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 2

Vet Center Inspection	24-00388-266	September 30, 2024

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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 2: Corona and Temecula, California; and Kauai and Western Oahu, Hawaii.[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 all four vet center directors (VCDs) ensured 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 made no recommendations related to suicide prevention. 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 independently licensed mental health external clinical consultant from a support VA medical facility.[6] One of four vet centers did not have an assigned clinical liaison.[7] Although external clinical consultation for clinically complex cases occurred at all four vet centers, all four VCDs did not ensure at least four hours of consultation per month.[8] One VCD did not complete a monthly review of 10 percent of each

[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).

[8] VHA Directive 1500(3).

counselor's client records.[9] Additionally, staff at all four vet centers were noncompliant with completing select required trainings related to suicide prevention, lethal means safety, military sexual trauma, and basic life support.[10]

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

Outreach

The OIG found one vet center did not have an outreach plan, and the three with plans lacked two or more required strategic components.[11] All three outreach plans had documented tailored outreach activities specific to cultural orientation.[12]

The OIG issued two recommendations to select vet centers specific to outreach.

Environment of Care

The OIG found all four vet centers posted building evacuation plans in communal areas.[13]

The OIG found that of the four vet centers,

- one did not have an annual fire or safety inspection,
- three did not have an annual risk and vulnerability assessment completed by VA police or local law enforcement,

[9] VHA Directive 1500(3).

[10] 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.

[11] 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 prevention and management of disruptive behavior coordinator.

[12] 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.

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

- two did not have monthly fire extinguisher inspections,
- one did not have annual servicing of fire extinguishers,
- two did not have an emergency and crisis plan with required components, and
- one did not have a desktop reference sheet for ancillary office staff to follow in case of a suicidal or homicidal client.[14]

Additionally, three of the four vet centers did not have an automatic external defibrillator (AED) on-site. The one vet center with an AED on-site had the AED serviced annually by VA medical center biomedical engineering.[15] However, the one vet center 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.

Incidental Finding

During the on-site environment of care inspection, the OIG found an exit door that was padlocked from the inside. The OIG did not make a recommendation about this safety hazard because the VCD removed the padlock and fixed the door's broken lock during the inspection.

Conclusion

The OIG conducted a focused inspection in four review areas and made 14 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.

[14] RCS, *Vet Center Clinical Site Visit (CSV) Report: Procedural Background Information*, accessed on January 23, 2023, from internal RCS website not publicly accessible. Vet center ancillary office staff includes veterans outreach program specialist and program support assistant or office manager.

[15] RCS, *Administrative Site Visit (ASV) Protocol*. The OIG was unable to evaluate AED monthly inspections and annual servicing for the three vet centers without an AED onsite.

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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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 2 for review: Corona and Temecula, California; and Kauai and Western Oahu, Hawaii (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.

