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 3

Vet Center Inspection	**24-00389-267**	**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 3: Phoenix and West Valley, Arizona; Antelope Valley, California; and Santa Fe, New Mexico.[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 a licensed provider participated on 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] Although external clinical consultation for clinically complex cases occurred at all four vet centers, three VCDs did not ensure that at least four hours of consultation were completed per month.[7] One VCD did not

[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).

complete a monthly review of 10 percent of each counselor's client records.[8] Additionally, a staff member at one of four vet centers was noncompliant with completing select training related to suicide prevention.[9]

The OIG issued three 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 four vet centers had documented tailored outreach activities specific to cultural orientation.[11]

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

Environment of Care

The OIG found all four vet centers complied with the following requirements: fire or safety inspections and fire extinguisher servicing annually, and a building evacuation plan posted in a communal area.[12]

The OIG found that of the four vet centers,

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

[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 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.

- one did not have monthly fire extinguisher inspections,
- 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.[13]

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

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

Conclusion

The OIG conducted a focused inspection in four review areas and made 10 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.

VA Comments and OIG Response

The Chief Readjustment Counseling Officer and District Director concurred with the recommendations and provided an acceptable action plan (see appendixes B and C). Based on information provided, the OIG considers 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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[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 includes veterans outreach program specialist and program support assistant or office manager. The OIG was unable to evaluate AED monthly inspections and annual servicing for the two vet centers without an AED on-site.

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

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 3 for review: Phoenix and West Valley, Arizona; Antelope Valley, California; and Santa Fe, New Mexico (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.

