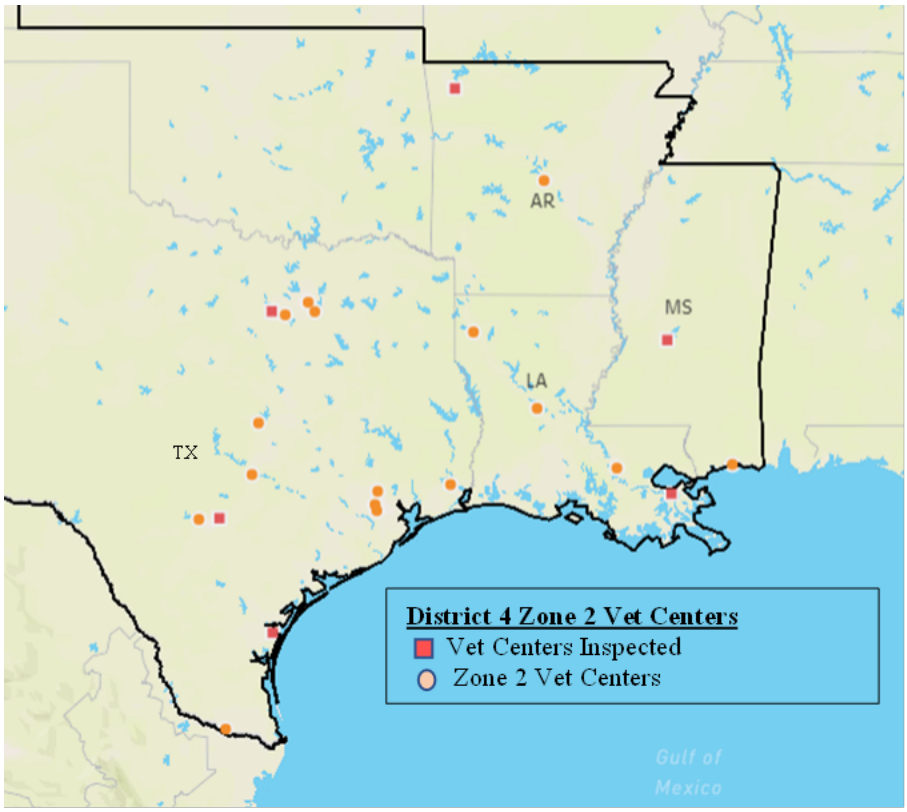

Figure 1. *Map of Continental District 4 zone 2 vet centers, including sites visited by the OIG. Source: OIG using RCS vet center data.*

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 through July 13, 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 interviewed VCDs and key staff, reviewed RCS practices and policies, and conducted client record reviews.

[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.

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.

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[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**	Fayetteville Vet Center	New Orleans Vet Center	Jackson Vet Center	Corpus Christi Vet Center	Fort Worth Vet Center	San Antonio Northeast 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 meetings 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 Jackson VCD was unaware a licensed staff member was required to attend the meetings. The Corpus Christi VCD was not on staff during the review period and could not provide documentation of staff attendance.[10]

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.

[10] The general inspection review period was from October 1, 2021, through September 30, 2022. During this time, the Corpus Christi Vet Center had an acting VCD from April 12, 2021, through March 13, 2023, who was unavailable to participate in inspection interviews. The current VCD was hired on March 12, 2023, approximately three months prior to the OIG inspection, and had limited knowledge of the prior processes. The former district 4 zone 2 Associate District Director for Counseling participated in interviews but had limited knowledge of specific issues related to the Corpus Christi Vet Center during that time frame.

Suicide Prevention Recommendations

Recommendation 1

District leaders and the Jackson and Corpus Christi 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.

Incidental Finding

Documentation containing inaccuracies, duplication, and sparse content can negatively affect coordination of care and limit vet center staff's understanding of a client's needs, progress in treatment, presenting safety concerns, and readiness for discharge.

Table 2. Fort Worth Vet Center Incidental Finding

RCS Requirement	Finding
Documentation standards met*	During the Fort Worth Vet Center suicide prevention client record review, the OIG identified concerns related to accuracy, duplication, and lack of substantive content in progress notes.

