US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Inspection of Select Vet Centers in Pacific District 5 Zone 1

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Report Overview

The VA Office of Inspector General (OIG) Vet Center Inspection Program's (VCIP's) purpose is to provide a focused evaluation of the quality of care delivered at vet centers. Vet centers are community-based facilities 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. The inspections evaluate key clinical and administrative processes associated with promoting quality care and service delivery at vet centers.[1]

The OIG inspected four randomly selected vet centers throughout Pacific District 5 zone 1: Anchorage, Alaska; Eugene, Oregon; and Everett and Walla Walla, Washington.[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 should 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(2), *Readjustment Counseling Service*, January 26, 2021, amended December 30, 2021, was in effect during part of the OIG's inspection period. It was amended and replaced by VHA Directive 1500(3), *Readjustment Counseling Service*, January 26, 2021, amended June 5, 2023, which was 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 Readjustment Counseling Service (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 to 26 vet centers.

Review Topics and Inspection Results

Suicide Prevention

The OIG found two of four 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 September 18, 2024, this recommendation remains open; therefore, the OIG will not issue a new recommendation.[5]

Consultation, Supervision, and Training

The OIG found all four vet centers had an assigned clinical liaison and independently licensed mental health external clinical consultant from a support VA medical facility.[6] In addition, all four VCDs completed monthly reviews of 10 percent of each counselor's client records.[7] Although external clinical consultation for clinically complex cases occurred at all four vet

[3] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008, amended November 16, 2015, required VA medical facilities to establish a mental health executive council that supports strategies, communication, and policies to improve mental health care and suicide prevention. Handbook 1160.01 was replaced with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service,* April 27, 2023, which maintains the mental health executive council requirement; however, the purpose was updated to focus on ensuring "the delivery of high-quality Veteran mental health care that is evidence-based and responsive to Veterans' preferences"; VHA Directive 1500(3). RCS requires a licensed vet center staff member to participate on all support VA medical facility mental health executive council meetings to assist with care coordination and collaboration for clients.

[4] 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. In early 2023, the OIG identified problems with the HRSF SharePoint data that made it difficult to determine if follow-up of clients was being conducted as required. Readjustment Counseling Service leaders were notified of the data inaccuracies. . The underlined terms are hyperlinks to a glossary. To return from the glossary, 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. The OIG will continue to monitor RCS's progress on the HRSF SharePoint site functionality recommendation in consideration of closure.

[6] VHA Directive 1500(3). 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(3).

centers, one VCD did not ensure at least four hours of consultation were completed per month.[8] Additionally, staff at three of four vet centers did not complete select required trainings related to suicide prevention, lethal means safety, military sexual trauma, and basic life support.[9]

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

Outreach

The OIG found all four vet centers had outreach plans; however, each lacked one or more required strategic components.[10] The OIG was unable to evaluate if outreach activities were tailored to cultural orientations in one of the four outreach plans because this component was not included in the plan. All three outreach plans that included cultural orientations had documented tailored outreach activities.[11]

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

Environment of Care

The OIG found VA police or local law enforcement completed annual risk and vulnerability assessments at all four vet centers.[12]

The OIG found that of the four vet centers,

- two did not have an annual fire or safety inspection,

[8] VHA Directive 1500(3).

[9] 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; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO), "Lethal Means Safety (LMS) Education and Counseling," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23), Medical Center Directors (00), VISN CMOs (10N1-23), VISN Chief Mental Health Officers (10N1-23), Readjustment Counseling Services (RCS) District Directors, RCS Deputy District Directors VISN CMOs (10N1-23), 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.

[10] VHA Directive 1500(3). 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 the prevention and management of disruptive behavior coordinator.

[11] VHA Directive 1500(3). RCS requires the outreach plan to include cultural orientations. Cultural orientations are defined as ethnic, gender, occupational, and generational, and outreach activities are required to be tailored to the identified orientations.

[12] RCS, *Administrative Site Visit (ASV) Protocol*, accessed on January 23, 2023, from an internal RCS website not publicly accessible.