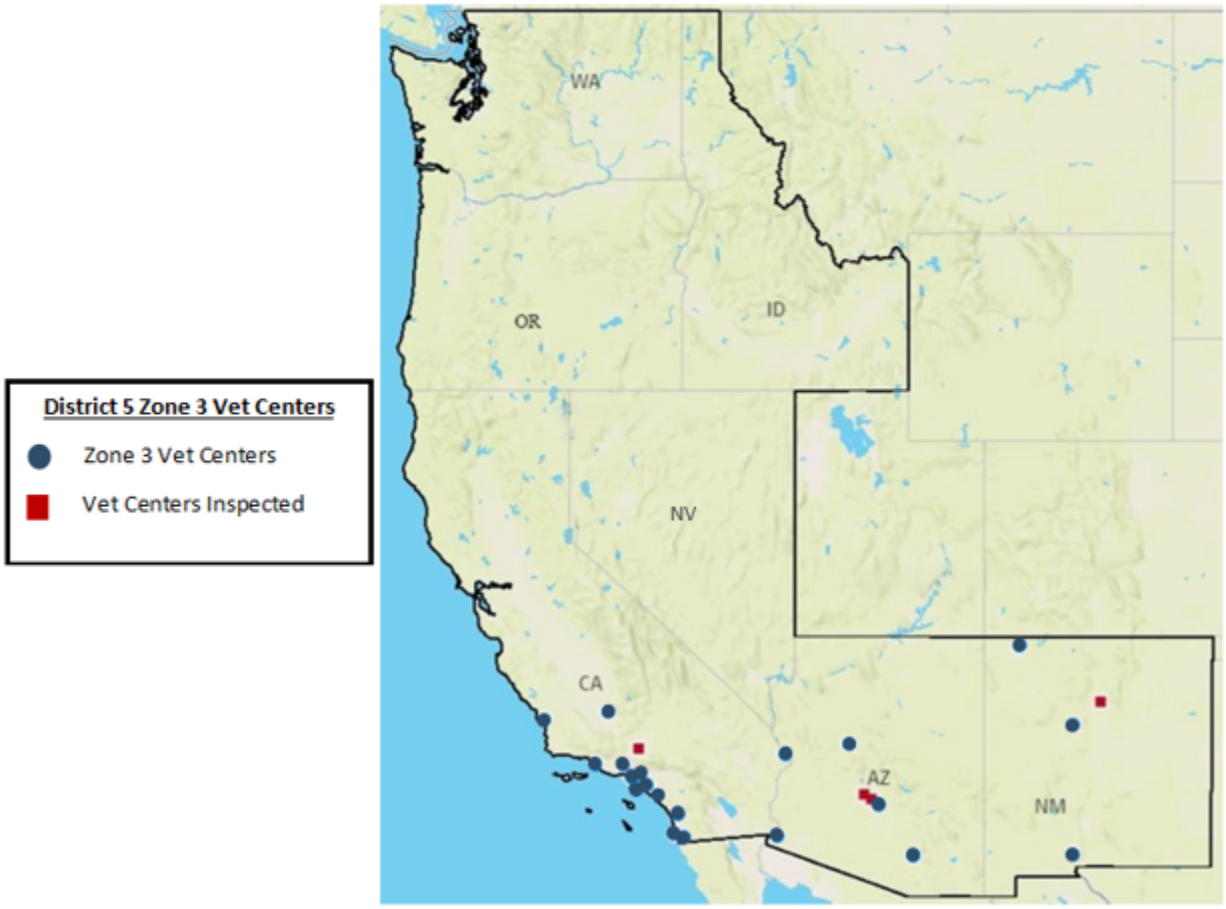

Figure 1. *Map of Pacific District 5 zone 3 vet centers, including sites visited by OIG.*
Source: OIG using RCS vet center data.

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 21, 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.[6] 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.[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

[6] According to a district leader, the Phoenix VCD was also appointed as the acting West Valley VCD on June 28, 2023, and was serving in that capacity throughout the OIG inspection. For this report, the acting West Valley VCD will be referred to as the West Valley VCD.

[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.

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 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**	Antelope Valley Vet Center	Phoenix Vet Center	Santa Fe Vet Center	West Valley Vet Center
A licensed vet center staff member participates in all support VA medical facility mental health executive council meetings.*	✓	✗	✓	✗

[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.

VCD ensure 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 VCD reported the following explanations for noncompliance:

- *Mental health executive council participation:* The Phoenix and West Valley VCD reported missing one of the four required meetings due to leave. The VCD reported attending for both Phoenix and West Valley Vet Centers and having a coverage plan in case of an absence; however, the covering staff member was transitioning out of the position at the time of the missed meeting.

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 one recommendation related to suicide prevention.

Suicide Prevention Recommendation

Recommendation 1

District leaders and the Phoenix and West Valley Vet Center Director 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.[13] Mandatory training completion supports a competent and skilled staff to provide services to clients.[14]

Reviewed trainings included:

[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.

- 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 training. 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 to Under Secretaries, Assistant Secretaries and Other Key Officials, October 15, 2020; 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	Antelope Valley Vet Center	Phoenix Vet Center	Santa Fe Vet Center	West Valley 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.	✓	✓	NA*	✗
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.

** NA indicates the OIG did not evaluate review of 10 percent of active client records because the vet center did not have a counselor with a caseload during the review period.*

‡ 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 an independently licensed mental health external clinical consultant.

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

- *Completion of required four hours of monthly external clinical consultation:* The Antelope Valley VCD explained meetings were canceled due to staff and consultant leave and not rescheduled due to the VCD's workload managing an additional vet center. The Phoenix and West Valley VCD reported consultation was canceled when there were no cases to review.
- *Completion of monthly 10 percent record review:* The West Valley VCD completed a monthly record review; however, the VCD reported 10 percent was not completed

for one month due to a change in a counselor's caseload occurring at the end of the month.

- *Completion of select staff trainings:* The Antelope Valley VCD stated that the training was not completed because it was not assigned to the counselor. The VCD reported reviewing required staff trainings but did not identify the missing training assignment.

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

Consultation, Supervision, and Training Recommendations

Recommendation 2

District leaders and the Antelope Valley, Phoenix, and West Valley 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 West Valley 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 Antelope Valley Vet Center Director 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]

[20] VHA Directive 1500(3).

