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VET CENTERS: SUPPORTING THE MENTAL HEALTH NEEDS OF SERVICEMEMBERS, VETERANS AND THEIR FAMILIES

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

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VET CENTERS: SUPPORTING THE MENTAL HEALTH NEEDS OF SERVICEMEMBERS, VETERANS AND THEIR FAMILIES

WEDNESDAY, JANUARY 31, 2024

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 3:30 p.m., in Room SR–418, Russell Senate Office Building, Hon. Jon Tester, Chairman of the Committee, presiding.

Present: Senators Tester, Brown, Blumenthal, Sinema, Hassan, King, Cassidy, Tillis, Sullivan, and Tuberville.

OPENING STATEMENT OF HON. JON TESTER, CHAIRMAN, U.S. SENATOR FROM MONTANA

Chairman TESTER. I want to call this hearing to order. Good afternoon. Welcome to this hearing on whether Vet Centers are meeting the mark in addressing our veterans need, particularly in the areas of mental health, and not only our veterans, but also their families.

Vet Centers were established in recognition that many Vietnam era veterans were experiencing readjustment challenges, and those various same veterans were wary of, or geographically far from VA medical centers. As a result, the Vet Center offers veterans the option to receive confidential mental healthcare services separate from those in the VHA facilities.

They are community-based and offer a range of mental health services to eligible servicemembers, vets, their loved ones who experience military related trauma. They also support a successful transition to military life by offering marriage and family counseling, and serving as a resource for other VA benefits and services.

Due to the recent efforts of this Committee, more veterans are eligible for services at the Vet Centers than ever before. And that's why it's critically important that the Vet Center program is delivering high quality services to the veterans who utilize it. Representatives from the VA, the Office of Inspector General, and the Government Accountability Office are here today to help us better understand improvements that could be made to the program so it meets the needs of all of our veterans.

For example, the OIG has indicated that the Vet Center Inspection Program looking into clinical administrative processes associated with promoting quality care, patterns have already emerged in the first nine inspections, covering 36 Vet Centers. I've said it

many times before, if there's a problem at one facility, there's likely to be problems at others. And I hope this hearing helps us better understand how the Vet Center Program is addressing the OIGs findings from a system-wide view.

To meet increased Vet Center demand, Congress has taken recent action through the Commander John Scott Hannon Veterans Mental Health Care Improvement Act, to the STRONG Veterans Act to expand our Veterans Center's workforce. Given VA's announcement on Friday about meeting its staffing goals which is good news, I do want to hear from Mr. Fisher about whether this policy shift affects VA Center hiring.

In addition, other initiatives such as a pilot program to provide childcare for those seeking face-to-face counseling at Vet Centers, and essentially updates to existing program to reduced transportation costs for veterans accessing in-person care have been too slow to get off the ground. These programs would help encourage veterans to utilize the important mental health services VA centers offer and need to be a focus of the department and the Vet Center program.

On a recent visit to Missoula Vet Center, my staff was made aware that the Montana Department of Veterans Affairs and the University of Montana both use the Vet Center to connect with veterans and to operate a veteran's legal clinic, which help veterans with discharge upgrades, claims, appeals, wills, and civil legal issues. This is a great example of how VA can partner with local stakeholders to expand services at the Vet Center and get more veterans coming through their doors. This is especially important in rural areas where Vet Centers are critical mental health access points for our veterans.

So I'm looking forward to our witnesses, share with us what's still lacking in the Vet Center Program and how we can work with the VA to make it better. With that, I turn it over to Senator Cassidy for his remarks.

HON. BILL CASSIDY,
U.S. SENATOR FROM LOUISIANA

Senator CASSIDY. Thank you, Chair Tester, and thanks to our witnesses for being here to discuss Vet Centers. Veterans' mental health and suicide prevention should be all of our top priority. In addition to Vet Centers, access to comprehensive mental health care and upstream crisis prevention are important factors in the holistic system of services available to veterans.

I was pleased to see the VA recently announced that it'll award another $50 million to community organizations to help prevent veteran suicide, under the Staff Sergeant Parker Gordon Fox Grant program, part of the Commander John Scott Hannon's Veterans Mental Health Care Improvement Act. You know, you'll sometimes meet the spouse of a vet and he or she will say, typically it's she, "I don't know where to go. I know there's a problem, but I'm not sure what to do."

Well, the Vet Centers are obviously a place, that's where you can go and if there's a gap between the veteran and the services and their families and the mental health and the readjustment, and you name it, that's what the Vet Center is there to do.

In the past year, nearly 250,000 veterans, servicemembers, and their families, were able to receive counseling at one of these 300 Vet Centers. Veterans like them. Vet Centers score high on the trust and satisfaction surveys, and Vet Centers continually succeed in building access to social and psychological services in rural areas, that are more difficult for a veteran to find services otherwise.

According to the written testimony from the GAO and the Office of Inspector General, there are challenges, though, at the Vet Center. Among these are outreach, staffing, recruitment. I'm also interested in learning how the Vet Centers interact with the rest of the VHA, where I have a higher level of concern about the effectiveness of the VA supporting veterans' mental health needs.

I'm going to soon introduce, it's really hard even on an oversight committee to kind of know these questions. Thank you again for being here, but I'm going to introduce legislation soon called VetPAC, patterned after MedPAC and MACPAC, and VetPAC we hope will allow not just this oversight committee, but others to understand these interactions, these workings in a way that will help Congress better address issues like mental health and suicide prevention.

This will help us work with individuals like our witnesses in front of us today to address these important priorities. Veterans in Louisiana and across the country, along with their family members and caregivers, rely, depend, expect, high quality care to be provided by the VA and Vet Centers. I'm committed to working with the department on finding solutions that help the facilities and the facility staff handle sudden influxes of vets and their family members, while making sure that all veterans nationwide receive the care they deserve. With that, I look forward to today's testimony, and I yield.

Chairman TESTER. Thank you, Dr. Cassidy. I appreciate you being here. I appreciate you filling in for Senator Moran* this afternoon. I'd like to invite our witnesses to the afternoon's hearing. First up is going to be Michael Fisher, who is chief officer of the Readjustment Counseling Service at the Department of Veterans Affairs. Thank you for being here, Michael.

Next, we have Dr. Julie Kroviak, who is the principal deputy assistant inspector general at the Office of Healthcare Inspections for the VA Office of Inspector General. Thank you for being here, Doctor.

And finally, we've got Sharon Silas, director of healthcare team at the Government Accountability Office. And thank you for being here, Sharon. You each have 5 minutes. I would ask you to try to keep it that 5 minutes knowing that your entire written proposal here will be put in the minutes and we'll start with you—we'll go in the same order that I introduced you. So, Michael, you're up.

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*An opening statement for Senator Moran appears on page 33 of the Appendix.

STATEMENT OF MICHAEL FISHER, MSW, CHIEF OFFICER, READJUSTMENT COUNSELING SERVICE, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Mr. FISHER. Thank you, and good afternoon, Chairman Tester, Senator Cassidy, and Members of the Committee. I appreciate the opportunity to join you today to discuss the services available at Readjustment Counseling Services or RCS Vet Centers. Vet Centers are a central component of the VHA comprehensive service delivery system, serving a distinct role and facilitating easy access to readjustment counseling, to eligible veterans, servicemembers and their families.

They also help overcome barriers to other resources within VA and local communities. These centers offer non-medical counseling to individuals who have served in combat operations, areas of hostility, stateside deployments, or have endured other military service-related trauma. They also cater to those receiving VA educational benefits. The culture and environment of Vet Centers, along with the military and trauma-informed training and experience of our staff, creates a supportive community that is non-stigmatizing, builds trust and effectively addresses the needs of our clients.

Vet Centers are legally separate from VA's general healthcare facilities and adhere to strict confidentiality practices. Although they operate independently from other places in VHA, there is a bi-directional referral and care coordination system in place to ensure seamless connectivity.

The Vet Center model has significant impact on clients' well-being, and according to over 72,000 customer feedback responses, more than 93 percent of clients trust Vet Centers to improve the quality of their life, and over 95 percent of both new and established clients reported an ability to schedule appointments within a reasonable time. Clients share heartfelt testimonies emphasizing the compassionate care they receive and positive impact on their lives.

One example is an OEF veteran who walked into a California Vet Center in crisis in 2019. This former paratrooper was not sleeping or getting along with his family. He barely found motivation to get out of bed and was experiencing suicide ideation. One counselor, or our counselor, who is also a veteran, met with him on the spot and handled the crisis. Further counseling sessions led to identifying personal goals to address anger, guilt, shame, and intrusive memories.

Our team supported with consistent individual and marriage counseling, and he was also able to create a renewed sense of comradery, through connecting with other veterans in a trauma writing group. As a veteran community, they processed their experiences and began to heal. Following this journey, he has a better relationship with his spouse, a new outlook as a father, earned his PhD in history, where he now works as a professor, and advocates for others to seek support at Vet Centers.

Recently enacted legislation, expanded services to new cohorts and strengthened our workforce. The STRONG Veterans Act of 2022 expanded Vet Center eligibility to veterans and servicemembers utilizing qualified education benefits and to fami-

lies of veterans and servicemembers who lost a loved one to suicide. To date, approximately 250 student beneficiaries and 180 family members have benefited from these services.

Further, RCS has hired an additional 50 counselors, 48 of whom are on board. Other legislation established the Vet Center Scholarship program for individuals pursuing advanced mental health related degrees, who will then work at a Vet Center. VA has awarded 46 scholarships with priority given to veterans, and more awards are anticipated as the application process continues.