- two did not have monthly fire extinguisher inspections,
- two did not have annual servicing of all fire extinguishers,
- two did not have a building evacuation plan posted in a communal area,
- two did not have an emergency and crisis plan with required components, and
- three did not have a desktop reference sheet for ancillary office staff to follow in case of a suicidal or homicidal client.[13]

Additionally, one of the four vet centers did not have an automatic external defibrillator (AED) on-site. All three vet centers with an AED on-site had the AED serviced annually by VA medical center biomedical engineering.[14] However, two of the three vet centers with an AED on-site did not have the AED inspected monthly.

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 12 recommendations to the District Director 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.

[13] RCS, *Administrative Site Visit (ASV) Protocol*; RCS, *Vet Center Clinical Site Visit (CSV) Report: Procedural Background Information*, accessed on January 23, 2023, from an internal RCS website not publicly accessible. Vet center ancillary office staff include veterans outreach program specialists and program support assistants or an office manager. The OIG was unable to evaluate AED monthly inspections and annual servicing for the vet center without an AED on-site.

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

VA Comments and OIG Response

The Chief Readjustment Counseling Officer and District Director concurred with the recommendation(s) and provided an acceptable action plan (see appendixes B and C). Based on information provided, the OIG considers all recommendations open and will follow up on the planned actions until they are completed.

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Assistant Inspector General
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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's) 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 facilities 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 5 and the following four vet centers in zone 1 for review: Anchorage, Alaska; Eugene, Oregon; and Everett and Walla Walla, Washington (see figure 1).[3]

[1] VHA Directive 1500(2), *Readjustment Counseling Service*, January 26, 2021, amended December 30, 2021, was in effect during part of the OIG's inspection period. It was amended and replaced by VHA Directive 1500(3), *Readjustment Counseling Service*, January 26, 2021, amended June 5, 2023, which was 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(3). 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 to 26 vet centers.