Table 3: Outreach Results

✓ Compliant ✗ Noncompliant **RCS Requirement**	Antelope Valley Vet Center	Phoenix Vet Center	Santa Fe Vet Center	West Valley Vet Center
Presence of a written current outreach plan.	✓	✓	✓	✓
Inclusion of required outreach plan strategic components.*	✗	✗	✗	✗
Outreach activities tailored to cultural orientations.	✓	✓	✓	✓

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.*

The OIG found all four vet centers had an outreach plan and tailored outreach activities to cultural orientations.

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

- *Inclusion of required strategic components:* All four VCDs reported being unaware of the requirement for strategic components to be included in the outreach plan.

The OIG made one recommendation related to outreach.

Outreach Recommendation

Recommendation 5

District leaders and the Antelope Valley, Phoenix, Santa Fe, and West Valley 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	Antelope Valley Vet Center	Phoenix Vet Center	Santa Fe Vet Center	West Valley Vet Center
Fire or safety inspection completed annually.	✓	✓	✓	✓
Risk and vulnerability assessment completed annually by VA police or local law enforcement.	✓	✓	✗	✓
Fire extinguishers inspected monthly.	✗	NA*	✓	✓
Fire extinguishers serviced annually.‡	✓	✓	✓	✓
Automated external defibrillator (AED) located on-site.	✗	✓	✗	✓
AED inspected monthly.	NA§	✓	NA§	✓
AED serviced annually by VA medical center biomedical engineering.	NA§	✓	NA§	✓
Building evacuation plan posted in communal area for staff and visitors to reference.	✓	✓	✓	✓

[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 on-site inspections.

✓ Compliant ✗ Noncompliant **RCS Requirement**	Antelope Valley Vet Center	Phoenix Vet Center	Santa Fe Vet Center	West Valley Vet Center
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 determine if the Phoenix Vet Center fire extinguisher monthly checks were completed during the review period. In December 2023, the extinguishers were serviced, and vet center staff reported the servicer removed the old monthly check tags.*
‡ The OIG considered inspections completed during the current calendar or previous year satisfactory.
§ The OIG was unable to evaluate these requirements due to the vet centers not having an AED.
‖ 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 includes veterans outreach program specialist and program support assistant or office manager.

The OIG found all four vet centers had an annual fire or safety inspection, annual fire extinguisher servicing, and posting of evacuation plans.

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

- *Risk and vulnerability assessment completed annually:* The Santa Fe VCD explained that the VA police and local law enforcement reported not completing these assessments for vet centers and denied the VCD's request.
- *Fire extinguisher inspected monthly:* The Antelope Valley VCD reported providing coverage for another vet center and monthly fire extinguishers were not completed due to competing priorities and a focus on client care.
- *AED located on-site:* The Antelope Valley VCD explained not having an AED on-site due to difficulty obtaining an AED from the support VA medical facility. The Santa Fe VCD reported not being aware of the requirement for an AED.
- *Emergency and crisis plan with all components:* The Phoenix VCD believed the violence in the workplace section was sufficient but acknowledged not including an

active shooter plan specifically. The Santa Fe VCD discussed not being aware that the emergency and crisis plan was required to have an active shooter plan.

- *Desktop reference sheet:* The Santa Fe 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 OIG made five recommendations related to environment of care.

Environment of Care Recommendations

Recommendation 6

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

Recommendation 7

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

Recommendation 8

District leaders and the Antelope Valley and Santa Fe Vet Center Directors 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 Phoenix and Santa Fe Vet Center Directors determine reasons for noncompliance with having an emergency and crisis plan that includes required components, ensure completion, and monitor compliance.

Recommendation 10

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

Appendix A

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

Antelope Valley Vet Center

According to the VCD, the Antelope Valley Vet Center serves clients throughout Los Angeles and Kern counties and is supported by the West Los Angeles VA Medical Center. The VCD reported 20,327 eligible veterans reside in the veteran service area, which includes Edwards Air Force Base. The VCD highlighted the integration of an additional veteran service officer into the vet center, which increased new client referrals.