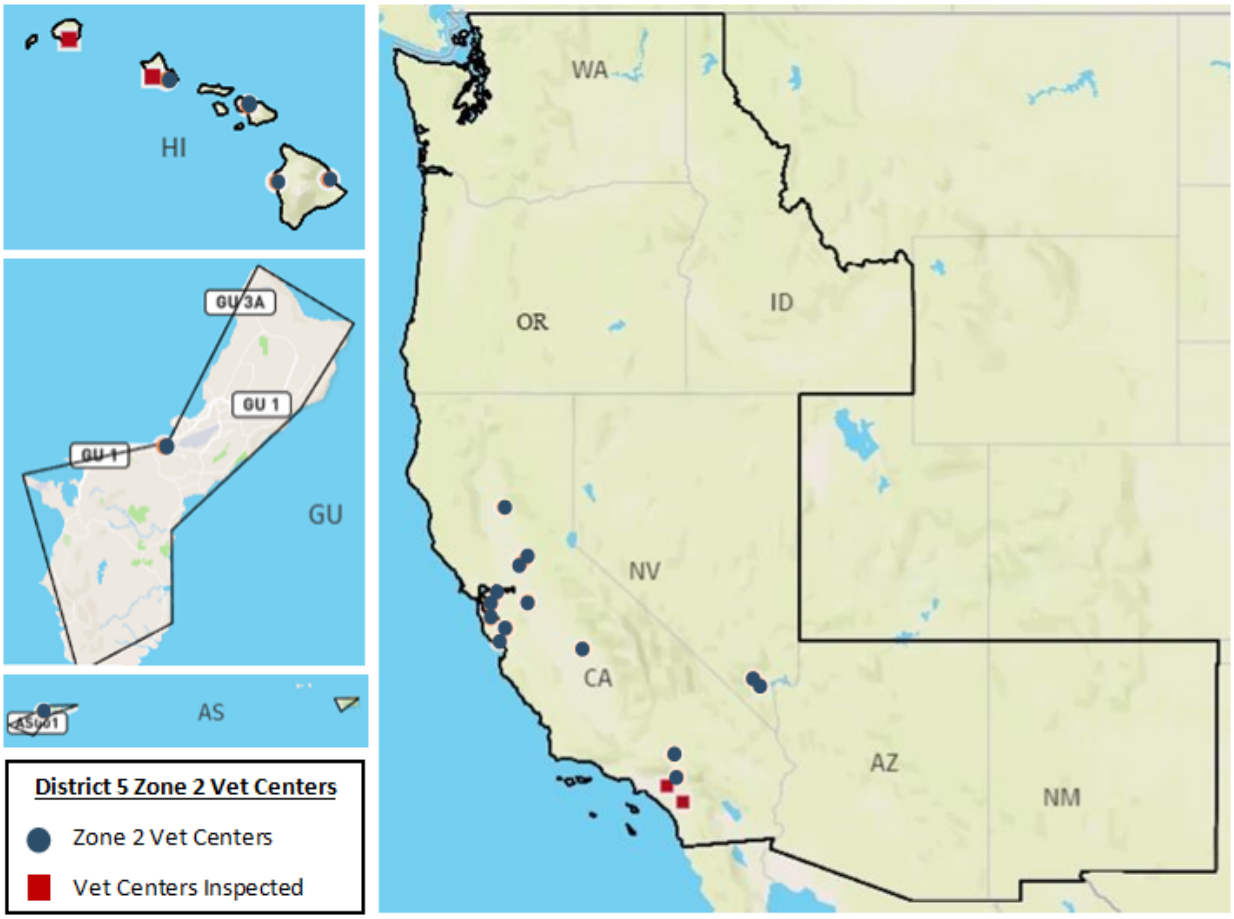

Figure 1. *Map of Pacific District 5 zone 2 vet centers, including sites visited by OIG.*
Source: OIG using RCS vet center data.

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 20, 2024.[5] The

[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.

OIG notified the 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 and reviewed RCS practices and policies.[6]

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.

[6] From January 18, 2024, through February 12, 2024, the San Bernadino VCD provided VCD coverage for the Corona Vet Center. Therefore, the OIG interviewed the San Bernadino VCD regarding RCS practices related to the Corona Vet Center. For the remainder of this report, the Corona Vet Center VCD is represented by the San Bernadino VCD.

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.[7] In an effort to reduce client risk for suicide and enhance care, each vet center aligns with a support VA medical facility.[8] 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.[9]

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.[10]

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.[11]

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

[8] 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.

[9] 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.

[10] 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.

[11] 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**	Corona Vet Center	Temecula Vet Center	Kauai Vet Center	Western Oahu 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.

The OIG found staff from all four vet centers participated in all support VA medical facility mental health executive council meetings.

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.[12]

The OIG made no recommendations related to suicide prevention.

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.[13] Mandatory training completion supports a competent and skilled staff to provide services to clients.[14]

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

[13] VHA Directive 1500(3).

[14] 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[15]
- Clinical Staff:
  - Initial or annual suicide risk management training[16]
  - One-time lethal means safety education and counseling[17]
  - One-time military sexual trauma training[18]
- All staff:
  - Bi-annual basic life support (BLS) certification[19]

[15] 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. Vet center nonclinical staff include veterans outreach program specialist and program support assistant or office manager.

[16] 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.

[17] 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.

[18] 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."

[19] 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 all RCS staff are required to complete BLS training biannually.

Table 2: Consultation, Supervision, and Training Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	Corona Vet Center	Temecula Vet Center	Kauai Vet Center	Western Oahu 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 independently licensed mental health external clinical consultant.

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

- *Assignment of a clinical liaison:* The Kauai VCD reported being unaware of the requirement for clinical liaisons to be mental health professionals assigned by the support VA medical facility.
- *Completion of required four hours of monthly external clinical consultation:* The Corona VCD reported meetings were canceled and not rescheduled due to staff and external consultant scheduling difficulties. The Temecula VCD explained that the tracking process did not capture the duration of the consultations; therefore, the VCD could not provide evidence of meeting the requirement. The Temecula VCD

also described difficulty rescheduling canceled meetings due to conflicts with the external consultant's schedule. In addition to the assigned external consultant, the Kauai VCD arranged for an RCS VCD to consult regularly. The Kauai VCD reported being aware that using the RCS VCD as an external consultant did not meet the requirements but continued because of the perceived benefits. The Western Oahu VCD could not provide evidence of the required monthly consultation hours and reported not meeting the required hours because meetings were canceled and not rearranged due to rescheduling challenges with the external clinical consultant.