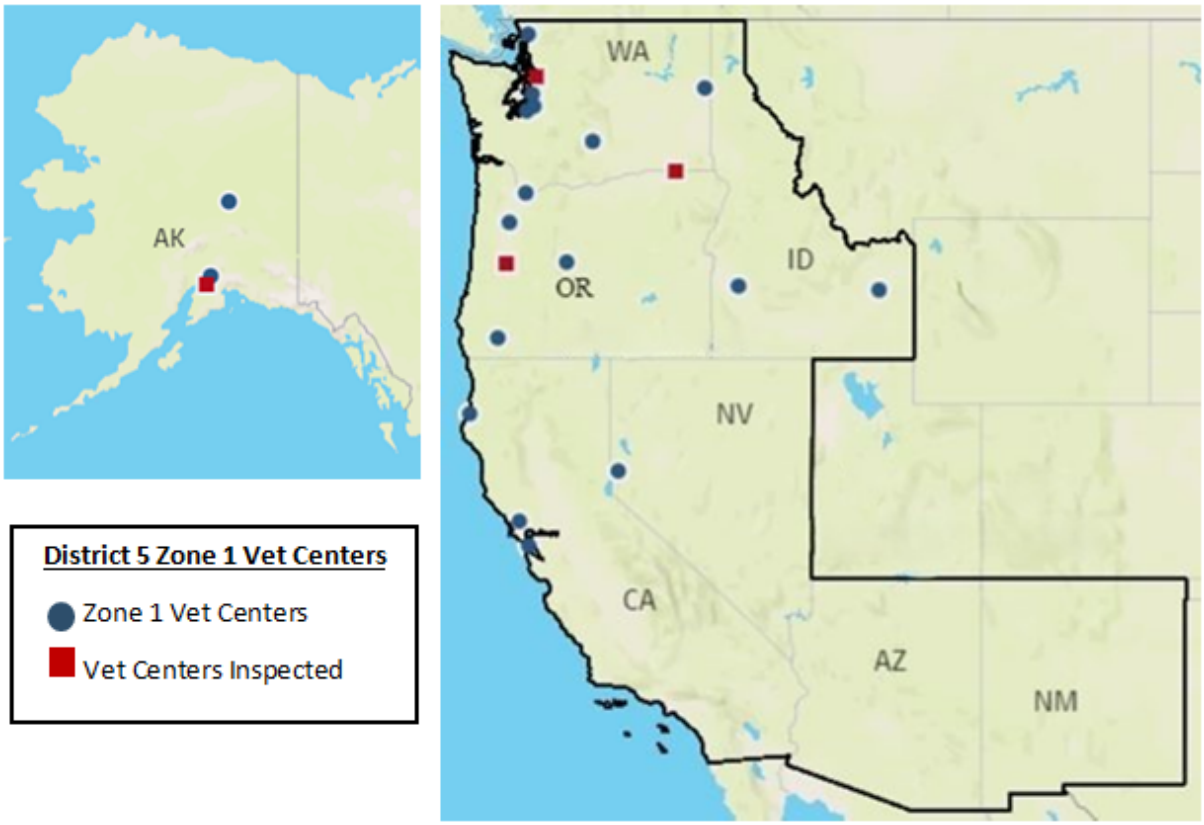

Figure 1. *Map of Pacific District 5 zone 1 vet centers, including sites visited by the OIG.*
Source: OIG using RCS vet center data.

The OIG review included vet center operations from October 1, 2022, through September 30, 2023, in the following categories:[4]

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

The OIG announced the inspection to district leaders on January 29, 2024, and conducted subsequent on-site and virtual visits from January 30, 2024, through February 21, 2024.[5] The OIG notified the selected vet center director (VCD) one day prior to the vet center site visit.

[4] The OIG review period was from October 1, 2022, through September 30, 2023, (fiscal year 2023) 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.

During the site visits, the OIG interviewed VCDs and key staff and reviewed RCS practices and policies.

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 four 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 and enhance care, each vet center aligns with a support VA medical facility.[7] VHA and RCS staff members participate with local VA's (support VA medical facility) mental health executive council meetings to coordinate the care of shared clients.[8]

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.[9]

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.[10]

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 April 19, 2024, RCS leaders reported being on track to

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

[7] VHA Directive 1500(3). Each vet center aligns with a support VA medical facility to ensure access to clinical services and coordination of care for shared clients.

[8] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008, amended November 16, 2015, required VA medical facilities to establish a mental health executive council that supports strategies, communication, and policies to improve mental health care and suicide prevention. Handbook 1160.01 was replaced with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service,* April 27, 2023, which maintains the mental health executive council requirement; however, the purpose was updated to focus on ensuring "the delivery of high-quality Veteran mental health care that is evidence-based and responsive to Veterans' preferences"; VHA Directive 1500(3). RCS requires a licensed vet center staff member participate on all support VA medical facility mental health executive council meetings to assist with care coordination and collaboration for clients.

[9] 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; The underlined terms are hyperlinks to additional information. To return from the linked information, press and hold the "alt" and "left arrow" keys together.

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

determine the cause for HRSF data concerns and to confirm that the HRSF SharePoint site functions as intended with accurate data.

Table 1: Suicide Prevention Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	Anchorage Vet Center	Eugene Vet Center	Everett Vet Center	Walla Walla 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‡

Sources: VHA Directive 1500(3); 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 participated in the meeting.*
‡ *The OIG did not review the HRSF SharePoint site due to concerns with data accuracy.*

In the identified area, the VCDs reported the following explanations for noncompliance:

- *Mental health executive council participation*: The Everett VCD reported being invited to attend the mental health steering committee, which replaced the mental health executive council; however, was unaware of the requirement to attend all scheduled meetings. The Walla Walla VCD believed only VCD participation met the requirement, and no coverage process was in place.

As of September 18, 2024, 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.[11]

The OIG made one recommendation related to suicide prevention.

[11] VA OIG, *Inspection of Southeast District 2 Vet Center Operations*.

Suicide Prevention Recommendation

Recommendation 1

District leaders and the Everett and Walla Walla 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.[12] Mandatory training completion supports a competent and skilled staff to provide services to clients.[13]

Reviewed trainings included:

- Nonclinical staff:
  - Initial or annual S.A.V.E. training[14]
- Clinical Staff:
  - Initial or annual suicide risk management training[15]
  - One-time lethal means safety education and counseling[16]

[12] VHA Directive 1500(3).

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

[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, *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 include veterans outreach program specialist and program support assistant or office manager.

[15] VA Secretary, "Agency-Wide Required Suicide Prevention Training," memorandum; 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. VHA Directive 1071.

[16] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO), "Lethal Means Safety (LMS) Education and Counseling," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23), Medical Center Directors (00), VISN CMOs (10N1-23), VISN Chief Mental Health Officers (10N1-23), Readjustment Counseling Services (RCS) District Directors, RCS Deputy District Directors VISN CMOs (10N1-23), 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.