Finally, RCS is partnering with other VA offices to establish new pilot programs that will benefit and improve access to individuals we serve to include a pilot to reimburse travel costs for those experiencing financial difficulties in rural and tribal communities, a pilot to provide grants to address food insecurity among veterans and their families, and a pilot to expand the VetSuccess on Campus program to additional tribal colleges and universities.

Chairman Tester, Senator Cassidy, we would like to express our gratitude for the opportunity to discuss these crucial issues. We value our ongoing partnership and as we collectively fulfill our responsibility to serve the Nation's veterans, servicemembers, and their families. Thank you, and I look forward to your questions.

[The prepared statement of Mr. Fisher appears on page 39 of the Appendix.]

Chairman TESTER. Michael, thank you for your testimony. And there will be questions, I guarantee it. Dr. Kroviak.

STATEMENT OF JULIE KROVIAK, MD, PRINCIPAL DEPUTY ASSISTANT INSPECTOR GENERAL, OFFICE OF HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS

Dr. KROVIAK. Chairman Tester, Senator Cassidy, Senator Tuberville, thank you for the opportunity to discuss the OIGs Vet Center Inspection program known as VCIP. These cyclical inspections are designed to help VA Vet Center counselors provide services that are safe and effective in meeting the needs of their clients.

While we recognize the wide array of services provided to veterans, servicemembers, and their families at these centers, we pay particular attention to policies and procedures that identify and support those veterans deemed high risk for suicide. Our oversight work is designed to support and strengthen VHA's important partnership with Vet Centers in reducing veteran suicide.

Independent oversight provides an objective analysis of leaders and frontline staff adherence to VHA policy and their performance in meeting their mission. Three years into VCIP implementation, we have published reports covering all five districts and nine zones in the Vet Center system. This week, our teams are in Hawaii, Alaska, Arizona, Oregon, California, and Washington, conducting inspections.

While we are often encouraged by the dedication of Vet Center staff during these site visits, we repeatedly find evidence of noncompliance with many required processes, most notably those for assessing and documenting a veteran's suicide risk. Further, our teams are finding repeated failures in internal oversight of staff

training and supervision. These deficiencies can have severe consequences.

Identifying the deficiencies was an important step, but now with multiple inspections completed, we better understand the factors that contribute to them. The first is a lack of clear and standardized policies necessary to support frontline staff in providing high quality services to clients. We have repeatedly found instances where Vet Center staff report confusion, conflicting policy language, or unnecessarily cumbersome processes to conduct basic tasks in support of their clients.

Tools such as a SharePoint site that identifies clients as high risk for suicide are neither effectively nor consistently utilized, as many staff report, they were never informed on the purpose, they're perplexed by the inefficiencies and multiple steps to enter basic information, and repeatedly misinformed by the site's inaccurate information.

Second, workload and staffing challenges are repeated concerns in most of the Vet Centers we have visited. During interviews we frequently meet with leaders in acting positions or leaders assuming multiple roles to compensate for vacancies, which are in part due to the inability to compete with the clinical salaries offered by VA medical centers. This leads to client workload some counselors have described as unsustainable.

Finally, a modern and efficient electronic recordkeeping system is critical to ensure that required collaboration, coordination, and quality oversight activities not only occur timely, but also meet quality standards. Staff have repeatedly shared their concerns and frustrations with the limited functionality of the current RCS net system. With the Oracle Health EHRM implementation in a reset phase, when and whether Vet Centers will have the opportunity to modernize their system remains unclear.

Just like in VHA clinical facilities, strong Vet Center leadership must set the tone for a culture that supports the safety and quality of services for everyone receiving care. A recent report at the South Bend Indiana Vet Center, highlighted leadership failures that jeopardized the care of several clients deemed to be high risk for suicide. The Vet Center director informally encouraged staff to underrate clients' suicide risks, failed to evaluate staff's completion of safety plans and clinical coordination, and failed to train staff on assessing and managing clients' risks of suicide.

Considering that Vet Centers can be the first door a veteran in crisis opens to engage in care, there is no room for careless and incompetent leadership. The OIG will continue our cyclical reviews of Vet Centers, building on the lessons learned in earlier reviews, and increasing our focus on leaders' oversight of quality operations. We have expanded our review of Vet Center outreach activities, including Mobile Vet Centers, as engaging those veterans living in underserved and more remote areas is critical to getting needed care to those at risk for suicide.

Similar to our recommendation to VHA medical facilities, clear policies and vigilant internal oversight must be structured and standardized, and leadership must hold themselves and their staff accountable to safe, high quality practices. Chairman Tester and

Committee members, this concludes my statement and I'd be happy to take any questions you may have.

[The prepared statement of Dr. Kroviak appears on page 50 of the Appendix.]

Chairman TESTER. Thank you, Doctor. And there will be some. Sharon, you're up.

STATEMENT OF SHARON M. SILAS, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE

Ms. SILAS. Chairman Tester, Senator Cassidy, and Senator Tuberville, thank you for the opportunity to be here today to discuss GAO's work on VA's Vet Centers. Vet Centers provide a non-institutional access point to receive VA mental health care. They are community-based and offer a range of mental health services in a variety of settings. Vet Centers may appeal to certain veteran populations who are reluctant to receive mental health services through a VA medical center and can provide flexibilities that may appeal to certain veterans and military servicemembers and their families.

In fiscal year 2023, over 300 Vet Centers located across the United States provided counseling services to over 104,000 clients. However, successfully meeting the potential of Vet Centers requires ensuring they're effectively meeting their client's needs, outreaching to potential populations who could benefit from its services, and addressing barriers to care. My testimony today is based on a report GAO issued in May 2022, which can provide some insights into VA's Vet Center efforts.

First, in our review, we found that while Vet Centers have tools to assess whether individual veterans' needs were being met throughout the course of treatment, there was not an assessment of whether veterans' needs were being met collectively. That is, by subpopulations that might face different challenges readjusting to civilian life. We found that the RCS had not analyzed information from assessments or surveys to assess what proportion of Vet Center clients were making progress overall.

For example, Vietnam veterans may have different needs than those who served in more recent conflicts, such as Iraq or Afghanistan. Having information across Vet Centers and assessment of differences across different subpopulations, could help RCS better understand and inform Vet Center efforts and help identify a need for additional services. In our report, we made a recommendation to address this finding, which RCS addressed last spring, and it is now closed as implemented.

Second, we found that Vet Centers lack data that would help better tailor their outreach activities and guidance on how to assess the effectiveness of these efforts. Vet Centers are required to develop annual outreach plans tailored to their service area population, and engage with community stakeholders to reach veterans. To do this, Vet Centers use some data to tailor outreach activities such as census data.

However, as we discuss in our report, having data that would allow Vet Centers to better identify certain populations such as transitioning servicemembers, could help Vet Centers be more ef-

fective in their outreach efforts. We also found Vet Centers were tracking outreach efforts and collecting data on their contacts with veterans. However, we found that Vet Centers could benefit from guidance that include metrics and targets for assessing the effectiveness of these outreach activities.

Lastly, RCS identified some barriers to Vet Center care and actions and had taken steps to address those barriers. Specifically, RCS identified barriers to veterans obtaining Vet Center services. For example, some veterans may lack awareness of Vet Centers and the services they offer or experience challenges accessing a Vet Center due to a lack of transportation.

RCS had taken steps to address these barriers, such as coordinating with DoD and the National Guard to increase the awareness of Vet Center services and providing the option to receive mental health services via telehealth. RCS also identified a barrier to Vet Centers providing services. Specifically, Vet Centers counselors are required to receive monthly clinical consults with VA medical center mental health staff on complex cases.

We learned that Vet Center counselors do not always get the required 4 hours a month because of the availability of VA Medical Center staff to provide those consults. RCS told us that these issues typically get raised at the annual site visits to Vet Centers, and that a VA medical staff are not available, district mental health staff can fill in. Although RCS had taken steps to address these issues, it had not determined the extent to which their actions had minimized the barriers.

Based on the findings for our review, we made five recommendations, four of them remain open. RCS has taken steps to address these four recommendations, including working with VA Office of Information Technology to develop a new software system and piloting a new measurement process to more effectively measure Vet Centers outreach efforts.

In closing, Vet Centers can be a powerful tool for VA and play a pivotal role in successfully reaching and delivering quality mental health care to veterans and servicemembers and their families as they adjust to civilian life. RCS and Vet Centers have taken steps to reach out to potential clients, meet clients' needs, and identify any barriers to access. Fully addressing our recommendations will help RCS and Vet Centers to increase the effectiveness of these efforts. This concludes my prepared statement. I'm happy to take any questions you have.

[The prepared statement of Ms. Silas appears on page 59 of the Appendix.]

Chairman TESTER. Well, thank you for that statement, Sharon, and I appreciate all of your statements. I'm going to start with you Mr. Fisher. We learned late last week from the VA that it has exceeded its healthcare hiring goals, but will continue to focus hiring on mental health care and concentrate on parts of the country where demand continues to grow. So the question is, will this continued hiring focus on mental health care also extend to Vet Centers?

Mr. FISHER. Thank you for the question, Senator. And yes, it will. There——

Chairman TESTER. But keep going if you want. That's the answer I wanted to hear.

Mr. FISHER. Yes, it will.

Chairman TESTER. Okay. So I want to go over to Dr. Kroviak's statement. In her document, her testimony, it says, "Through interviews and surveys of RCS staff, the OIG garnered consistent reports that non-competitive salaries of Vet Center positions with low grade levels on the general salary pay schedule contribute to vacancies." I couldn't find it here where you said that there are a lot of vacancies in our Vet Centers. In your research, did you find a lot of open positions?

Dr. KROVIAK. So these are interviews we have with leadership when we go on-site where it is more than anecdotal that they are complaining of staffing shortages and——

Chairman TESTER. Got you.