- *Completion of monthly 10 percent record review:* The Western Oahu VCD completed a monthly review; however, the VCD acknowledged not completing 10 percent for one staff member for one month due to miscalculating the required number of record reviews.
- *Completion of select staff trainings:* The Corona, Temecula, and Kauai VCDs reported being unaware of the required trainings since trainings were not entered into the VA training application. The Western Oahu VCD discussed being unaware that the S.A.V.E. training was an annual requirement for nonclinical staff. The Western Oahu VCD reported awareness of the BLS training requirement and could not explain the incomplete training for the two counselors and the office manager.

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

Consultation, Supervision, and Training Recommendations

Recommendation 1

District leaders and the Kauai Vet Center Director determine reasons for noncompliance with assigning a licensed mental health professional as a clinical liaison, ensure a process is implemented, and monitor compliance.

Recommendation 2

District leaders and the Corona, Temecula, Kauai, and Western Oahu Vet Center Directors determine reasons for noncompliance with completing four hours of external clinical consultation for clinically complex cases per month, ensure a process is implemented, and monitor compliance.

Recommendation 3

District leaders and the Western Oahu Vet Center Director determine reasons for noncompliance with Vet Center Director review of 10 percent of active client records monthly for each counselor's caseload, ensure completion, and monitor compliance.

Recommendation 4

District leaders and the Corona, Temecula, Kauai, and Western Oahu 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.[20]

Table 3: Outreach Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	Corona Vet Center	Temecula Vet Center	Kauai Vet Center	Western Oahu Vet Center
Presence of a written current outreach plan.	✓	✓	✓	✗
Inclusion of required outreach plan strategic components.*	✗	✗	✗	NA‡
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 inclusion of required outreach plan strategic components or if outreach activities were tailored to community demographics because the vet center did not have a current outreach plan.

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

- *Presence of a written plan:* The Western Oahu VCD explained not having a current written outreach plan because the vet center was without a veteran outreach program specialist whose primary role is the development of the plan.

[20] VHA Directive 1500(3).

- *Inclusion of required strategic components:* The Corona, Temecula, and Kauai Vet Center VCDs reported being unaware of the inclusion of requirements for strategic components in the outreach plan.

The OIG made two recommendations related to outreach.

Outreach Recommendations

Recommendation 5

District leaders and the Western Oahu Vet Center Director determine reasons for noncompliance with completion of a current written outreach plan, ensure completion, and monitor compliance.

Recommendation 6

The District Director and zone leaders, in conjunction with the Corona, Temecula, and Kauai 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.[21]

Table 4: Environment of Care Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	Corona Vet Center	Temecula Vet Center	Kauai Vet Center	Western Oahu Vet Center
Fire or safety inspection completed annually.	✓	✓	✓	✗
Risk and vulnerability assessment completed annually by VA police or local law enforcement.	✗	✗	✓	✗

[21] 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 onsite inspections. Additionally, the OIG evaluated annual fire and/or safety inspection, annual fire extinguisher servicing, annual AED servicing by VAMC Biomedical Engineering and annual risk and vulnerability assessments based on a calendar year.

✓ Compliant ✗ Noncompliant **RCS Requirement**	Corona Vet Center	Temecula Vet Center	Kauai Vet Center	Western Oahu Vet Center
Fire extinguishers inspected monthly.	✓	✗	✓	✗
Fire extinguishers serviced annually.‡	✓	✗	✓	✓
Automated external defibrillator (AED) located on-site.	✗	✗	✗	✓
AED inspected monthly.	NA*	NA*	NA*	✗
AED serviced annually by VA medical center biomedical engineering.	NA*	NA*	NA*	✓
Building evacuation plan posted in communal area for staff and visitors to reference.	✓	✓	✓	✓
Emergency and crisis plan with required components.§	✓	✓	✗	✗
Desktop reference sheet outlining steps for ancillary staff to follow in case of a suicidal or homicidal client.‖	✓	✓	✓	✗

Sources: RCS, Administrative Site Visit (ASV) 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 centers 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 building evacuation plan posted in a communal area for staff and visitors to reference.