    - One-time military sexual trauma training[17]
- All staff:
    - Bi-annual basic life support (BLS) certification[18]

[17] 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. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1115.01, *Military Sexual Trauma Mandatory Training Requirements*, July 15, 2024. The two directives contain the same or similar requirements for training. 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."

[18] VHA Directive 1177, *Cardiopulmonary Resuscitation,* January 4, 2021. Any VA healthcare provider actively participating in direct patient care must maintain BLS training. The OIG was informed by an RCS leader that all RCS staff are required to complete BLS training biannually.

Table 2: Consultation, Supervision, and Training Results

✓ Compliant ✗ Noncompliant RCS Requirement	Anchorage Vet Center	Eugene Vet Center	Everett Vet Center	Walla Walla 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(3); VHA Directive 1115.01(1); VHA Memorandum, Lethal Means Safety (LMS) Education and Counseling; VA Memorandum, Agency-Wide Required Suicide Prevention 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 not completed within the required time frame. The OIG evaluated BLS training for all staff and evaluated annual training requirements for staff who had been employed prior to July 1, 2023. The OIG evaluated timeliness for completion of initial trainings for staff hired between October 1, 2022, and June 30, 2023.*

The OIG found all four vet centers had an assigned clinical liaison and independently licensed mental health external clinical consultant. Additionally, all four VCDs completed a monthly review of 10 percent of active client records for each counselor's caseload.

In identified areas, the VCDs reported the following explanations for noncompliance:

- *Completion of required four hours of monthly external clinical consultation:* The Eugene VCD acknowledged a lack of attention to detail in tracking monthly external clinical consultation.
- *Completion of select staff trainings:* The Anchorage VCD reported being aware of the requirement and acknowledged not verifying that staff had completed the correct training. The Eugene and Everett VCDs reported being unaware of staff training requirements.

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

Consultation, Supervision, and Training Recommendations

Recommendation 2

District leaders and the Eugene Vet Center Director 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 Anchorage, Eugene, and Everett 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.[19]

[19] VHA Directive 1500(3).

Table 3: Outreach Results

Compliant / Noncompliant RCS Requirement	Anchorage Vet Center	Eugene Vet Center	Everett Vet Center	Walla Walla Vet Center
Presence of a written current outreach plan.	✓	✓	✓	✓
Inclusion of required outreach plan strategic components.*	✗	✗	✗	✗
Outreach activities tailored to cultural orientations.	✓	NA‡	✓	✓

Sources: VHA Directive 1500(3); 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 service providers, and identification of all strategic VA medical facility partners.*
‡ NA indicates the OIG did not evaluate if outreach activities were tailored to community demographics because the cultural orientations component was not included in the plan.

The OIG found all four vet centers had an outreach plan.

In identified areas, the VCDs reported the following explanations for noncompliance:

- *Inclusion of required strategic components:* The Anchorage VCD described misinterpreting the requirements because the policy was vague. The Everett VCD reported being aware of the outreach plan requirements; however, did not verify inclusion of the required components. The Eugene and Walla Walla VCDs discussed being unaware of all component requirements of the outreach plan.

The OIG made one recommendation related to outreach.

Outreach Recommendation

Recommendation 4

District leaders and the Anchorage, Eugene, Everett, and Walla Walla 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.[20]

Table 4: Environment of Care Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	Anchorage Vet Center	Eugene Vet Center	Everett Vet Center	Walla Walla 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.	✓	✗	✗	✓
Fire extinguishers serviced annually.‡	✓	✗	✗	✓
Automated external defibrillator (AED) located on-site.	✓	✗	✓	✓
AED inspected monthly.	✓	NA*	✗	✗
AED serviced annually by VA medical center biomedical engineering.	✓	NA*	✓	✓
Building evacuation plan posted in communal area for staff and visitors to reference.	✓	✓	✗	✗
Emergency and crisis plan with required components.§	✓	✗	✓	✗

[20] 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. Unless otherwise specified, the requirements in the June 2021 directive contain the same or similar language as the amended September 2023 document. The OIG evaluated compliance of monthly inspections for fire extinguishers and AEDs by reviewing inspection documentation for the three full months prior to district notification. The OIG evaluated the presence of an AED, a building evacuation plan, and a desktop reference during on-site inspections.