Dr. KROVIAK [continuing]. Increasing workloads.

Chairman TESTER. By the way, we all on this Committee value the work that both the IG and the GAO does. So I want to thank you for that. They also found that a lot of the positions were in acting positions, which further contributes to not being able to hire people, because unless you're in a full-time position, that becomes a problem.

So, for you Mr. Fisher, Michael, what are you as the head of the Vet Centers doing, number one. And number two, does the secretary know about this? Do the folks up the chain know about this, and are they going to address it moving forward?

Mr. FISHER. Yes, sir. So there's a couple of things that we are doing. The first thing that we are doing is that we've done this past year a full review of all position descriptions and functional statements within our organization to make sure that they are appropriately graded, given our peers within other places in VA medical centers that those documents are going through the final concurrence process, and we are starting implementation planning to include union notification for rollout.

Second thing that we are doing is working to improve our time to fill. Last year was 154 days. Fiscal year to date, we are at 104 days, and looking for efficiencies and being able to bring people on faster.

Chairman TESTER. But if in fact our salaries are substandard, you're going to have a hard time getting anybody, much less good people to go to work for you. Would you agree with that?

Mr. FISHER. I would agree with that.

Chairman TESTER. And hopefully, somebody is addressing that. If it's not——

Mr. FISHER. We are. We are addressing.

Chairman TESTER. Good. Good. So one of the things that has always appealed to me about Vet Centers is the same thing that appeals to me about taking somebody that has PTSD and putting them on a river fishing or riding a horse or doing yoga or any of that stuff. Is that, it's more laid back. It's much less structured, much more welcoming, and to be honest with you, from my perspective when I've been in the stress level is zero. I mean, it's just, things are cool. Okay?

So, number one, do you see that as being a priority for Vet Centers, and do you encourage that kind of less structured atmosphere where people can let their hair down and talk to other veterans about stuff?

Mr. FISHER. So yes, we do encourage that. And I think that's at the heart of what Vet Centers are. A nonbureaucratic, no wrong door, come in to begin that journey to set goals.

Chairman TESTER. Okay. And are you seeing overall—and this is a tough question, because we've established a lot of Vet Centers that weren't around 5 years ago or a lot more than 10 years ago. Are you seeing use by the veterans increasing?

Mr. FISHER. We are seeing increasing usage in certain areas.

Chairman TESTER. What areas are you talking about? Talk to me. What areas are you seeing the increase?

Mr. FISHER. We're seeing areas increasing in the south.

Chairman TESTER. Oh, Okay. You're talking about regions. I thought you were talking about health issues.

Mr. FISHER. Regions, excuse me.

Chairman TESTER. Okay. And then the last question is, what kind of use are you seeing from the physically disabled veterans' groups?

Mr. FISHER. That is data that we don't have. And that's something that we can take back for the record and be able to answer that more effectively.

Chairman TESTER. That'd be good. I'm just curious, you know. Dr. Cassidy.

Senator CASSIDY. Thank you. Obviously as we all know, there's been an issue at the VA in which a person at suicide risk was counseled by their supervisor to frankly lie about the incident. And so it comes to mind, Dr. Kroviak, because in your testimony we'll get it quite right, but you said someone was encouraged to understate the risk for suicide and then you speak of perilous and incompetent leadership remaining in place.

Dr. KROVIAK. So it was actually the Vet Center director at the time that was encouraging staff to underrate the client's suicide risk.

Senator CASSIDY. Okay. Did that Vet Center supervisor stay in place?

Dr. KROVIAK. No.

Senator CASSIDY. They're gone?

Dr. KROVIAK. Correct.

Senator CASSIDY. That's a good thing.

Dr. KROVIAK. Yes.

Senator CASSIDY. Great. Next you had mentioned the problems with the EHR. How well is somebody who is at risk for suicide integrated into the VA health system? In the sense that, do they get, "Don't stop, don't—boom, go. You're going to the ER right now, you're going to be in the ER, and you're going to be evaluated and you're going to—they're going to check you out." How well is that integration between those two entities?

Dr. KROVIAK. So there's no integration between the systems.

Senator CASSIDY. No, we're both docs. The integration may not be formal, but the integration may be, "Hey, Sam, I got you to take this patient right now."

Dr. KROVIAK. Correct. So there are requirements for coordination based on an assessment done within the Vet Center. And much of our work is showing there are inconsistencies or underperformance in meeting the requirements to ensure that veterans who are rated as intermediate or high risk are getting the type of coordination with the clinical or medical side of VHA that they need.

Senator CASSIDY. Okay. How pervasive, do you have a sense of how pervasive that is?

Dr. KROVIAK. It is quite pervasive. We've published nine reports. We have been to 36 Vet Centers, and it's a repeated finding.

Senator CASSIDY. Mr. Fisher, how would you respond to that? If this has been going on for some time, it's not brand new, it's pervasive, but not being fixed apparently.

Mr. FISHER. Last year we recognized that this was an enterprise challenge, and we went in and did some process improvements at the national level to ensure that those individuals who come into a Vet Center are getting those risk assessments and documenting those risk assessments in that first session. Now, if at the outcome of those risk assessments it's determined that they need a higher level of care, our staff are making those connections.

Senator CASSIDY. Now, I'm hearing though they're not making the connections. I gather on paper they're supposed to, but Dr. Kroviak and the IG has looked at it and said they're not making them. Do you dispute those findings?

Mr. FISHER. What my concern is that I don't know if we are documenting those results correctly.

Senator CASSIDY. Dr. Kroviak?

Dr. KROVIAK. So that may very well be true. The ability to document and timestamp application of these processes is quite limited in RCS net. But we've also noticed that there are issues with even ensuring that staff are properly trained to conduct the assessments and screenings. So it is a training and oversight problem as well.

Senator CASSIDY. And again, the training issue is pervasive as well.

Dr. KROVIAK. Correct.

Senator CASSIDY. Mr. Fisher, I mean, we're talking suicide, you see what I'm saying? So is there a stepwise plan that you could send the two of us and we could look at it and we say, "Oh, this is reasonable. They're addressing it." And we could actually go someplace and see it being implemented, and we say it's actually being implemented. Because I'm hearing from Dr. Kroviak that that's not the case. She didn't say it precisely, but implicit in what she's saying is that it's not happening.

Mr. FISHER. Yes, sir. There is a plan in place and in locations that that finding happens. That district office creates an action plan to improve those concerns, and we can provide that.

Senator CASSIDY. Okay. And Dr. Kroviak, I don't want to keep on putting you on the spot, but I've learned, I practiced medicine for a long time in institutions that sometimes were not good, even though they have motivated people. An action plan does not necessarily create results. Have you seen the institutions in which these action plans have been implemented and have you seen whether or not they have been actually effective?

Dr. KROVIAK. So we don't close the recommendations until we actually review the action plan and accept the action plan as reasonable, and accept data that suggests not only is it working, but it's a sustainable improvement place. So for those recommendations that have been closed, you can be assured that we went through that rigorous process before we closed them.

Senator CASSIDY. Implicitly though, that if they are still open, it means that you've not yet seen that.

Dr. KROVIAK. Correct.

Senator CASSIDY. That's important, Mr. Fisher.

Mr. FISHER. Agreed.

Senator CASSIDY. I yield.

Chairman TESTER. Thank you, Senator Cassidy. Senator Blumenthal.

HON. RICHARD BLUMENTHAL,
U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thanks, Mr. Chairman. I want to ask about a topic that, or an issue that may seem kind of elementary. Why are the Vet Centers operated separately from the VA healthcare system?

Mr. FISHER. That goes back to our founding in 1979 as being a safe place for the Vietnam combat veteran to come in and to begin to access services. Now, when that individual or those individuals were comfortable, our focus is to create care coordination referral to other benefits and resources. So, our partnership with our local medical centers is about bi-directional referral and care coordination.

Senator BLUMENTHAL. But why should the records be completely separate? Why isn't there some integration or joint recordkeeping?

Mr. FISHER. That goes back to another founding principle of making sure that the veteran or servicemember is in the driver's seat of their care and they make decisions about who they want their care team to be. Now, if the veteran or servicemember says, "I want my medical center care team to be a part of that," then we begin those conversations. We release records, and we also release information if they're to avert crisis.

Senator BLUMENTHAL. Is that something the Inspector General has an opinion on?

Dr. KROVIAK. So we very much respect the origins of the Vet Center program, and it really was founded on the spirit of a separation between VA and unfortunately a lot of mistrust on the part of veterans back during the time when it was founded. So we don't take issue with the fact that there's a separate record, but we take issue with is, especially focusing on reducing veteran suicide, is when that required coordination doesn't take place regardless of the records communicating with each other.

Senator BLUMENTHAL. Well, it seems to me that more than suicide ought to be involved, healthcare generally ought to be integrated. You know, the whole principle. I understand the mistrust at the time of Vietnam.

Dr. KROVIAK. Sure.

Senator BLUMENTHAL. But the VA healthcare system has come a long way since then, or it should come a long way. And rather

than kind of accepting the mistrust as a given, shouldn't we overcome it because the VA healthcare system has the psychiatric and the counseling and other services that are necessary?

Dr. KROVIAK. Certainly. I just want to be careful to say that there are not—these are not clinical or medical services provided in Vet Centers. So the distinction should be made that it's not that a lack of clinical information is separated by the record separation, but I appreciate what you're saying with how the ease of connecting the two could be appropriate and important for many veterans.

Senator BLUMENTHAL. Let me ask you. You know, we have an investigation going in the Permanent Subcommittee on Investigation, which is a part of the Homeland Security Committee. Permanent Subcommittee on Investigation is looking into a program called Operation Fouled Anchor, which was an investigation itself within the Coast Guard of sexual assault.