Sources: VHA Directive 1500(2); OIG analysis of vet center results.
**RCS requires progress notes to contain substantive counseling content, relevant parts of the counseling contact, and interventions and expected counseling outcomes. RCS also requires progress notes to contain the counselor's observations, the client's case progress, and the counselor's plan to therapeutically address the client's readjustment problems.*

The OIG made one recommendation related to this incidental finding.

Recommendation 2

District leaders and the Fort Worth Vet Center Director determine reasons for noncompliance with Readjustment Counseling Service documentation standards, ensure completion, 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.[11] Mandatory training completion supports a competent and skilled staff to provide services to clients.[12]

[11] VHA Directive 1500(2).

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

Reviewed trainings included:

- Nonclinical staff:
  - Initial or annual S.A.V.E. training[13]
- Clinical Staff:
  - Initial or annual suicide risk management training[14]
  - One-time lethal means safety education and counseling[15]
  - One-time military sexual trauma training[16]
- All staff:
  - Biannual basic life support (BLS) certification[17]

[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, *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.

[14] 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.

[15] 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.

[16] 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."

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

Table 3. Consultation, Supervision, and Training Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	Fayetteville Vet Center	New Orleans Vet Center	Jackson Vet Center	Corpus Christi Vet Center	Fort Worth Vet Center	San Antonio Northeast 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 Fayetteville VCD reported consultation was not completed and was unable to provide additional details as to why. The New Orleans and Corpus Christi VCDs reported the missed consultation meetings occurred prior to being assigned as VCDs and were unable to provide additional details. The Jackson VCD reported consultation meetings were canceled and not rescheduled. The Fort Worth VCD reported consultation hours were not completed due to staff or external clinical consultant being on leave, and in some instances, consultation occurred but was not documented. The San Antonio Northeast VCD reported ending consultation meetings early when all cases were reviewed despite

being aware of the four-hour monthly requirement, and not rescheduling meetings canceled by the external clinical consultant.

- *Completion of monthly 10 percent record review:* The Jackson VCD reported not rounding up the total number of record reviews to meet the requirement. The San Antonio Northeast VCD reported not completing one month of record reviews for a staff member due to an error in the VCD's record review process.
- *Completion of select staff trainings:* The New Orleans, Jackson, Fort Worth, and San Antonio Northeast VCDs reported not being aware of which training courses met the requirements. The Jackson and San Antonio VCDs reported trainings were not assigned to staff learning plans in the VA training application. The Fayetteville VCD reported not having a good reason why training was not done. The Corpus Christi VCD and former District 4 associate district director for counseling were unable to provide a reason why training was not completed.

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

Consultation, Supervision, and Training Recommendations

Recommendation 3

District leaders and the Fayetteville, New Orleans, Jackson, Corpus Christi, Fort Worth, and San Antonio Northeast 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 4

District leaders and the Jackson and San Antonio Northeast Vet Center 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 5

District leaders and the Fayetteville, New Orleans, Jackson, Corpus Christi, Fort Worth, and San Antonio Northeast 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.[18]

Table 4. Outreach Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	Fayetteville Vet Center	New Orleans Vet Center	Jackson Vet Center	Corpus Christi Vet Center	Fort Worth Vet Center	San Antonio Northeast 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 the outreach plan requirements including a strategic map of the vet center service area identifying local eligible population concentrations, strategic coordination with mobile vet center (MVC) 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 Fayetteville, New Orleans, Jackson, Fort Worth, and San Antonio Northeast VCDs were unaware of the required outreach plan components. The Corpus Christi VCD and former District 4 Zone 2 associate district director for counseling were unable to provide a reason why outreach requirements were not included.
- *Outreach Activities:* The Fayetteville VCD was unaware of the requirement to have outreach activities related to veteran cultural orientation.

[18] VHA Directive 1500(2).

The OIG made one recommendation related to outreach.