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	Antelope Valley Vet Center
Budget	$568,606.56
Total Unique Clients	286
New Clients	125
Active Duty Clients	3
Bereavement Clients	7
Family Clients	23
Total Number of Positions	
Total Authorized Full-time Positions	5
Total Filled Positions	5
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 5 of the 12 months reviewed.

Staff training:

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

Outreach

Outreach plan: The outreach plan did not identify the required strategic VA medical facility partners.[22]

Environment of Care

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

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

[22] 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.

Phoenix Vet Center

According to the VCD, the Phoenix Vet Center serves clients in Maricopa County, Arizona and is supported by the Carl T. Hayden VA Medical Center. The VCD reported 85,363 eligible veterans reside in the veteran service area, which includes Papago Park Military Reservation and Goldwater Air National Guard Base. The VCD highlighted implementing new, standardized intake and referral processes resulting in shorter appointment wait times and improved clinical documentation.

Table A.2. Fiscal Year 2023 Vet Center Profile

Profile	Phoenix Vet Center
Budget	$1,158,060.48
Total Unique Clients	474
New Clients	154
Active Duty Clients	10
Bereavement Clients	7
Family Clients	47
Total Number of Positions	
Total Authorized Full-time Positions	9
Total Filled Positions	8
Total Vacancies	1

Source: RCS data.

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

Identified Deficiencies

Suicide Prevention

Mental health executive council participation: Of the four meetings held during the 12 months reviewed, vet center staff attended three.

Consultation, Supervision, and Training

External clinical consultation hours: Four hours of external clinical consultation were not provided for 6 of the 12 months reviewed.

Outreach

Outreach plan: The outreach plan was missing identification of strategic VA medical facility partners.[23]

[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.

Environment of Care

Emergency and crisis plan: The emergency and crisis plan was current but did not include an active shooter plan.

Santa Fe Vet Center

According to the VCD, the Santa Fe Vet Center serves clients throughout 11 counties across northern and eastern New Mexico and is supported by the Raymond G. Murphy VA Medical Center. There are 32,161 eligible veterans who reside in the veteran service area, which includes the headquarters of the New Mexico National Guard and Kirtland Air Force Base. The VCD highlighted collaborating with the Marine Corps Reserve to support the annual Toys for Tots event.

Table A.3. Fiscal Year 2023 Vet Center Profile

Profile	Santa Fe Vet Center
Budget	$729,246.85
Total Unique Clients	241
New Clients	19
Active Duty Clients	4
Bereavement Clients	0
Family Clients	4
Total Number of Positions	
Total Authorized Full-time Positions	7
Total Filled Positions	5
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

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.[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.

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

Emergency and crisis plan: The emergency and crisis plan was current but did not include contingencies for violence in the workplace, including an active shooter plan.

[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.

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

West Valley Vet Center

According to the VCD, the West Valley Vet Center serves clients throughout the Western Phoenix metropolitan area and is supported by the Carl T. Hayden VA Medical Center. The VCD reported 141,811 eligible veterans reside in the veteran service area, which includes the Luke Airforce Base. The VCD highlighted a collaboration with Arizona State University to offer veterans a course to develop business ideas.

Table A.4. Fiscal Year 2023 Vet Center Profile

Profile	West Valley Vet Center
Budget	$728,305.16
Total Unique Clients	491
New Clients	165
Active Duty Clients	14
Bereavement Clients	6
Family Clients	86
Total Number of Positions	
Total Authorized Full-time Positions	6
Total Filled Positions	5
Total Vacancies	1

Source: RCS data.

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

Identified Deficiencies

Suicide Prevention

Mental health executive council participation: Vet center staff attended three of the four meetings held during the 12 months reviewed.

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 perform record reviews for at least 10 percent of cases for one of the three months reviewed for one counselor.

Outreach

Outreach plan: The outreach plan did not identify the required strategic VA medical facility partners.[25]

[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.