Operation Fouled Anchor was covered up sexual assaults. Many of them were never properly investigated or pursued. And many of those survivors left the Academy, Coast Guard Academy. Are they able to access services through the Vet Centers and through your program?

Mr. FISHER. Yes. Individuals who experience a military sexual trauma while serving can come into Vet Centers and also enjoy that confidentiality, because they might not yet be ready to have those conversations.

One other thing Senator, if I can bring back up to our separate record system. Not every individual that comes into a Vet Center is eligible for the larger VHA healthcare or ready to make that step. And I think about law enforcement or other individuals who don't have that comfort level yet. Our focus through the informed consent process to help them get there and then make—you know, allow them to make decisions.

Senator BLUMENTHAL. But let me just ask about someone who is a survivor or victim of sexual assault while going to one of our academies, whether it's West Point or Naval Academy or a Coast Guard, or in training somewhere. They haven't been in combat. They haven't actually maybe been formally commissioned. They leave while they're still there. They haven't graduated. Can they get care for the sexual assault that they've suffered and the trauma?

Mr. FISHER. My understanding is that that individual at that point is a member of the military, which would then be eligible for those kind of services at Vet Centers. But I would like to take that back and just make sure I'm giving you accurate information.

Senator BLUMENTHAL. I appreciate that. Thanks, Mr. Chairman.

Chairman TESTER. Senator Tuberville.

HON. TOMMY TUBERVILLE,
U.S. SENATOR FROM ALABAMA

Senator TUBERVILLE. Thank you, Mr. Chairman. Thanks for what you guys do. What a tough job with all the vets we have and all the wars we've had and look like we're going to have. Ms. Silas, we're not going to leave you out here. I'm going to ask you my first question.

The GAO report referenced in your testimony describes many issues related to the lack of effective promotion of Vet Centers, specifically ensuring Vet Centers have data on eligible individuals in their service areas to whom they could reach out. Your report points out that Vet Centers may be able to obtain some data on veterans in their service area, but it is not tailored enough for Vet Centers to conduct effective overreach or outreach. What progress has the GAO identified, you know, this situation?

Ms. SILAS. Thank you for that question.

Senator TUBERVILLE. I didn't want you to go to sleep.

[Laughter.]

Ms. SILAS. Yes. So what we found was that Vet Centers were primarily using census data to try to tailor their outreach efforts. And the census data really only goes down to county level and it doesn't have some of the specific information that would help them be able to target specific veteran populations. And so we made a recommendation for RCS to have some more robust data for the Vet Centers to tap into.

And so RCS is now developing a software solution for Vet Centers, which would provide Vet Centers with access to a VA, DoD software, or a data system that has information on transitioning servicemembers. And it also goes down to the zip code level, so it gets more granular, and then it has more of the demographic information that will help them better identify veterans to outreach to.

Senator TUBERVILLE. So is that software, is it active as we speak? Is it working?

Ms. SILAS. My understanding, it's still developing. I'm going to defer to Mr. Fisher.

Mr. FISHER. You are correct. We are still developing and we will be rolling out that this fiscal year after we go through union notification. That will give us access to transitioning servicemembers so we can reach out to them. We also have a projection model that allows us to go and get understanding of the counseling needs in local communities, given our unique eligibility, which can also help our outreach staff to go and determine where to do targeted outreach.

Senator TUBERVILLE. Yes. It's about people, right? It's about having good people, especially doing your job. Mr. Fisher, what happens when an individual comes to a Vet Center seeking counseling, but it is evident to the counselor that the individual is in crisis, perhaps on the verge of hurting themselves or someone else. What happens next?

Mr. FISHER. It is all about getting that individual to the level of care that they need.

Senator TUBERVILLE. Immediately?

Mr. FISHER. Immediately. That could be to our VA medical center peers. It could also be through the local community healthcare systems, 911.

Senator TUBERVILLE. Is there any follow up from the processing center following that individual to the VA?

Mr. FISHER. There is follow up. In fact, we have examples of where staff then accompany that veteran to that higher level of care.

Senator TUBERVILLE. Okay. How do vets and the larger Veterans Health Administration interact with each other when it comes to technology, information data? Do you all interact pretty well from the processing centers to the VAs?

Mr. FISHER. When it comes to us with our peers at VA medical centers, we have that bi-directional referral where, you know, I think about it, if you walk into a Vet Center with a broken foot, we've got to get you over to the place to fix that. And that is our focus, is on warm handoffs. Now, I think we have locations and communities that we need to do a better job and work on that relationship, that back and forth.

Senator TUBERVILLE. I had a buddy of mine about 4 years ago, mental health, bad Navy SEAL. He had seen and done things probably none of us would ever imagine. Had huge problems, but had a tough time getting past the front door at some of our VAs. You know, and again, it's about people, you know, actually security had to escort him out because when you get to that level, you know, it's pretty tough. You know, so again, it all goes back to people. I guess that's all I've got, Mr. Chairman. Thank you.

Chairman TESTER. You bet. Senator Sinema.

HON. KYRSTEN SINEMA,
U.S. SENATOR FROM ARIZONA

Senator SINEMA. Thank you, Chairman Tester, and thank you to Ranking Member Moran for holding this hearing today. Thank you to our witnesses for being here today. You know, Vet Centers provide a great resource that focus on the readjustment and mental health needs of our veterans and current servicemembers. In Arizona, where roughly 10 percent of our State's population is currently serving or has previously served as a member of our armed forces, the challenges facing veterans are varied.

Based on concerns heard by my office, Vet Centers can be hard to access for those residing in Arizona's rural and tribal communities. And deficiencies in the client record system and staffing shortages have contributed to heavy workloads prescribed by RCS policies can make accessing mental health care even more difficult. Enhancing access to mental health care is crucial, especially in a confidential setting as provided at our Vet Centers.

I understand that RCS and Vet Centers have implemented one of GAO's recommendations in its May 2022 report, and have taken some steps in implementing the other four recommendations. I encourage RCS and Vet Centers to continue this progress, especially working to minimize barriers to Vet Center care. That'll be the focus of my questions.

So my first question is to you, Mr. Fisher. My office has been hearing from Arizona veterans and VA staff regarding concerns about unmanageable counselor's workloads, which leads to burnout, high turnover, and of course, impacts the quality of care that veterans are receiving. Is RCS still following the 1.5 visits per hour policy? And how are Vet Centers managing the demand for mental health services while ensuring the quality of care is not impacted?

Mr. FISHER. Sure. So thank you for the question, Senator. I'd like to address the 1.5. There is a formula that we use for what we consider a fully successful counselor. Really, we're asking our coun-

selors to spend half their time doing counseling, outreach, and then associated travel.

The other side of that, what I hear in your question, is workload. Veterans and servicemembers coming in in places where there are demand issues, meaning we have more individuals coming in or the amount of time we're spending in front of veterans is increasing. We look to recruit more staff. We also look to move some of that work through virtual services to other Vet Centers as a band aid while we bring in more staff where needed.

The other side of that is our first line of defense, is our first level supervisors. That Vet Center director, who then takes those incoming needs and manages it within the various counselors, as well as requesting those additional resources.

Senator SINEMA. Does the VHA have plans to improve its recruitment and retention policy for quality counselors, including in rural and tribal areas?

Mr. FISHER. We do have plans, and have implemented plans to ensure recruitment and retention, whether that is using special salary rates, the recruitment, retention relocation incentives, scholarships, loan repayments that we are actively using right now, to both hire and retain great staff.

Senator SINEMA. And with which incentive program have you seen the most success when you're onboarding quality Vet Center employees? And then how are Vet Centers supporting current staff to reduce attrition rates and help the staff manage the increasing demand for services?

Mr. FISHER. We'll have to take it for the—we'd like to respectfully take it for the record on which of those incentives is working the best, and can—I'm sorry, ma'am, can you repeat your second part of your question?

Senator SINEMA. How are the Vet Centers currently supporting staff to try and reduce attrition rates and help them manage increased demand for services?

Mr. FISHER. Yes. Well, we go back to we have processes in place where Vet Centers can ask for more resources. We also have the incentives that we've talked about to ensure retention as well as recruitment. And then also, our district offices have had conversations and are creating action planning with our Vet Centers around burnout, ideas of burnout that are not covered in workload and other things. It could very well be, staff might be interested in going to certain trainings. So we create those opportunities.

Senator SINEMA. So for both Mr. Fisher and Dr. Kroviak, the Tucson Vet Center recently shared concerns with my team about their electronic client record system, and how it's slowing down the delivery of provider care. The Vet Center staff reported the system is decades out-of-date, and contains redundant steps for documenting patient and family interactions. So could you talk to me about what the VA is doing to ensure that Vet Centers get more effective and up-to-date IT systems for their clinical staff?

Dr. KROVIAK. So from an oversight perspective, everything you said is exactly what we're finding across the system. The inefficiencies are real. It is a primitive system. It doesn't support functions that you would assume it should in terms of collaboration, coordination, and oversight. Again, we don't understand where the Vet

Centers fit into the modernization attempt, but they have made attempts to enhance the current program.

An example would be a reminder that pops up when a suicide risk assessment is due. So, we think there can be or there is space to consider what enhancements can be made to the current program to ensure safety and certainly reduce some of the burdensome workloads through electronic efficiencies. Pardon me.

Mr. FISHER. We have partnered with OIT as well as VHA to begin to review needs, what our needs are for a future record system, and then begin to implement those needs. We can provide updates as we go through that process.

Senator SINEMA. I appreciate that. Thank you, Mr. Chair.