Outreach Recommendation

Recommendation 6

District leaders and the Fayetteville, New Orleans, Jackson, Corpus Christi, Fort Worth, and San Antonio Northeast 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.[19]

Table 5. Environment of Care Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	Fayetteville Vet Center	New Orleans Vet Center	Jackson Vet Center	Corpus Christi Vet Center	Fort Worth Vet Center	San Antonio Northeast Vet Center
Fire or safety inspection completed annually.	✓	✓	✓	✓	✓	✓
Risk and vulnerability assessment completed annually by VA police or local law enforcement.	✗	✓	✓	✓	✓	✓
Fire extinguishers inspected monthly.	✓	✗	✓	✓	NA*	✓
Fire extinguishers serviced annually.	✓	✓	✓	✓	✓	✓
Automated external defibrillator (AED) located on-site.	✓	✓	✓	✓	✓	✓
AED inspected monthly.	✓	✗	✗	✗	✓	✓

[19] 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**	Fayetteville Vet Center	New Orleans Vet Center	Jackson Vet Center	Corpus Christi Vet Center	Fort Worth Vet Center	San Antonio Northeast Vet Center
AED serviced annually by VA medical center biomedical engineering.	✓	✓	✓	✓	✓	NA‡
Building evacuation plan posted in a communal area for staff and visitors to reference.	✓	✓	✓	✓	✓	✓
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 OIG was unable to determine whether the Fort Worth Vet Center fire extinguisher monthly checks were completed during the review period. In May 2023, the extinguishers were serviced and the servicer removed the old monthly check tags.*

‡The OIG did not review this element because the AED was new and did not require annual servicing until March 2024.

§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 a fire or safety inspection, annual fire extinguisher servicing, AEDs on-site, annual AED servicing, and posting of evacuation plans.

The VCDs reported the following reasons for noncompliance:

- *Risk and vulnerability assessment completed annually:* The Fayetteville VCD reported that a risk and vulnerability assessment was completed during the review period but was unable to provide evidence.
- *Fire extinguisher inspected monthly:* The New Orleans VCD was unaware the building maintenance department did not complete monthly fire extinguisher inspections for the months reviewed.

- *AED inspected monthly:* The New Orleans VCD did not have a process in place to complete monthly checks of the AED. The Jackson VCD reported being unaware of the requirement to inspect the AED monthly. The Corpus Christi VCD could not provide evidence of monthly inspections because the tracking document was discarded.
- *Emergency and crisis plan with all components:* The Fayetteville VCD reported being unaware the fiscal year 2023 plan did not contain the required sections. The Fort Worth VCD was unaware that the emergency and crisis plan must contain an active shooter plan.
- *Desktop reference sheet:* The Fayetteville VCD reported giving the ancillary staff a copy of the desktop reference. The Corpus Christi VCDs reported not verifying that ancillary staff's offices had copies of the desktop reference sheet. The Fort Worth and San Antonio Northeast VCDs reported being unaware of the requirement prior to the OIG inspection.

The OIG made five recommendations related to environment of care.

Environment of Care Recommendations

Recommendation 7

District leaders and the Fayetteville Vet Center Director 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 New Orleans Vet Center Director determine reasons for noncompliance with monthly fire extinguisher inspections, ensure completion, and monitor compliance.

Recommendation 9

District leaders and the New Orleans, Jackson, and Corpus Christi Vet Center Directors determine reasons for noncompliance with monthly automated external defibrillator inspections, ensure completion, and monitor compliance.

Recommendation 10

District leaders and the Fayetteville and Fort Worth Vet Center Directors determine reasons for noncompliance with having an emergency and crisis plan that includes required components, ensure completion, and monitor compliance.

Recommendation 11

District leaders and the Fayetteville, Corpus Christi, Fort Worth, and San Antonio Northeast Vet Center Directors 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.

Fayetteville Vet Center

The Fayetteville Vet Center serves clients throughout 13 counties within Northwest Arkansas and is supported by the Fayetteville VA Medical Center. The vet center's outreach plan indicated approximately 58,081 veterans reside in the veteran service area, which includes Arkansas Air and Army National Guard units and a US Army Reserve unit. The VCD highlighted several outdoor groups for veterans, including hiking and fishing.