✓ Compliant ✗ Noncompliant **RCS Requirement**	Anchorage Vet Center	Eugene Vet Center	Everett Vet Center	Walla Walla Vet Center
Desktop reference sheet outlining steps for ancillary 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 evaluate these requirements due to the vet center not having an AED.*
‡ The OIG considered inspections completed during the current calendar or previous year satisfactory.
§ The OIG evaluated if the plan had been reviewed or updated within two years of the inspection date. The emergency and crisis plan includes 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 include veterans outreach program specialist and program support assistant or office manager.

The OIG found all four vet centers had a risk and vulnerability assessment completed annually by VA police or local law enforcement, and all three sites with an AED had VA medical center biomedical engineering service the AED annually.

In identified areas, the VCDs reported the following explanations for noncompliance:

- *Fire or safety inspection completed annually:* The Everett VCD reported being aware of the requirement but unaware the inspection was not completed. The Walla Walla VCD described ensuring the inspection was completed annually in preparation for the administrative site visit, which did not occur in 2023.
- *Fire extinguisher inspected monthly:* The Eugene VCD reported being aware of the requirement; however, reported there was no oversight process in place to ensure staff completed monthly checks. The Everett VCD discussed not receiving training and therefore, was unaware of the requirement.
- *Fire extinguishers serviced annually:* The Eugene VCD described being aware of the requirement but lacked an oversight process to ensure the requirement was met. The Everett VCD reported being unaware why one fire extinguisher was not serviced.
- *AED located on-site:* The Eugene VCD discussed being unaware of the requirement.

- *AED inspected monthly:* The Everett and Walla Walla VCDs reported being unaware of the requirement.
- *Building evacuation plans posted in communal areas*: The Everett and Walla Walla VCDs stated they had not received specific training related to this requirement and discussed being unaware that a plan was required.
- *Emergency and crisis plan with all components:* The Eugene and Walla Walla VCDs reported being unaware of plan requirements.
- *Desktop reference sheet:* The Eugene VCD acknowledged lacking an oversight process to ensure the desktop reference met requirements and was available to all ancillary staff. The Everett VCD reported having a desktop reference but was unaware of the requirement for the document to be physically available for ancillary office staff use. The Walla Walla VCD reported providing the desktop reference to all staff; however, did not verify the reference remained available.

The OIG made eight recommendations related to environment of care.

Environment of Care Recommendations

Recommendation 5

District leaders and Everett and Walla Walla Vet Center Directors determine reasons for noncompliance with fire or safety annual inspection, ensure completion, and monitor compliance.

Recommendation 6

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

Recommendation 7

District leaders and the Eugene and Everett Vet Center Directors determine reasons for noncompliance with annual fire extinguisher servicing, ensure completion, and monitor compliance.

Recommendation 8

District leaders and the Eugene Vet Center Director determine reasons for noncompliance with having an automated external defibrillator located on-site and ensure compliance with the requirement.

Recommendation 9

District leaders and the Everett and Walla Walla Vet Center Directors determine reasons for noncompliance with monthly automated external defibrillator inspections, ensure completion, and monitor compliance.

Recommendation 10

District leaders and the Everett and Walla Walla Vet Center Directors determine reasons for noncompliance with building evacuation plans posted in a communal area for staff and visitors and ensure compliance with the requirement.

Recommendation 11

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

Recommendation 12

District leaders and the Eugene, Everett, and Walla Walla 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.

Anchorage Vet Center

The VCD reported the Anchorage Vet Center serves clients throughout Anchorage and the boroughs of Kenai Peninsula and Kodiak Island within Alaska, and is supported by the Colonel Mary Louise Rasmuson Campus of the Alaska VA Healthcare System.[21] The VCD reported 24,982 eligible veterans reside in the veteran service area, which includes the Joint Base Elmendorf-Richardson. The VCD highlighted the partnership with the Aleutian Pribilof Island Association which enables the vet center to offer yoga and mind, body, and medicine group classes.

Table A.1. Fiscal Year 2023 Vet Center Profile

Profile	Anchorage Vet Center
Budget	$904,432.04
Total Unique Clients	267
New Clients	70
Active Duty Clients	45
Bereavement Clients	2
Family Clients	31
Total Number of Positions	
Total Authorized Full-time Positions	6
Total Filled Positions	4
Total Vacancies	2

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

Staff training:

- The one nonclinical staff member reviewed did not complete the initial S.A.V.E. training.