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

- *Fire or safety inspection completed annually:* The Western Oahu VCD discussed not ensuring inspection completion because of increased VCD responsibilities due to personnel changes.
- *Risk and vulnerability assessment completed annually:* The Corona VCD reported being unaware of the requirement for an annual assessment and being told by the support VA medical facility that the assessment was needed every two years. The Temecula VCD reported that the support VA medical facility conducted bi-annual assessments. The Western Oahu VCD reported not scheduling an annual risk and vulnerability assessment with the VA police service and being unaware that the assessment could be conducted by local law enforcement.
- *Fire extinguisher inspected monthly:* The Temecula VCD explained that the office manager assigned to complete the monthly inspections left the position and duties were not reassigned. The Western Oahu VCD reported being unaware of the requirement to complete monthly inspections.
- *Fire extinguishers serviced annually:* The Temecula VCD stated that fire extinguishers had not been serviced since October 26, 2022, because the office manager assigned to ensure annual fire extinguisher service left the position and duties were not reassigned.
- *AED located on-site:* The Corona VCD reported the belief AEDs were optional and the former Corona Vet Center Office Manager reported a district leader gave guidance that on-site AEDs were recommended. The Temecula VCD reported being aware of the requirement and perceived the vet center compliant due to being informed verbally during a district office site visit that vet centers are not required to have AEDs. The Kauai VCD reported being unaware of the requirement.
- *AED inspected monthly:* The Western Oahu VCD reported being unaware of the monthly AED inspection requirement. The VCD also discussed an inability to ensure completion of monthly AED inspections because of increased VCD responsibilities due to personnel changes.
- *Emergency and crisis plan with all components:* The Kauai VCD reported being aware of the annual requirement to review and update the plan but did not have documented proof of annual review since 2019. The Western Oahu VCD acknowledged being aware of the requirement to review and update the emergency and crisis plan annually and cited compounding VCD responsibilities due to personnel changes as a reason for noncompliance.
- *Desktop reference sheet:* The Western Oahu VCD reported the office manager was new and had not been provided training on the desktop reference sheet.

The OIG made eight recommendations related to environment of care.

Environment of Care Recommendations

Recommendation 7

District leaders and Western Oahu Vet Center Director determine reasons for noncompliance with fire or safety annual inspection, ensure completion, and monitor compliance.

Recommendation 8

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

Recommendation 9

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

Recommendation 10

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

Recommendation 11

District leaders and the Corona, Temecula, and Kauai Vet Center Directors determine reasons for noncompliance with having an automated external defibrillator located on-site and ensure compliance with the requirement.

Recommendation 12

District leaders and the Western Oahu Vet Center Director determine reasons for noncompliance with monthly automated external defibrillator inspections, ensure completion, and monitor compliance.

Recommendation 13

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

Recommendation 14

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

Incidental Finding

During the environment of care inspection at the Western Oahu Vet Center, the OIG identified that an exit door was padlocked from the inside due to a broken latch. To ensure safe egress in the event of an emergency, exit doors must not be locked from the inside, and employees must be able to open the door without keys.[22] The OIG did not make a recommendation because the VCD removed the padlock and fixed the broken door lock during the inspection.

[22] 29 C.F.R. § 1910.36 (2024).

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.

Corona Vet Center

According to the VCD, the Corona Vet Center serves clients throughout most of Riverside County, California and is supported by the Loma Linda VA Medical Center. The VCD reported that 112,052 veterans reside in the veteran service area, which includes March Air Force Base.[23] The VCD highlighted multiple outreach events, including a fishing trip for veterans located in rural areas.

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 2023 Vet Center Profile

Profile	Corona Vet Center
Budget	$897,329.79
Total Unique Clients	306
New Clients	69
Active Duty Clients	8
Bereavement Clients	3
Family Clients	3
Total Number of Positions	
Total Authorized Full-time Positions	7
Total Filled Positions	7
Total Vacancies	0

Source: RCS data.

Identified Deficiencies

Consultation, Supervision, and Training

External clinical consultation hours: Four hours of external clinical consultation were not provided for 4 of the 12 months reviewed.

Staff training:

- One of five clinical staff did not complete suicide risk management training.

[23] The Corona Vet Center is one of the vet centers serving Riverside County. The VCD reported the number of eligible veterans residing in Riverside County.

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 operations.[24]

Environment of Care

Risk and vulnerability assessment: An annual risk and vulnerability assessment was not completed by the VA police or local law enforcement since July 2022.