Chairman TESTER. Thank you, Senator Sinema. Senator Tillis.

HON. THOM TILLIS,
U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. Thank you, Mr. Chairman. And thank you all for being here. Mr. Fisher, this should be just a nit. I wouldn't expect you to know this, but my staff had recently gone out to the VA website and then went into the Vet Center National Resource Directory, and the next level down you only find three sites. I think it's Raleigh, Greensboro, Fayetteville, and then you have to drill down further to find Jacksonville. It sounds like simple when you hit North Carolina, get all the locations, people I know, you know, regional areas well, but you may have other people looking for these resources to give it to them quickly. So that's just a software modification request. I'm sure your OIT people can take care of that.

I also want to talk about the pilot related to outreach. I think you have a path forward there, from the GAO report they recommended that you're doing a pilot and tracking effectiveness of outreach. You know what I'm talking about?

Mr. FISHER. Yes.

Senator TILLIS. Do you have a path forward? I don't think that it's materialized yet. Can you give me an idea of what the, you know, how many locations are going to be piloted at what sort of timeframe we can expect to be implemented?

Mr. FISHER. Yes. We do expect to implement that in the coming months. As far as locations, we are going to negotiate with the union, and then we will have a set number of locations for that. But it is really focused on looking at the quality of outreach and specifically how many individuals are coming in from outreach into counseling services.

Senator TILLIS. Yes. So tell me a little bit more about that. I mean, how are you going to be able to measure it? Tell me a little bit about the pilot to where you're really able to connect specific activities to moving the needle in the right direction or not moving the needle, and therefore you have to look at a different alternative.

Mr. FISHER. If we can respectfully take that for the record so we can give you a full outline of everything that we are doing.

Senator TILLIS. Good.

Mr. FISHER. Also on your comment about the website, we have recently implemented websites for every Vet Center that includes

up-to-date information on the type of services we provide at those locations. We will also take that other item back to look for some inefficiencies.

Senator TILLIS. Thank you. Just get the information as quick—if somebody's taken the initiative to find this service, you want to make it as easy as possible to get down to that brick and mortar location that——

Mr. FISHER. Agreed.

Senator TILLIS [continuing]. They can go to. Ms. Kroviak, did I pronounce that right?

Dr. KROVIAK. You did.

Senator TILLIS. Tell me a little bit in the research—I guess, maybe let's look at it a different way. I got a few specific questions, time allowing, but if we've got veteran center directors listening to this hearing right now, what's the main takeaway from your perspective, from the office of OIG that they, they should take away?

Dr. KROVIAK. Read every report we publish, even if it's not about your Vet Center. These are risk assessment tools, and it should be spreading like wildfire across the system as to what they need to look at and what they need to fix, or at least assess whether or not they need to fix it.

Senator TILLIS. Do you know if the department—I think that's a great suggestion. It's only as good as the take rate for the suggestion to read it, internalize it, execute it. Do you feel that the department is doing enough to make sure that that's being communicated in the manner that you've just communicated it here?

Dr. KROVIAK. Honestly, no. I think we'd be seeing more improvements across the system if that was actually into practice as we would like it to be.

Senator TILLIS. Yes. Give me a silver lining if there is one. In your research, did you identify any particularly good, better, or best practices that should be emulated?

Dr. KROVIAK. Oh, it's communication. So within a Vet Center, if they have strong communication with the medical center in their locality, we see much better data coming from those centers and much more effective relationships and support of particularly those high risk clients that we're worried about.

Senator TILLIS. You would've thought that that connection would've just been systematized as standard operating procedure. Are there lapses and exactly what are veterans saying?

Dr. KROVIAK. We certainly see inconsistencies, lack of clarity——

Senator TILLIS. Does that mean that we're deviating from standard operating procedure or we haven't properly communicated SOP at that level?

Dr. KROVIAK. I think the effective oversight and communication to frontline staff has been inconsistent to understand how important, just what I described, connecting with the Vet Center, or connecting with the VA medical centers, knowing the names of the people that you need to reach out to for urgent and non-urgent issues, you know, really making that the community for a veteran.

Senator TILLIS. And Mr. Fisher, again, you're going to give me details on the outreach report?

Mr. FISHER. Yes, sir.

Senator TILLIS. Then Mr. Chair, I will conclude at this point. Thank you.

Chairman TESTER. Thank you, Senator Tillis. Senator Hassan.

HON. MARGARET WOOD HASSAN,
U.S. SENATOR FROM NEW HAMPSHIRE

Senator HASSAN. Well, thanks, Mr. Chair, and to you and Ranking Member Moran for this hearing. And thank you to our witnesses, not only for being here today, but for the work that you do. Mr. Fisher, Vet Centers support the mental health needs of veterans who are transitioning out of the military. One of the most critical elements for a successful transition from the military into civilian life is building ties within the local community.

So what are Vet Centers doing to help newly separated veterans build stronger connections within their surrounding communities, and what more should we be doing? One of the things I hear from veterans, and actually from community members is, "We'd love to be there for our veterans. We don't necessarily know who they are. We don't know what they need."

Mr. FISHER. Sure. So the first thing is going out and creating community partnerships within those communities to welcome home all those who serve. And then from there, we, we decide which partners we are going to partner with based off of the needs of those local servicemember, veteran populations. We've talked previously about a new outreach application that we will be implementing that will give us access to all transitioning servicemembers. So we view that as an opportunity to be able to reach out to them as they come back into their community and begin those conversations, welcome them to a Vet Center, have them come and check it out, and then from there, use our partnership.

Senator HASSAN. Right. And have those partners kind of ready and able at those moments of——

Mr. FISHER. Yes, ma'am.

Senator HASSAN [continuing]. The first visit, okay. So another question for you, because I want to dig more into one of the ways that we can build this sense of community, and that's peer support counseling, right? So, other VA offices such as the Women's Veterans Network have seen success in implementing these types of programs, which create peer support groups using trained peer support specialists. How can Vet Centers maximize opportunities to incorporate peer support models into the services that they offer?

Mr. FISHER. Sure. So our view on peer support is veteran to veteran, which is why we hire a large number of veterans. All of our outreach staff are veterans, so they can have that shared experience. We will go out to the Office of Mental Health and Suicide Prevention to see if there's other opportunities around true peer supports that we can begin to leverage within Vet Centers that we can report back to you on our State.

Senator HASSAN. Sure. Look, the Veterans Service Organizations around my State have really raised this, and, you know, whether it's the Buddy Check program or other kinds of programs, what they're telling us and what veterans tell us is that, just knowing who the other veterans are in their communities and having that

opportunity to find the right match is really important. So I'd love to hear more about that from you.

Another question for you, Mr. Fisher. I'm particularly interested in how Vet Centers are tailoring their resources to meet the needs of women veterans. Women are the fastest growing group of veterans using VA services, tripling in number over the past two decades. So what type of specialized training do Vet Center employees receive on the unique military experiences and post-service needs of women veterans, and how does that training impact the care that these women receive?

Mr. FISHER. Sure. So every new employee that comes into RCS goes through new employee orientation, in which we have a military culture block of instruction. And also have blocks instruction around working with women veterans. Every one of our districts also create training that is important to the needs within those local communities. Now, your second part of the question is, are we seeing that working? Our customer feedback scores, specifically our trust scores for women veterans are in line with the national average. So we're seeing that that work is successful.

Senator HASSAN. Okay. Just an aside, what I hear from women veterans in New Hampshire is simply they'd like to know where all the other women veterans are, you know, to talk to them, to have a relationship with them. So again, that talks to the kind of informal peer outreach and peer supports that you all can help build.

And then last question for you, Mr. Fisher. The May 2022 GAO report that Ms. Silas mentioned in her testimony, included a recommendation to assess how well Vet Centers are collectively meeting the needs of subgroups of veterans. Can you discuss the VA's implementation of this recommendation, what analyses have you completed, and how has Vet Center leadership made adjustments to services based on these analyses?

Mr. FISHER. So we use our veteran signals, our V signals, customer feedback tool, to measure those things, which we rolled out in 2021. At the national level, we have enough data to be able to start looking at gender and other demographics. And what we're finding is that there is no real difference in trust scores. Our trust scores are still high. As we move forward and get more data specific to local Vet Centers, we can start trending and looking to see any opportunities within those local Vet Centers. Lastly, we've hired a customer experience officer whose role is to really dive down into where are our pockets within the country that we can improve around that experience.

Senator HASSAN. Okay, thank you. Thank you, Mr. Chair.

Chairman TESTER. Thank you, Senator Hassan. Senator Brown.

HON. SHERROD BROWN,
U.S. SENATOR FROM OHIO

Senator BROWN. Thank you, Mr. Chairman. I'm really kind of perplexed by all this. We have in my State, 700,000 veterans at least. I've done in the last since the PACT Act passed in August '20, which probably started right before that. I've done 40 roundtables in 88 counties, and I have a full-time veteran staff person who does others of them that did. We go to Veterans Halls, we

go to DAVs or Legions or AMVETS and 15 veterans sit around the table and talk about all this.

We have increasing mental health challenges based on all kinds of issues, from Vietnam Sense and we have, it seems, if not increasing rates of suicide, certainly far, far too many suicides. So why don't, Mr. Fisher, really all three of you, why don't I hear more about these centers? Why do I not hear more from veterans? Well, Ohio has 88 counties, each of the counties has a appointed office, veteran service office. Some of them 2 people, some of them 50 people in the big counties. And I'm talking to veterans all the time. We've been on this Committee with Chairman Tester for our whole careers. Why am I not hearing more about these centers? You want to start with you, Mr. Fisher, and then Dr. Kroviak, and then Ms. Silas.