[21] "As of July 1, 2019, the state had 19 organized boroughs, which are equivalent to counties in the rest of the United States." "Current Alaska Population Overview," Alaska Department of Labor and Workforce Development, accessed June 17, 2024, http://live.laborstats.alaska.gov/pop/popestpub.html.

Outreach

Outreach plan: The outreach plan was missing three required strategic components: a strategic map identifying local eligible population concentrations, personal points of contact for non-VA service providers, and strategic VA medical facility partners.[22]

[22] Alaska does not have a mobile vet center assigned to any vet centers; therefore, the OIG was not able to evaluate strategic coordination. Strategic VA medical facility partners did not include clinical and administrative liaisons, an external clinical consultant, or the facility contact for prevention and management of disruptive behavior.

Eugene Vet Center

The Veteran Outreach Program Specialist reported the Eugene Vet Center serves clients throughout six counties within Oregon and is supported by the Roseburg VA Health Care System. The VCD reported that 56,330 eligible veterans reside in the veteran service area, which includes the Oregon-based US Coast Guard Air Station in North Bend, the Armed Forces Reserve Center in Springfield, and the Army Reserve Center in Eugene. The VCD highlighted capitalizing on local natural resources through the recent initiation of a program for outdoor exploration, which promotes veterans' well-being.

Table A.2. Fiscal Year 2023 Vet Center Profile

Profile	Eugene Vet Center
Budget	$978,296.53
Total Unique Clients	498
New Clients	77
Active Duty Clients	5
Bereavement Clients	0
Family Clients	40
Total Number of Positions	
Total Authorized Full-time Positions	8
Total Filled Positions	8
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

Consultation, Supervision, and Training

External clinical consultation hours: Four hours of external clinical consultation were not provided for 2 of the 12 months reviewed.

Staff training:

- Four 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 an approved military sexual trauma training.

Outreach

Outreach plan: The outreach plan was missing all required strategic components.[23]

Environment of Care

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

Fire extinguisher servicing: None of the three fire extinguishers were serviced annually.

AED on-site, inspection, and servicing: The vet center did not have an AED; therefore, monthly AED inspections and annual servicing were not completed.

Emergency and crisis plan: The emergency and crisis plan included all required components; however, multiple elements were dated after the announcement of the OIG inspection.

Desktop reference sheet: The desktop reference sheet provided did not outline steps to follow in case of a suicidal or homicidal client. Additionally, one out of two ancillary office staff was unable to provide a desktop reference sheet to the OIG during the on-site inspection.

[23] Strategic VA medical facility partners did not include clinical and administrative liaisons, an external clinical consultant, a suicide prevention coordinator, or the facility contact for prevention and management of disruptive behavior.

Everett Vet Center

The VCD reported the Everett Vet Center serves clients throughout three counties within Washington and is supported by the Seattle VA Medical Center. The VCD reported that 61,332 veterans reside in the veteran service area, which includes the Naval Station Everett, Smokey Point Navy Complex, Armed Forces Building, and the Snohomish Armory. The VCD highlighted that the vet center offers non-traditional groups related to hiking, meditation, and guitars.
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 2023 Vet Center Profile

Profile	Everett Vet Center
Budget	$1,115,334.33
Total Unique Clients	468
New Clients	115
Active Duty Clients	11
Bereavement Clients	5
Family Clients	59
Total Number of Positions	
Total Authorized Full-time Positions	9
Total Filled Positions	8
Total Vacancies	1

Source: RCS data.

Identified Deficiencies

Suicide Prevention

Mental health executive council participation: Of the 23 meetings held in fiscal year 2023, the vet center had representation at 4.

Consultation, Supervision, and Training

Staff training:

- Three of five clinical staff did not complete suicide risk management training.
- One of five clinical staff did not complete military sexual trauma training.
- One of the eight staff members did not complete BLS training.

Outreach

Outreach plan: The outreach plan was missing three required strategic components: a strategic map identifying local eligible population concentrations, personal points of contact for non-VA service providers, and identification of VA medical facility partners.[24]

Environment of Care

Fire or safety inspection: The vet center did not have an annual fire or safety inspection.

Fire extinguisher inspection: Of the three months the OIG reviewed, monthly inspections were not completed on any of the four extinguishers.