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

[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.

Temecula Vet Center

According to the VCD, the Temecula Vet Center serves clients throughout Riverside County, California and is supported by the Loma Linda VA Medical Center. The VCD reported that 112,052 veterans reside in the veteran service area, which has no local military bases and installations; however, Air Force, Marine, and Naval bases are within commuting proximity.[25] The VCD highlighted unique outreach programs, such as equestrian therapy and participation in multiple community meetings and groups.

Table A.2. Fiscal Year 2023 Vet Center Profile

Profile	Temecula Vet Center
Budget	$964,899.85
Total Unique Clients	624
New Clients	218
Active Duty Clients	26
Bereavement Clients	7
Family Clients	55
Total Number of Positions	
Total Authorized Full-time Positions	8
Total Filled Positions	7
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: Four hours of external clinical consultation were not provided for any of the 12 months reviewed.

Staff training:

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

[25] The Temecula Vet Center is one of the vet centers serving Riverside County. The VCD reported the number of eligible veterans residing in Riverside County.

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.[26]

Environment of Care

Risk and vulnerability assessment: An annual risk and vulnerability assessment was not completed by the VA police or local law enforcement since July 2022.

Fire extinguisher inspection: Of the three months the OIG reviewed, no monthly fire extinguisher inspections were completed.

Fire extinguisher servicing: The one fire extinguisher was not 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.

[26] 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.

Kauai Vet Center

According to the VCD, the Kauai Vet Center serves clients throughout the island of Kauai and is supported by the Honolulu VA Pacific Islands Health Care System. The VCD reported that 4,207 eligible veterans reside in the veteran service area, which includes the Pacific Missile Range Facility. The VCD highlighted outreach programs such as honoring the native Hawaiian island culture by leading individual and group adjustment counseling centered on surfing, paddling, and stand-up paddling.

Table A.3. Fiscal Year 2023 Vet Center Profile

Profile	Kauai Vet Center
Budget	$466,304.10
Total Unique Clients	79
New Clients	12
Active Duty Clients	0
Bereavement Clients	1
Family Clients	10
Total Number of Positions	
Total Authorized Full-time Positions	3
Total Filled Positions	3
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

Clinical liaison assigned: The clinical liaison assigned during the review period was not a mental health professional.

External clinical consultation hours: Four hours of external clinical consultation were not provided for 8 of the 12 months reviewed.

Staff training:

- One of two clinical staff did not complete suicide risk management training.

Outreach

Outreach plan: The outreach plan was missing three required strategic components: personal points of contact for non-VA community service providers, strategic VA medical facility partners, and strategic coordination with mobile vet center operations.[27]

Environment of Care

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 had not been updated since September 2019, and did not include active shooter within the violence in the workplace plan.

[27] 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.

Western Oahu Vet Center

According to the VCD, the Western Oahu Vet Center serves clients throughout the island of Oahu and is supported by the VA Pacific Islands Health Care System. The VCD reported that 68,811 eligible veterans reside in the veteran service area, which includes the Joint Base Pearl Harbor-Hickam, Fort Shafter, Schofield Barracks, Wheeler Army Airfield, Air Detachment Kaneohe, Marine Corps Base Hawaii, Naval Computer and Telecommunications Area Master Station Pacific, and Naval Security Group Activity Kunia. As a vet center highpoint, the VCD highlighted participation in outreach programs such as the highly visible annual Na Koa Wounded Warrior Canoe Regatta event.

Table A.4. Fiscal Year 2023 Vet Center Profile

Profile	Western Oahu Vet Center
Budget	$730,632.90
Total Unique Clients	336
New Clients	129
Active Duty Clients	15
Bereavement Clients	3
Family Clients	24
Total Number of Positions	
Total Authorized Full-time Positions	5
Total Filled Positions	2
Total Vacancies	3

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 any 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 one of the last three months of the review period.

Staff training:

- One nonclinical staff did not complete the S.A.V.E. training.
- Three of four staff did not complete required BLS training.

Outreach

Outreach plan: The outreach plan was not developed for fiscal year 2023; therefore, the OIG did not evaluate required elements.

Environment of Care

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

Risk and vulnerability assessment: An annual risk and vulnerability assessment was not completed by the VA police or local law enforcement.

Fire extinguisher inspection: Of the three months the OIG reviewed, no monthly fire extinguisher inspections were completed.

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

Emergency and crisis plan: An annual emergency and crisis plan was not completed.