Mr. FISHER. Thank you for the question, Senator. I believe that just shows that we have more work to do to get the word out. Every Vet Center has outreach specific staff whose focus is to go out and not only create face-to-face connections with veterans, but create partnerships to get that word out.

Lastly, as one of the GAO recommendations, we did roll out a survey to try to get a better understanding of why are individuals not understanding or getting more information about Vet Centers. We're analyzing the results of that and then we'll get into action planning from there.

Senator BROWN. Okay. Dr. Kroviak?

Dr. KROVIAK. Yes. And we do look at the outreach activities that are conducted at each Vet Center site, and they are not meeting the mark for the requirements of the number of activities. And that typically relates to competing priorities, workloads, acting positions, vacancies they're trying to compensate, so they're not consistently engaging in all the outreach activities that they certainly want to and could be.

Senator BROWN. Ms. Silas?

Ms. SILAS. I was just simply going to mention the same thing that Mr. Fisher mentioned about surveying veterans that are not already engaging with Vet Centers, and trying to gauge awareness, and let other veterans know what the services that are available, especially for some of those veterans that are at high risk for suicide.

Senator BROWN. So, thank you. My State's 12 million people. We have centers in some big cities, Toledo, Columbus, and then we have centers in a medium-sized city, Canton. And then we have centers in sort of suburban areas of big cities, Kettering near Dayton, Norwood near Cincinnati, Oakwood near Dayton, Parma Heights near Cleveland.

Should there be more to serve 12 million—well, serve 700,000 plus veterans? Should there be more of these? Should they be staffed at higher rates? You talked about falling short on outreach. What's the problem, Mr. Fisher?

Mr. FISHER. I think to answer that question, while we have those seven locations, we also have additional multiple sites of care, which we call community access points that allow us to get into further communities. We can provide you with the number of com-

munity access points that we have in your State, but that allows us to get into those distant communities.

Senator BROWN. Okay. I have a bill that Daniel Harvey and Adam Lambert Improving Servicemember Transition to Reduce Veteran Service Suicide Act, to better prepare servicemembers for civilian lives—life for civilian life, I'm sorry, by connecting them with a VA social worker or nurse. Clearly, we need to, I assume you would support them, Mr. Fisher, do you know yet?

Mr. FISHER. Yes, sir.

Senator BROWN. Okay. Would you then, and I'll, I'll stop, give some of my time back, Mr. Chairman. Would each of you tell Drew in my office, send me what we need to do, specifically chapter and verse so that people understand this service? Because I said, I rarely hear about this and I interact with veterans. Perhaps partly because of the size of my State, perhaps as much as anybody on this Committee except Senator Tester.

And I just don't hear about this, when I hear about problems, I don't hear about this option enough. So would you give me each of the three of you, give my office a step-by-step playbook, if you will, on, sorry, the metaphor there, playbook on what we should be doing?

Mr. FISHER. I think the first thing is making sure that we are committing to regularly scheduled updates with your staff to let them know what we're working on, where our challenges are, where our successes are within your State.

Senator BROWN. Okay. The other two of you would do that, please?

Dr. KROVIAK. If I could also add that as much as we would like to see the services expand, if your offices could locally support the recommendations in our report and the improvements needed. So enhancing and expanding the services won't help unless the shortcomings and findings that we have identified are resolved.

Senator BROWN. Ms. Silas?

Ms. SILAS. And I would just add, I mean, basically all three of the findings that we had in our report, if RCS implements those recommendations, it will help with outreach. It will help make sure that veterans are getting information about the services that are involved. And if they are continuing to do periodic assessments of barriers to care at Vet Centers, then they will also know where they need to kind of target their efforts to make sure that they're being more effective.

Senator BROWN. Okay. And of course, I didn't give any time back. Mr. Chairman, could I have another 30 seconds?

Chairman TESTER. Sure.

Senator BROWN. Thank you. How many on the average at these seven or any other around the country, how many people in the average work at one of the Vet Centers?

Mr. FISHER. Between six and seven individuals.

Senator BROWN. Six and seven, okay. I mean, it just seems, when I'm doing these Veterans Roundtable, I said I've done 39, 40, 41 of them and doing regularly, and a staff person's doing most of the other 80 of the 88 counties. I generally talk for two or three minutes at the outset, and then the rest of the time is questions and letting the 15 veterans, or asking 15 veterans for questions.

This is something I should announce at the beginning of every one of these, what services are available at the Vet Centers. And I don't do that because I don't know enough to do that. So I need help on that too.

Mr. FISHER. Yes, sir.

Senator BROWN. Thank you.

Chairman TESTER. Thank you, Senator Brown. Senator King.

HON. ANGUS S. KING, JR.,
U.S. SENATOR FROM MAINE

Senator KING. Thank you, Mr. Chairman. First, I want to thank the Chairman and the Ranking Member and the Committee staff for facilitating an authorized field hearing that we had in Maine last Friday on—it was fabulous—on long-term care. We had really good witnesses. We had veterans, we had officials from the VA, and it was very illuminating and educational and indicated, for example, that we have nursing home care and we have home-based care, but we have little, if any, assisted living coverage. There's a gap.

And also the workforce problems, as you can imagine, were front and center. So it was an excellent hearing and thank you very much for facilitating that. We almost got closed down by a snowstorm, but we reminded them that their driver's license said Maine, not Arizona. So we managed to stay open.

Chairman TESTER. I'm going to have one in Montana.

Senator KING. There you go. First, Mr. Fisher, we, as you may recall, we had a problem with the Vet Center in Portland, fire hazard. They had to move, find temporary quarters. Joanne Boyle of District One, I want to acknowledge, did a lot of work to get us into temporary space. And we are looking, we believe that we'll have a permanent location by May. Do you have any information on that? Is that something that we can count on?

Mr. FISHER. Yes. We are still on track to do that. I also want to thank your staff for helping us move into that temporary space, which is in the same building that our permanent location is.

Senator KING. Good. Excellent. There's a pilot under the Cleland-Dole Act for transportation to Vet Centers, and there's a part of it, one of them is in Bangor, and we have 68 veterans that are using it. But the implementation of the pilot seems to be stuck in rulemaking. And the rulemaking is, what constitutes financial hardship. When do you expect we're going to get the pilot operational, and this is really important for rural veterans. The top part of the State of Maine is extremely rural, and a lot of veterans up there, it's a long way to the nearest Vet Center. Talk to me about getting this pilot up and running.

Mr. FISHER. Well, we expect the rulemaking process is averaging now 24 months to be able to get through. What's important to us——

Senator KING. Eisenhower retook Europe in 11 months.

Mr. FISHER. Yes, sir.

Senator KING. Just say it.

Mr. FISHER. Yes, sir. What's important to us is the public comment period. Because this is new, we want to make sure that we're accurately defining what the financial hardship is.

Senator KING. I understand that you want to have input, but let's get on with it.

Mr. FISHER. Yes, sir.

Senator KING. In the meantime, we've got veterans that can't get to the Vet Center. How about workforce? The Vet Centers have limited staff. They're really dedicated people. Are you having the same—are the Vet Centers having the same workforce issues that practically everybody else is?

Mr. FISHER. We are experiencing those workforce issues, and we're working to reduce those. Whether that is how we are looking at our time to fill and looking for other ways to bring on staff.

Senator KING. Your time to fill, as I look at the data, is better than VHAs however. I'll compliment you on that.

Mr. FISHER. Thank you. Thank you.

Senator KING. Maybe that's damning with faint praise. I'm not sure.

Mr. FISHER. I'm sorry, say that again.

Senator KING. Damning with faint praise.

Mr. FISHER. Yes. I think we still have a lot of work to do to bring on staff faster.

Senator KING. I've looked down the list of all the things that the Vet Centers, the services, they provide really good important services. But we've had testimony here that one of the factors, particularly with regard to veteran suicide, is financial questions. And I wonder of your thoughts of adding financial counseling to this list of services VA benefits, screening, medical issues, substance abuse, financial advice, and counseling, I think could be an important adjunct to what the Vet Center provides.

Mr. FISHER. Thank you for that suggestion. We actually have Vet Centers that have partnered with that type of community partner to be able to provide those services, but we can look into doing that in a more robust way.

Senator KING. I would urge you to take a serious look at that. And we have had testimony at this Committee that this is one of the suicide factors. And it strikes me as it fits well within the list of services that you are providing. I just want to thank you for the oversight and the work that you've done. Are you satisfied with implementation of your recommendations?

Dr. KROVIAK. We are satisfied with the action plans that are put forward to our recommendations. We are not as satisfied that we are repeatedly finding the same things as we go across different Vet Centers. So we would like the information in one report to be dispersed broadly across the system so that all the Vet Centers can use that as a risk assessment tool, even though it's not about their particular facility.

Senator KING. Well, my experience has been that the Vet Centers in Maine are a high return, low cost service very cost-effective way of serving the needs, meeting the needs of veterans. And I know our veterans appreciate it. So keep it up. Thank you very much. Thank for your work. Thank you, Mr. Chairman.

Chairman TESTER. Thank you, Senator King. Senator Sullivan.

HON. DAN SULLIVAN,
U.S. SENATOR FROM ALASKA

Senator SULLIVAN. Thank you, Mr. Chairman. Mr. Fisher, I wanted to kind of dig deep on a very specific Alaska issue. And I know my staff's been working with your team on it, but we are in the midst of a very heartbreaking spike in mental health challenges among our military members. Now, these are the active duty members, but you're probably tracking particularly the U.S. Army has had—just the number of suicides in the last, I think it's four to five years, has been 45—north of 45 in one region. I mean, this is more than—the numbers are like through the roof.