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	Fayetteville Vet Center
Budget	$737,456.40
Total Unique Clients	373
New Clients	123
Active Duty Clients	6
Bereavement Clients	9
Family Clients	56
Total Number of Positions	
Total Authorized Full-time Positions	7
Total Filled Positions*	8
Total Vacancies	0

Source: RCS data
**For a brief period in FY 2022 there was an overlap, which put the facility in excess.*

Identified Deficiencies

Consultation, Supervision, and Training

External clinical consultation hours: Counselors did not receive four hours of external clinical consultation for 3 of the 12 months reviewed.

Staff training:

- One of three clinical staff did not complete suicide risk management training.
- One of three clinical staff did not complete military sexual trauma training.
- All five staff did not complete BLS training.

Outreach

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

and strategic coordination with mobile vet center (MVC) operations. The outreach plan did not include outreach activities tailored to cultural orientations.[20]

Environment of Care

Risk and vulnerability assessment: The VA police service or local law enforcement had not completed an annual risk and vulnerability assessment since 2021.

Emergency and Crisis Plan: The emergency and crisis plan did not contain the phone and computer contingency plan, weather and natural disaster plan, temporary relocation plan, disruptive behavior plan, and the workplace violence and active shooter plan.

Desktop reference sheet: Staff were unable to provide a desktop reference sheet during the OIG on-site inspection.

[20] Strategic VA medical facility partners did not include clinical and administrative liaisons, external clinical consultant, suicide prevention coordinator, or the facility contact for prevention and management of disruptive behavior. Outreach activities were not tailored to cultural orientations identified in the outreach plan.

New Orleans Vet Center

The New Orleans Vet Center serves clients throughout 13 parishes in Louisiana and is supported by the New Orleans VA Medical Center. The vet center's outreach plan indicated approximately 84,663 veterans reside in the veteran service area, which according to the VCD includes the Marine Corps Support Facility and Naval Air Station Joint Reserve Base. The VCD reported due to the location of the New Orleans Vet Center, large festivals negatively affected veterans by preventing them from accessing the location. The VCD highlighted the use of virtual appointments instead of in-person visits on these days.

Table A.2. Fiscal Year 2022 Vet Center Profile

Profile	New Orleans Vet Center
Budget	$579,320
Total Unique Clients	235
New Clients	52
Active Duty Clients	6
Bereavement Clients	7
Family Clients	11
Total Number of Positions	
Total Authorized Full-time Positions	7
Total Filled Positions	6
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

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:

- Two of five clinical staff did not complete suicide risk management training.
- One of five clinical staff did not complete military sexual trauma training.
- Two of seven staff members did not complete BLS training.

Outreach

Outreach plan: The outreach plan was missing five required strategic components: a map of the veteran service area identifying local eligible population concentrations, background information regarding cultural orientations, personal points of contact for non-VA community service

providers, identification of VA medical facility partners, and strategic coordination with MVC operations.[21]

Environment of Care

Fire extinguisher inspection: The New Orleans Vet Center had two fire extinguishers. Of the three months reviewed, one fire extinguisher was missing one and the other fire extinguisher was missing two of the monthly inspections.

AED inspection: The VCD did not have a process in place to complete monthly checks of the AED.

[21] Strategic VA medical facility partners did not include clinical and administrative liaisons, external clinical consultants, suicide prevention coordinators, or the facility contact for prevention and management of disruptive behavior.

Jackson Vet Center

The Jackson Vet Center serves clients throughout 50 counties in Mississippi and is supported by the G.V. (Sonny) Montgomery VA Medical Center. The vet center's outreach plan indicated approximately 91,218 veterans reside in the veteran service area, which includes the 172 Airlift Wing, Joint Forces Headquarters, and Camp Shelby. The VCD highlighted the use of virtual appointments and phone calls to keep clients engaged.

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	Jackson Vet Center
Budget	$512,763
Total Unique Clients	308
New Clients	44
Active Duty Clients	3
Bereavement Clients	4
Family Clients	17
Total Number of Positions	
Total Authorized Full-time Positions	7
Total Filled Positions	5
Total Vacancies	2

Source: RCS data.