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 3

To: Director, Office of Healthcare Inspections, Vet Center Inspection Program (54VC00)
Director, GAO/OIG Accountability Liaison (VHA 10BGOAL Action)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report*, Inspection of Select Vet Centers in Pacific District 5 Zone 3*. 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 3 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 Phoenix and West Valley 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

Due to a misunderstanding of the requirement, participation in the Mental Health Executive Council (MHEC) meetings was inconsistent. Clarification was provided regarding the requirement to attend the MHEC meeting each occurrence. Attendance is also reviewed during monthly quality assurance meetings conducted by District 5 Leadership. The VCDs track compliance locally and the District confirms compliance during the annual clinical site visit. The Phoenix and West Valley 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 Antelope Valley, Phoenix, and West Valley 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 5 Leadership provided education to the VCDs on the requirement and proper documentation. VCDs coordinated with their VA support facility to ensure the requirement was understood at their facility. In addition, the VCDs track compliance locally, ensure coverage is provided external to the Vet Center by alternate consultant and the district confirms compliance monthly on the Vet Center's RCSNet Oversight Tracker. Vet Centers are 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 West Valley Vet Center Director determine reasons for noncompliance with Vet Center Directors review of 10 percent of active client records monthly for each counselor's caseload, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Requesting closure.

Director Comments

The position of Vet Center Director at the West Valley Vet Center was vacant for half of FY23 and did not meet full compliance for mandatory chart audits for 10% of all counselors' charts during the Vet Center Inspection Program (VCIP) period of review. District Leadership provided instruction to all VCDs to ensure the correct percentage of audits was completed for all clinical staff every month. Vet Center chart audit compliance is tracked locally by Vet Center Directors, compliance is then confirmed by the District during monthly quality assurance meetings and the annual clinical site visit. The West Valley Vet Center is now compliant with this requirement.

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 Antelope Valley Vet Center Director 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 all VCDs 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. This Vet Center is now 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 Antelope Valley, Phoenix, Santa Fe, and West Valley 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 5 Leadership provided instruction and templates for creating an outreach plan that incorporates 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. The updated plans are reviewed by District Leadership during the annual site visit and VCDs track compliance locally.

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 Santa Fe Vet Center Director determine reasons for noncompliance with having an annual risk and vulnerability assessment completed by VA police or local law enforcement, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Requesting closure.

Director Comments

The VCD had on several occasions requested annual risk and vulnerability assessment be completed by VA Police at the VA New Mexico HCS prior to the VCIP inspection. Since then, the VA Police have completed the assessment. Documentation of assessments is included as evidence in this submission.

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 Antelope Valley Vet Center Director determine reasons for noncompliance with monthly fire extinguishers inspections, ensure completion, and monitor compliance.

_X _Concur

____Nonconcur

Target date for completion: Requesting closure.

Director Comments

District 5 Leadership provided instruction and has confirmed that the Antelope Valley Vet Center had their monthly inspections completed. The Antelope Valley VCD 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 Antelope Valley and Santa Fe 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: September 30, 2024

Director Comments

District 5 leadership misunderstood the requirement for all Vet Centers to have an AED on-site during the VCIP review. As a result, the Santa Fe and Antelope Valley Vet Centers did not have an AED at their locations during the VCIP visit in February 2024. District Leadership communicated the requirement to all Vet Centers in District 5. The Santa Fe Vet Center requested an AED, which has been installed and all staff were trained on its use. The District office confirmed installation of the AED through photographic and electronic communication documentation. Antelope Vet Center requested an AED, it was procured by VA GLA HCS Contracting Office and it is due to be delivered and installed no later than September 30, 2024. Staff will be trained on its use at the time of installation.

Recommendation 9

District leaders and the Phoenix and Santa Fe 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 5 Leadership provided instruction to the VCDs. VCDs revised accordingly and the District staff reviewed and confirmed compliance. Ongoing reviews will be included during the annual administrative site visit. The Santa Fe and Phoenix Vet Centers are now compliant with their emergency and crisis plans for their Veteran Service Areas.

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 Santa Fe 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 5 Leadership provided instructions to VCD, who posted desktop reference sheets in each workstation area for staff. The VCDs verified compliance locally with photographic documentation and the District will continue to confirm compliance during annual administrative site visits.

OIG Comments

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

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] *American Red Cross*, "What is AED?," 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).

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