I was literally just on the phone with the Secretary of Defense on this. And so the challenges that relate—so there's a lot of attention being brought to the active duty force in Alaska. But we are having, again some challenges on this issue as it relates to our veterans. You know, we're struggling with our work force with regard to the VA. We have more vets per capita in the State, in the country. But one of the things that I wanted to mention is that our Vet Centers are very busy places. They can provide both case management and mental health services.

There's this comparison that I know that has been made at the VA here in DC about caseloads as high as 100 per provider. And our caseloads are about 50 per provider. And so I think the VA's either saying, "Hey, you don't have a problem relative, or you guys are more inefficient." But the results is that no new providers are getting placed in our Vet Centers and we think we actually need them. The case managers have a lot more to manage in other States.

For example, our hub and spoke model of healthcare means that coordinating both interstate and out-of-state is more common than other States. Travel in Alaska, as you know, is, you know, very challenging. We're a continental-wide State, almost three times as big as Texas. We have less road miles than Connecticut. Seasonal depression rates are higher due to the winters. So even though we have might have smaller per capita caseloads, our workers we see are overwhelmed, and the formula at the VA is saying there should be no new placements in Alaska.

So what I wanted to do that we need to get more efficient before we get more workers. So what I wanted to do, I know that's a big windup, but I wanted to work with you and your team on how the VA formula can be reevaluated to better reflect some of the realities on the ground. As you guys know, one size doesn't fit all. And would you commit to working with me and my office on these issues? And I know we've been talking to your team about it.

Mr. FISHER. Yes, we will commit to that. We'll do a deep dive into service provision there to see where our opportunities are.

Senator SULLIVAN. Good. Let me turn to another, the Cleland-Dole Act, which I voted for, required the VA to hire 50 full-time employees for Vet Centers to expand mental health services. The bill required the VA to select 50 different locations with unique geography. Were any added to the Vet Centers in Alaska, do you know under that, or are you guys still implementing that?

Mr. FISHER. None of the positions were identified for Alaska, but we have other opportunities to increase our workforce and I think that goes back to the deep dive that we'll commit to.

Senator SULLIVAN. Okay. Good. And let me ask one final question. Are we seeing any—so I'm very Alaska focused, but of course we're here in the U.S. Senate, so I care about all veterans. Are we seeing any kind of positive signs on veteran mental health or suicide issues nationally, or are the trends still trending in a direction that is continuing to be alarming?

And, you know it's an issue that of course this Committee cares a lot about. But what are the trend lines and is there anything in terms of a silver lining that we're seeing with regard to veteran issues, particularly veteran suicide?

Mr. FISHER. Well, I'm going to speak to Vet Centers specific, and I'm going to go to our customer feedback, our trust scores. And that is, we find that Vet Centers trust us to improve their quality of life. And that means to me, we need to make sure we're providing the right services that meet the needs in those local communities, that keep those veterans and servicemembers engaged in services, and then to be able to feel comfortable enough to voice that if they're having a bad day, to say that out loud.

Senator SULLIVAN. Okay. Good. But the national trends, that's kind of a little bit beyond the mission of the Vet Centers that you're focused on? In terms of what you can tell this Committee.

Mr. FISHER. Yes, sir.

Senator SULLIVAN. Anyone else on the panel? Do you guys have a view on that?

Dr. KROVIAK. So in terms of oversight, the reason we're so involved in overseeing these Vet Centers is because of that. That VHA is not making the gains that it would like to in reducing veteran suicide and the risk for veteran suicide. I'll add that our oversight teams are actually in Alaska this week. So they will be looking at Vet Centers in your State this week.

Senator SULLIVAN. Look, when the Vet Centers are there, I agree with Mr. Fisher, the response, you know, it's been great. Right? They're really great facilities and so I think it's a wonderful program, innovative, and maybe it's too early to tell the impact, but I would hope that we're going to start to see some kind of positive impact, particularly on this issue that all of us really care about, which is veteran suicide and these rates that are heartbreaking and no one wants to see those rates continue. But you think it's too early to tell, Doctor?

Dr. KROVIAK. Is your question, is it too early to tell, to tell the impact of Vet Centers——

Senator SULLIVAN. Yes.

Dr. KROVIAK [continuing]. On the suicide rate?

Senator SULLIVAN. Yes.

Dr. KROVIAK. Well, I can tell you because we're finding consistent shortcomings in the coordination and the steps needed to ensure a veteran's safety in a Vet Center when they're deemed high risk, I think until we see those improvements at the local Vet Centers, it is hard to say what type of impact they're having. But we would be happy to reach out to you when we have our conclusions from the sites we visit in Alaska to get some——

Senator SULLIVAN. That would be great.

Dr. KROVIAK [continuing]. Some local insight into what we're finding.

Senator SULLIVAN. Great. I appreciate it. All right. Thank you, Mr. Chairman. Appreciate it.

Chairman TESTER. Thank you, Senator Sullivan. I do want to thank the witnesses here. I think this whole Committee looks forward to continuing to work to make sure the Vet Centers are the best they can be. I would say whether it's a GAO recommendation or an IG recommendation, really should roll up the sleeves and get those closed as quickly as possible. I think the GAO recommendations have been out there since May of last year. That's a long time.

And I know it's hard to say because we don't have a lot of urgency in the United States Senate or Congress in general, but you have to do better than us. Okay? I'll appreciate that. Making sure that we're meeting the needs of the servicemembers and the veterans and the families, is what this Committee is about. And I think that's the same charge you have, Michael, and I appreciate your work, when we can always do better.

We will keep the record open for a week. Until then, this hearing is adjourned.

[Whereupon, at 4:48 p.m., the hearing was adjourned.]

A P P E N D I X

Opening Statement

SVAC Opening Statement:
"Vet Centers: Supporting the Mental Health Needs of Service Members, Veterans, and their Families"
January 31, 2024

Thank you, Chairman Tester and thank you to our witnesses for being here today to discuss Vet Centers.

Veterans mental health and suicide prevention is one of my top priorities, and in addition to Vet Centers, access to comprehensive mental health care and upstream crisis prevention play important roles in the holistic system of services available to our veterans. I was pleased to see VA recently announced it will award another $50 million to community organizations to help prevent veteran suicide under the Staff Sergeant Parker Gordon Fox Grant Program, which was part of the Commander John Scott Hannon Veterans' Mental Health Care Improvement Act.

Vet Centers have been instrumental in bridging the gap between veterans, their families, and the necessary mental health care and readjustment counseling they need. In the past year, nearly 250,000 veterans, service members, and their families were able to receive counseling at VA's over 300 Vet Centers around the nation.

Vet Centers receive high trust and satisfaction scores among veterans based on the overall quality of services they are receiving. More importantly, they continually succeed in building access to social and psychological services in rural areas that may be more difficult for veterans and their families to access.

Recently however, my staff and I were notified of an issue at a Vet Center in Eastern Kansas. The VA Eastern Kansas Healthcare System had a sudden decrease in mental health care personnel due to planned retirements and others leaving VA for other opportunities.

Due to the decrease in clinicians, the VA medical center handed off a large number of their patients to a local Vet Center. That increase created an issue, as the Vet Center did not have the capacity to effectively provide care to each of these veterans.

One female veteran who was handed off to the Vet Center to receive mental health care encountered severe delays in care and was told that the Vet Center could not treat someone unless they were in an active suicidal crisis due to the patient overflow issues. Not once did VA offer this veteran a community care appointment. While not entirely the fault of the Vet Center, I think we can all agree this issue could have been handled better. I would like to hear from our witnesses how they think that can be accomplished.

Veterans in Kansas and across the country, along with their family members, and caregivers rely on receiving high-quality care provided by

VA and Vet Centers. I am committed to working with the Department on finding solutions that help the facilities and staff handle sudden influxes of veterans and family members, while making certain that veterans nationwide are receiving the care they deserve.

With that, I look forward to hearing today's testimony. Thank you, Mr. Chairman. I yield back.

Prepared Statements

STATEMENT OF MICHAEL FISHER
CHIEF OFFICER, READJUSTMENT COUNSELING SERVICE
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

January 31, 2024

Good afternoon, Chairman Tester, Ranking Member Moran, and Members of the Committee. I appreciate the opportunity to discuss the readjustment counseling services available at Vet Centers.

Readjustment Counseling Service (RCS) Vet Centers are community-based locations that offer readjustment counseling in a safe and confidential environment to eligible Veterans, certain Active Duty Service members (ADSM), and their families. Statute 38 U.S.C. §1712A tasks Vet Centers with three major functions: direct counseling services, outreach, and referral. A core value of RCS is to promote access to support by helping eligible Veterans, ADSMs, and families overcome barriers that may impede them from using Vet Center services.

Purpose, Mission, and Culture

RCS Vet Centers aid eligible Veterans and members of the Armed Forces, including members of the Reserve components, in adjusting successfully to life after deployment or activation. They also assist eligible individuals who experienced certain military service-related trauma and those actively using qualifying educational benefits. The RCS mission is to welcome home and honor those who served, those still serving, and their families by reaching out to them, engaging their communities, and providing a broad range of counseling, outreach, and referral services. Family members are also eligible for readjustment counseling services when it is found to benefit the readjustment of those who have served or in other situations, such as the death of an ADSM or Veteran by suicide. Additionally, Vet Centers are, by law, separate from VA's general health care facilities.

Vet Center services are designed to provide non-medical readjustment services to eligible individuals. The non-medical Vet Center approach within a Veteran/ADSM population with shared/similar experiences allows for access to a supportive community that is non-stigmatizing, builds trust, and creates an environment conducive to addressing trauma exposure and concerns.