Identified Deficiencies

Suicide Prevention

Mental health executive council participation: The VCD attended all mental health executive council meetings held during the review period. However, the VCD was not a licensed mental health staff member; therefore, did not meet the requirement.

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 complete a record review of at least 10 percent of active counseling records for one counselor for two out of the three months and another counselor for one out of the three months.

Staff training:

- One of two clinical staff did not complete suicide risk management training.
- One of two clinical staff did not complete lethal means safety education and counseling training.

Outreach

Outreach plan: The outreach plan was missing one required strategic component: identification of VA medical facility partners.[22]

Environment of Care

AED inspection: Of the three months reviewed, monthly AED inspections were not completed.

[22] Strategic VA medical facility partners did not include clinical and administrative liaisons, external clinical consultants, suicide prevention coordinators, or the facility contact for prevention and management of disruptive behavior.

Corpus Christi Vet Center

The Corpus Christi Vet Center serves clients throughout 15 counties in southeast Texas and is supported by the Harlingen VA Clinic. The vet center's outreach plan indicated approximately 46,960 veterans reside in the veteran service area, which includes several Naval Air Stations. The Corpus Christi VCD highlighted that a Veteran Service Officer was on-site at the vet center five days per week to offer benefits assistance.[23]

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

Table A.4. Fiscal Year 2022 Vet Center Profile

Profile	Corpus Christi Vet Center
Budget	$457,933.92
Total Unique Clients	300
New Clients	42
Active Duty Clients	8
Bereavement Clients	42
Family Clients	34
Total Number of Positions	
Total Authorized Full-time Positions	6
Total Filled Positions	6
Total Vacancies	0

Source: RCS data.

Identified Deficiencies

Suicide Prevention

Mental health executive council participation: The support VA medical facility's mental health executive council meetings occurred quarterly; however, the VCD was unable to provide documentation confirming staff participation.

Consultation, Supervision, and Training

External clinical consultation hours: Counselors did not receive four hours of external clinical consultation for 3 of 12 months reviewed. The external clinical consultant was unavailable during the weekly scheduled meeting one week of each of these three months.

Staff training:

- The one nonclinical staff reviewed did not complete S.A.V.E. training.[24]
- One of two clinical staff did not complete suicide risk management training.

[23]Veteran service officers are accredited by the VA to serve as representatives to veterans to ensure claimants have access to responsible and qualified representation on their VA benefits.

[24] VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training*, May 11, 2022.

- One of two clinical staff did not complete lethal means safety education and counseling training.

Outreach

Outreach plan: The outreach plan was missing four required strategic components: a map of the veteran service area identifying local eligible population concentrations, 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

AED inspection: Of the three months reviewed, the VCD did not have evidence confirming completion of monthly AED inspections.

Desktop reference sheet: Staff were unable to provide a desktop reference sheet during the OIG on-site inspection.

Fort Worth Vet Center

The Fort Worth Vet Center serves clients throughout nine counties in Texas and is supported by the Dallas VA Medical Center. The vet center's outreach plan indicated approximately 190,468 veterans reside in the veteran service area, which includes the Naval Air Station Joint Reserve Base. The Fort Worth VCD highlighted the counseling services provided by the vet center to local military installations.

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

Table A.5. Fiscal Year 2022 Vet Center Profile

Profile	Fort Worth Vet Center
Budget	$723,854
Total Unique Clients	426
New Clients	117
Active Duty Clients	8
Bereavement Clients	27
Family Clients	34
Total Number of Positions	
Total Authorized Full-time Positions	7
Total Filled Positions	7
Total Vacancies	0

Source: RCS data.

Identified Deficiencies

Incidental Finding

During the Fort Worth Vet Center suicide prevention client record review, the OIG identified concerns related to accuracy, duplication, and lack of substantive content in progress notes.

Consultation, Supervision, and Training

External clinical consultation hours: Counselors did not receive four hours of external clinical consultation for 2 of the 12 months reviewed.