Fire extinguisher servicing: One of the four fire extinguishers was not serviced annually.

AED inspection: Of the three months the OIG reviewed, no monthly AED inspections were completed.

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

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

[24] Strategic VA medical facility partners did not include clinical and administrative liaisons, an external clinical consultant, a suicide prevention coordinator, or the facility contact for prevention and management of disruptive behavior.

Walla Walla Vet Center

The VCD reported the Walla Walla Vet Center serves clients throughout 14 counties across southeastern Washington, Northwest Oregon, and central Idaho and is supported by the Jonathan M. Wainwright Memorial VA Medical Center. The VCD reported that 49,724 eligible veterans reside in the veteran service area. The VCD highlighted a close partnership with the Coyote Ridge Correctional Facility and acknowledged expanding this partnership to include the Washington State Penitentiary for fiscal year 2024.

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 2023 Vet Center Profile

Profile	Walla Walla Vet Center
Budget	$798,112.92
Total Unique Clients	464
New Clients	236
Active Duty Clients	12
Bereavement Clients	4
Family Clients	26
Total Number of Positions	
Total Authorized Full-time Positions	5
Total Filled Positions	4
Total Vacancies	1

Source: RCS data.

Identified Deficiencies

Suicide Prevention

Mental health executive council participation: Of the 12 meetings held during the review period, vet center staff participated in 7.

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.[25]

Environment of Care

Fire or safety inspection: An annual fire or safety inspection was not completed since October 2022.

[25] Strategic VA medical facility partners did not include clinical and administrative liaisons, an external clinical consultant, a suicide prevention coordinator, or the facility contact for prevention and management of disruptive behavior.

AED inspection: Of the three months the OIG reviewed, no AED inspections were completed.

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

Emergency and crisis plan: The emergency and crisis plan was not current for relocation, active shooter and violence in the workplace, or handling of bomb threats. Additionally, the plan did not include contingencies for management of disruptive behavior.

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

Appendix B: RCS Chief Readjustment Counseling Officer Memorandum

Department of Veterans Affairs Memorandum

Date: August 14, 2024

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

Subj: Inspection of Select Vet Centers in Pacific District 5 Zone 1

To: Director, Office of Healthcare Inspections, Vet Center Inspection Program (VC00)
Director, GAO/OIG Accountability Liaison (VHA 10B GOAL Action)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, *Inspection of Select Vet Centers in Pacific District 5 Zone 1*. I have reviewed the recommendations and submitted 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 August 14, 2024.]

Appendix C: RCS Pacific District 5 Director Memorandum

Department of Veterans Affairs Memorandum

Date: August 13, 2024

From: Debra Moreno, District 5 Director, Pacific Region, (RCS5)

Subj: Inspection of Select Vet Centers in Pacific District 5

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

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 Readjustment Counseling Service Pacific District 5.

2. District Leaders and Vet Center Directors reviewed the recommendations and have taken actions to resolve concerns identified during the District 5 Zone 1 inspection. Specific actions taken are outlined in the attachments and include evidence of compliance over at least a ninety-day period. District Leaders have also made it a point of emphasis to confirm and validate compliance during annual clinical and administrative site visits.

3. Please express our appreciation to the team for their professionalism and assistance in our continuing efforts to improve the care we provide to our Veterans, Service members and their families.

(*Original signed by*:)

Debra Moreno, MPA
District 5 Director

[**OIG comment:** The OIG received the above memorandum from VHA on August 14, 2024.]

District Director Response

Recommendation 1

District leaders and the Everett and Walla Walla 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

District Leadership provided instruction regarding the requirement to attend the Mental Health Executive Council (MHEC) meeting and track each occurrence. Attendance is also reviewed during monthly Vet Center Director meetings conducted by District Leadership. The Vet Centers track compliance locally and the District confirms compliance during the annual clinical site visit. The Everett and Walla Walla Vet Centers have coordinated with their support VA medical centers to ensure they are on all communications concerning the meeting and are now attending the MHEC.

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 Eugene Vet Center Director 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

District Leadership provided education to the Vet Center on the requirement and proper documentation. The Vet Center Director coordinated with their local VA support facility to ensure the requirement was understood at their facility. The Vet Center will continue to track

compliance locally and the District confirms compliance monthly on the Vet Center's RCSNet Oversight Tracker. The Eugene Vet Center is now consistently completing four hours of external clinical consultation each month.