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

Incidental Finding

During the Western Oahu Vet Center on-site environment of care rounds, the OIG identified concerns related to an emergency exit door that was padlocked from the inside.

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 2

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 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 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 2 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 Kauai Vet Center Director determine reasons for noncompliance with assigning a licensed mental health professional as a clinical liaison, ensure a process is implemented, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Requesting closure.

Director Comments

The prior Kauai Vet Center Clinical Liaison did not possess a mental health professional license. VA Pacific Islands Healthcare System Associate Chief of Staff for Mental Health has agreed to serve as the designated Clinical Liaison on 2/1/2024. Kauai Vet Center Director will monitor compliance.

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 Corona, Temecula, Kauai, and Western Oahu 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

District Leadership provided education on the requirement and proper documentation. Vet Center Directors coordinated with VA support facility to ensure the requirement was understood at their facility. The Vet Center Directors track compliance locally and the District confirms compliance monthly on the Vet Center's RCSNet Oversight Tracker.

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 Western Oahu Vet Center Director determine reasons for noncompliance with Vet Center Director 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

District Leadership reviewed the guidance and process with the Vet Center Director, clarifying the requirements to complete a full 10 percent review of active client records monthly for each counselor's caseload. The Vet Center Director tracks compliance locally, and the District Leadership 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 4

District leaders and the Corona, Temecula, Kauai, and Western Oahu 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 ensuring 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 5

District leaders and the Western Oahu Vet Center Director determine reasons for noncompliance with completion of a current written outreach plan, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Requesting closure.

Director Comments

District Leadership provided instruction and templates 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 which complies with the standards. Vet Center Directors track compliance locally, and the District confirms compliance during the annual clinical site visit.

OIG Comments

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

Recommendation 6

The District Director and zone leaders, in conjunction with the Corona, Temecula, and Kauai 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 and templates 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 which complies with the standards. Vet Center Directors 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 7

District leaders and Western Oahu Vet Center Director 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 Center Directors followed up with their local medical center support facility to get the appropriate inspections completed. These inspections have been completed and the Vet Center Director understands their responsibility to 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 8

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

_X _Concur

____Nonconcur

Target date for completion: Requesting closure.

Director Comments

Vet Center Directors have been educated on the requirements by District Leadership. Vet Center Directors track compliance locally and the District confirms compliance during the annual administrative site visit. The Western Oahu Vet Center will be relocating to the new VA Clinic in Kapolei, HI on September 30, 2024. The annual risk and vulnerability assessment will be completed in conjunction with VHA.

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 Temecula and Western Oahu 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 Center Directors and developed a monitoring log for monthly fire extinguisher inspections. Vet Center Directors track compliance locally and the District confirms compliance during the annual administrative site visit. These Vet Centers are now consistently completing and documenting 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 10

District leaders and the Temecula Vet Center Director 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 has confirmed that the Temecula Vet Center had their annual inspection completed. The 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 11

District leaders and the Corona, Temecula, and Kauai Vet Center Directors 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: November 30, 2024.

Director Comments

District Leadership confirmed and communicated the requirement to all Vet Centers in District 5. All Vet Center Directors have requested an AED from the local VA Medical Centers. The District Office will monitor the procurement and installation and will confirm once AEDs have been installed.

Recommendation 12

District leaders and the Western Oahu Vet Center Director 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 the Vet Center Directors and developed a monitoring log for monthly AED inspections. Vet Center Directors track compliance locally and the District has confirmed compliance and will review compliance on the annual administrative site visit. The Western Oahu Vet Center is now consistently completing monthly inspection of their AED.

OIG Comments

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

Recommendation 13

District leaders and the Kauai and Western Oahu Vet Center Directors determine reasons for noncompliance with having an updated 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 Kauai and Western Oahu Vet Center Directors have updated their emergency and crisis plan for FY24. Vet Center Directors track compliance locally and the district has confirmed compliance. The District will continue to monitor compliance during 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 14

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

_X _Concur

____Nonconcur

Target date for completion: Requesting closure.

Director Comments

District Leadership provided instruction and the Vet Center Director has made corrections to ensure all ancillary staff have the crisis desktop reference sheet available at their phones. Vet Center Director monitors ongoing compliance locally and District confirmed compliance during recent site visits to these locations. District 5 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."[28] 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."[29]

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.[30]

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."[31]

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.[32]

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

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

[30] VHA Directive 1500(3).

[31] VHA Directive 1500(3).

[32] VHA Directive 1500(3).

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