Staff training:

- One of two nonclinical staff did not complete S.A.V.E. training.
- Four of five clinical staff did not complete suicide risk management training.
- Three of five clinical staff did not complete lethal means safety education and counseling training.
- Four of seven staff did not complete BLS training.

Outreach

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

Environment of Care

Emergency and crisis plan: The emergency and crisis plan did not include a contingency for violence in the workplace, including an active shooter plan.

Desktop reference sheet: Ancillary staff did not have the desktop reference sheet during the OIG inspection.

San Antonio Northeast Vet Center

The San Antonio Northeast Vet Center serves clients throughout 10 counties, mostly to the east of San Antonio and is supported by the Audie L. Murphy Memorial Veterans' Hospital. The vet center's outreach plan indicated approximately 198,598 veterans reside in the veteran service area, which includes Army and Air Force bases, per the VCD. The VCD reported the staff utilized the MVC to offer counseling at the Uvalde school shooting.[25]

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

Table A.6. Fiscal Year 2022 Vet Center Profile

Profile	San Antonio Northeast Vet Center
Budget	$729,125.91
Total Unique Clients	735
New Clients	208
Active Duty Clients	32
Bereavement Clients	16
Family Clients	68
Total Number of Positions	
Total Authorized Full-time Positions	8
Total Filled Positions	7
Total Vacancies	1

Source: RCS data.

Identified Deficiencies

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 complete record reviews of at least 10 percent of active counseling records for one staff member during the last three months of the review period.

Staff training:

- Three of five clinical staff did not complete suicide risk management training.
- One of five clinical staff did not complete the lethal means safety education and counseling training.
- One of five clinical staff did not complete military sexual trauma training within the required time frame.

[25] On May 24, 2022, a mass shooting took place at an elementary school in Uvalde, Texas, which is within the San Antonio Vet Center catchment area.

Outreach

Outreach plan: The outreach plan was missing three required strategic components: personal points of contact for non-VA community service providers, identification of VA medical facility partners, and strategic coordination with MVC operations.

Environment of Care

Desktop reference sheet: Staff were unable to provide a desktop reference sheet during the OIG on-site inspection.

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 2

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 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

[OIG comment: The OIG received the above memorandum from VHA on June 27, 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 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 4 Zone 2.

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

Carrie Crownover
District Director

[OIG comment: The OIG received the above memorandum from VHA on June 27, 2024.]

District Director Response

Recommendation 1

District leaders and the Jackson and Corpus Christi 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: Requesting Closure.

Director Comments

Vet Center Directors (VCD) were not consistent with staff participation on the Mental Health Executive Council (MHEC). District 4 Zone 2 leadership provided education to VCDs and ongoing reminders to meet this requirement. District 4 has since developed a compliance tracker for all Vet Centers. The Jackson and Corpus Christi 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. The district will continue to confirm compliance during annual clinical site visits.

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 Worth Vet Center Director determine reasons for noncompliance with Readjustment Counseling Service documentation standards, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: December 31, 2024

Director Comments

Documentation at the Fort Worth Vet Center was not compliant with Readjustment Counseling Service documentation standards. On June 17, 2024, district leadership provided the VCD at the Fort Worth Vet Center additional education regarding the content requirements for Data, Assessment, Plan (DAP) notes. Additionally, district leadership in conjunction with the VCD are creating a staff training for the Fort Worth Vet Center counseling staff that will include DAP note templates, as well as examples of notes that do meet Readjustment Counseling Service documentation standards. The VCD will review progress notes during the required 10% chart audit for each Readjustment Counselor's caseload. In order to ensure compliance and staff understanding of the requirements, the Associate District Director for Counseling (ADD/C) will increase monitoring. The Deputy District Director (DDD) will meet with the VCD monthly to review compliance.

Recommendation 3

District leaders and the Fayetteville, New Orleans, Jackson, Corpus Christi, Fort Worth, and San Antonio Northeast 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: Requesting Closure.