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 Anchorage, Eugene, and Everett 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

District Leadership provided instruction to Vet Centers to ensure the correct courses were identified for completion. Vet Center staff training is documented in the Talent Management System (TMS) and tracked locally by Vet Center Directors. Compliance is confirmed by the District during the annual administrative site visit. All staff at these three Vet Centers are compliant with mandatory training outlined in the OIG Report.

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 Anchorage, Eugene, Everett, and Walla Walla 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

District Leadership provided instruction for creating an outreach plan and templates that 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. Vet Centers have provided updated outreach plans which complies with the standards. 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 5

District leaders and Everett and Walla Walla Vet Center Directors determine reasons for noncompliance with fire or safety annual inspection, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Requesting closure.

Director Comments

District Leadership provided instructions and the Vet Centers followed up with their VAMC support facility to get the appropriate inspections completed. These inspections have been accomplished at both locations and Vet Centers Directors will ensure these inspections are completed on an annual basis.

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 Eugene and Everett Vet Center Directors determine reasons for noncompliance with monthly fire extinguisher inspections, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Requesting closure.

Director Comments

District Leadership provided instruction to Vet Centers and developed a monitoring log for monthly fire extinguisher inspections. The Vet Center Director will track compliance locally and the District Leadership will confirm compliance during the annual administrative site visit. These Vet Centers are now consistently completing the monthly inspections of their fire extinguishers.

OIG Comments

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

Recommendation 7

District leaders and the Eugene and Everett Vet Center Directors determine reasons for noncompliance with annual fire extinguisher servicing, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Requesting closure.

Director Comments

District Leadership provided instruction and have confirmed that the Eugene Vet Center had their annual inspection completed. The Eugene Vet Center Director tracks compliance locally and the District confirms compliance during the annual administrative site visit.

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 Eugene Vet Center Director determine reasons for noncompliance with having an automated external defibrillator located on-site and ensure compliance with the requirement.

_X _Concur

____Nonconcur

Target date for completion: Requesting closure.

Director Comments

District Leadership communicated the requirement to all Vet Centers in District 5 to have an AED on-site. The Eugene Vet Center requested an AED on March 25, 2024, and it was delivered and installed on April 3, 2024. The District office confirmed the installation of the AED on April 5, 2024.

OIG Comments

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

Recommendation 9

District leaders and the Everett and Walla Walla 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

District Leadership provided instruction to Vet Centers and developed a monitoring log for monthly AED inspections. Vet Center Directors track compliance locally and compliance is reviewed during the annual administrative site visit. The Everett and Walla Walla Vet Centers are now consistently completing monthly inspections of their AED.

OIG Comments

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

Recommendation 10

District leaders and the Everett and Walla Walla Vet Center Directors determine reasons for noncompliance with building evacuation plans posted in a communal area for staff and visitors and ensure compliance with the requirement.

_X _Concur

____Nonconcur

Target date for completion: Requesting closure.

Director Comments

District Leadership provided instructions and Vet Center Directors established and posted building evacuation plans in communal areas for staff and visitors. The Vet Center Directors verified compliance locally and the District Leadership confirmed compliance during a video call with the Vet Center Director at both sites.

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 Eugene and Walla Walla 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

District Leadership provided instructions and an example of a comprehensive format which addresses all the required components. The Eugene and Walla Walla Vet Center have updated their emergency and crisis plan for FY24. The Vet Center Director tracked compliance locally and the District Leadership confirmed compliance and will follow up on future 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 12

District leaders and the Eugene, Everett, and Walla Walla 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

District Leadership provided instruction and Vet Center Directors has made corrections to ensure all ancillary staff have the crisis desktop reference sheet available at their phones. Vet Center Directors monitor ongoing compliance locally and District Leadership confirmed compliance during recent site visits to these locations. District staff will continue to monitor 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.

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."[26] 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."[27]

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 shared VA medical facility clients.[28]

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. "In situations where the VA medical facility is unable to provide an external consultant due to local staffing logistics, the Vet Center will be authorized to seek such services from the private sector."[29]

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 if 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.[30]

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

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

[28] VHA Directive 1500(3).

[29] VHA Directive 1500(3).

[30] VHA Directive 1500(3).

OIG Contact and Staff Acknowledgments

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