Director Comments

VCDs were not consistently documenting external consultation. District 4 Zone 2 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 office has provided the last three months, and each of these Vet Centers were compliant. The district will continue to confirm compliance during annual clinical site visits.

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 Jackson and San Antonio Northeast Vet Center 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: Requesting Closure.

Director Comments

VCDs were not consistently reviewing the correct number of active client records. District 4 Zone 2 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. The district will continue to confirm compliance during annual clinical site visits.

OIG Comments

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

Recommendation 5

District leaders and the Fayetteville, New Orleans, Jackson, Corpus Christi, Fort Worth, and San Antonio Northeast 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: Requesting Closure.

Director Comments

In fiscal year (FY) 2023, these Vet Centers did not meet full compliance for 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 confirms compliance. All staff at these Vet Centers are compliant with mandatory training.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 6

District leaders and the Fayetteville, New Orleans, Jackson, Corpus Christi, Fort Worth, and San Antonio Northeast 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: Requesting Closure.

Director Comments

In FY 2022, these Vet Centers did not include all required strategic components in the outreach plans. District 4 Zone 2 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 closed.

Recommendation 7

District leaders and the Fayetteville Vet Center Director 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: Requesting Closure.

Director Comments

The Fayetteville Vet Center did not have an annual risk and vulnerability assessment completed. District 4 Zone 2 leadership provided instruction, and the Vet Center had an assessment

completed 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 closed.

Recommendation 8

District leaders and the New Orleans Vet Center Director determine reasons for noncompliance with monthly fire extinguishers inspections, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Requesting Closure.

Director Comments

The New Orleans Vet Center was not ensuring completion of monthly inspections for fire extinguishers. District 4 Zone 2 leadership provided instruction to the VCD. The lessor completes all monthly fire extinguisher inspections at the New Orleans Vet Center. District leadership has begun sending automatic reminders each month to ensure inspections have been completed. VCD is tracking compliance locally by reviewing the fire extinguishers tag. District leadership confirmed the Vet Center's fire extinguishers have been inspected monthly, and the district will continue to monitor during annual administrative site visits.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 9

District leaders and the New Orleans, Jackson, and Corpus Christi 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: Requesting Closure.

Director Comments

In FY 2023, these Vet Centers were not consistently conducting monthly automated external defibrillator (AED) inspections. District 4 Zone 2 leadership provided instruction to VCDs on inspecting and documenting. 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 will continue to monitor during annual administrative site visits.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 10

District leaders and the Fayetteville and Fort Worth Vet Center Directors determine reasons for noncompliance with having an emergency and crisis plan that includes required components, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Requesting Closure.

Director Comments

These Vet Centers did not have an emergency and crisis plan that included required components. District 4 Zone 2 leadership provided instruction to establish a comprehensive plan with those components. The Fayetteville and Fort Worth Vet Centers have updated their plans for FY 2024. The VCDs track compliance locally, and the district confirms compliance during the annual clinical and administrative site visits.

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 Fayetteville, Corpus Christi, Fort Worth, and San Antonio Northeast Vet Center Directors 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: Requesting Closure.

Director Comments

These Vet Centers did not have a desktop reference sheet available for ancillary office staff to use in case of a suicidal or homicidal client. District 4 Zone 2 leadership provided instruction for maintaining a desktop reference sheet by their phones. District leadership confirmed these Vet Centers have the reference sheet onsite for ancillary office staff. 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. "An electronic device that applies an electric shock to restore the rhythm of a fibrillating heart."[1] 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."[2]

clinical liaison. 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 shared VA medical facility clients.[3]

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.

independently licensed mental health external clinical consultants. Are assigned by the VA support medical facility to provide vet center counseling staff with a minimum of four hours per month of consultation for clinically complex cases.[4]

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.[5]

[1] *Merriam Webster.com Dictionary*, "defibrillator," accessed August 8, 2022, https://www.merriam-webster.com/dictionary/defibrillator?src=search-dict-box.

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

[3] VHA Directive 1500(2).

[4] VHA Directive 1500(2).

[5] VHA Directive 1500(2).

OIG Contact and Staff Acknowledgments

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