The readjustment counseling model uses community-based, interdisciplinary clinical and team-based therapies to provide trauma-informed services that are delivered with military cultural competence. This model uses a variety of different events and engagements with the stakeholder community. Many of these services are

delivered by staff who are combat Veterans, fostering an empathetic connection to the client.

Vet Center Customer Experience

Direct Feedback through from individuals served by Vet Centers shows that these services have a significant and positive impact on the overall wellbeing of individuals served across RCS. The provision of culturally competent services and focus on individual needs has also resulted in strong customer satisfaction and experience scores. Customer experience is the product of interactions between an organization and a customer over the duration of their relationship. VA measures these interactions through Ease, Effectiveness, and Emotion, all of which impact the overall trust the customer has in the organization. RCS surveys of Veterans and other beneficiaries are designed to measure this performance by asking users their level of agreement with statements about their experience with Vet Centers. Data provided below are for the time period of July 1, 2021, to December 31, 2023, and are based on over 72,500 respondents' scores. These data are limited to the Vet Center participants who responded to this survey, and the responses were not weighted to reflect the larger sample. Vet Center customer experience survey agreement is measured on a 5-point Likert scale. The data reported is the percentage of individuals responding to the following questions with a 4-Agree or 5-Strongly agree to the following areas of focus:

- Ease/Simplicity (91.4% of users agreed): The Vet Center offers remote and in-person services to clients that are assessable and appointment times that are convenient to the client.

- Efficiency/Speed (95.3% of users agreed): The Vet Center schedules appointments within a reasonable amount of time.

- Quality (95.9% of users agreed): The Vet Center staff makes clients feel welcome and safe. Individualized services are provided to the client.

- Employee Helpfulness (90.7% of users agreed): The Vet Center provided or connected the client to services, resources, or help that was needed to meet goals.

- Equity and Transparency (93.3% of users agreed): I was aware of the intake process to become a Vet Center client. My counselor explained my role in my counseling in a way I could understand.

- Satisfaction (92.2% of users expressed agreement): The services received at Vet Centers have met or exceeded the expectations of the client.

- Confidence/Trust (93.2% of users expressed agreement): The client trusts the Vet Centers to provide services for improving their quality of life.

VA uses VSignals surveys to collect, analyze and track customer experience feedback from service members, Veterans and other stakeholders, and use it to identify opportunities to enhance customer experience. For all VSignals surveys across the Department, VA uses the "trust score" as a standard measure to assess the overall trust the customer has in the organization. The "trust score" for Vet Center services is a direct measure of the Confidence/Trust question above and is an indicator of the satisfaction ratings by Vet Center clients.

Services and Locations

RCS offers a broad range of services to assist eligible Veterans, ADSMs, and their families in readjusting to life during and after military service. These services include readjustment, family, bereavement, and military sexual trauma (MST) counseling. Other services include counseling and referrals for mental health and substance abuse, outreach, and referrals for benefits assistance. To support service demands that are specific to respective communities, readjustment counseling may be provided through a Vet Center, Vet Center Outstation, Vet Center Community Access Point (CAP) or Mobile Vet Center (MVC); each are described in more detail below. These assets are available in every state, the District of Columbia, Puerto Rico, Guam, American Samoa, the United States Virgin Islands, and the Commonwealth of the Northern Marianas Islands. Established in rural and urban communities, RCS has grown from a few established service locations in major cities to a service comprised of 303 Vet Centers, 21 Vet Center Outstations, over 440 Vet Center CAPs (the specific number fluctuates based upon demand), and 84 MVCs. The number of Vet Centers and Vet Center Outstations includes new sites approved in fiscal year (FY) 2023 that may not yet have workload associated with those specific locations. As of January 29, 2024, RCS consists of an authorized 2321 positions across the organization.

<u>Vet Centers</u>

Vet Centers offer a comprehensive range of readjustment counseling services, including for military service-related trauma, MST, and family counseling. They provide individual, group, and marriage and family counseling, as well as referrals to other VA or community benefits and services. The team of service providers consists of a variable mix of licensed mental health professionals, other master's level professionally trained counselors, and non-licensed outreach workers and program support assistants. Vet Center staff do not diagnose clients; rather, staff work to identify client-reported symptoms of conditions and take a holistic and strength-based approach to improve them. Many of these services are delivered by staff who are combat Veterans, fostering an empathetic connection to the client. Vet Centers are in leased space in the community outside of the larger VA medical facilities and average six staff, which includes supervisory, counseling, outreach, and administrative personnel. The placement of Vet Centers within the community is intentional, designed to maximize access for local Veterans, ADSMs, and their families via all modes of transportation, such as public, private vehicle, and pedestrian traffic. The RCS program seeks to mitigate barriers to accessing Vet Center services through the national implementation

of non-traditional service hours (i.e., early mornings, evenings, weekends, and holidays).

Vet Center Outstations

Vet Center Outstations are locations where at least one Vet Center counselor is permanently assigned to provide full-time services in a community distant from one of the 303 Vet Centers. Vet Center Outstations are established in leased space as an adjunct to an existing Vet Center. Vet Center Outstations are generally located within a community with a demand for services that does not support the need for a full Vet Center. These locations are generally staffed with a minimum of one to two Vet Center counselors and are designed to increase access to services by taking the Vet Center services to the communities where Veterans, ADSMs, and their families live.

Vet Center Community Access Points (CAP)

Vet Center staff regularly deliver readjustment counseling services outside of the existing 303 "brick and mortar" Vet Centers and 22 Vet Center Outstations. Vet Center CAPs are typically located in donated space established in conjunction with a community organization for the purpose of providing readjustment counseling services to a small number of Veterans, ADSMs, and their families. These may be staffed from one day per month up to several times per week depending on demand. Typically, the workload does not support a full-time Vet Center employee five days per week. The use of Vet Center CAPs allows RCS significant flexibility to stand up new sites or reallocate existing sites to areas of high demand without requiring the lengthy contracting processes involved with establishment of Vet Centers and Vet Center Outstations. Use of Vet Center CAPs allows RCS to rapidly respond to the changing needs of the communities they serve.

Mobile Vet Centers (MVC)

MVCs are used to take services to communities that are distant from a Vet Center or Vet Center Outstation and do not meet the requirements for one of these venues. In many instances, these communities are distant from existing services and are considered rural or highly rural communities. Staffing for these vehicles may include readjustment counselors or outreach specialists. MVCs can provide direct readjustment counseling, access to services offered at Vet Centers, assistance with benefits, and rapid response to crisis situations. Each MVC includes a confidential counseling space for direct service provision, as well as a state-of-the-art satellite communications package that includes fully encrypted teleconferencing equipment, thatprovides access to all relevant VA information technology systems, and connectivity to emergency response systems. MVCs attempt to take advantage of community events where large gatherings of eligible individuals may be found.

Allocation and Expansion of Vet Center Assets

Determining how to meet the needs of a community starts with identifying the number of eligible Veterans, ADSMs, and family members in that respective community and the type of readjustment counseling services they may require. This process also considers the closest established Vet Center and the potential overlap of services. Other factors include an assessment of need for daily, weekly, or monthly services in the community, the availability of space that can be used to provide the needed services, and the ability to meet community needs with an MVC.

RCS seeks to provide services where clients are located and in FY 2021, collaborated with an actuarial contractor to project future readjustment counseling use through an experience-based use projection model and an anticipated demand-based projection model. The experience-based model relies on historical use patterns to project future use, while the demand model uses program eligibility projections and average use rates to forecast demand. The difference between the two models highlights areas where eligible individuals may benefit from additional RCS assets and services and provides a data-informed process for RCS to identify areas for service analysis. RCS looks at projected demand in estimated RCS service hours by zip code through an ArcGIS Geospatial interface (a mapping and analytics application) based on demand projections for FY 2024-2028. These service projections are refined annually, and RCS will incorporate changes in policy, eligibility, operations, or other significant events affecting the program in future versions of the model.

The demand projection model is one key element to determining future placement of Vet Center assets. The projected service data must be validated for each geographic location through the following: evaluation of capacity of existing RCS assets in the region; geographic specific barriers and other considerations; outreach to potential clients; evaluation of other local services; and other variables specific to identified areas for analysis. RCS relies on this process to assess how use is projected to develop over time and how Vet Center resources could be allocated or reallocated geographically to best meet demand for the entire eligible population served.

In response to this demand analysis over the past year, RCS has increased the overall number of Vet Centers and Vet Center Outstations to better meet the needs of those we serve. In FY 2023, RCS gained approval to create three new Vet Centers including the Clarksville, Tennessee and U.S. Virgin Islands Vet Centers, which were both upgraded from Vet Center Outstations, and the Fredericksburg, Virginia Vet Center, which is a new service location that was identified as the highest area of unmet demand that is more than 30 miles from an existing RCS service asset. Additionally, RCS received approval in early FY 2024 to upgrade the CAP in Vineland, New Jersey to a permanent Vet Center Outstation with full-time staffing.

Additionally, RCS will continue to use Vet Center CAPs, which highlight RCS' ability to be flexible in determining service locations while allowing Vet Center staff to provide regularly scheduled services in areas with higher demand for services that do

not require full-time resources. If service demand increases, decreases, or shifts, this model allows RCS to easily shift service locations accordingly. As service demand grows in a Vet Center CAP, RCS can convert these locations to Vet Center Outstations where staff will be permanently assigned. If demand continues to grow beyond capabilities for a Vet Center Outstation, RCS can establish a full Vet Center. Every effort is made to tailor Vet Center services to the needs of the community. RCS works collaboratively with communities to meet these needs in a manner that works best for eligible clients.

RCS plans to further use the demand projection model to explore areas for further expansion throughout FY 2024 and beyond. RCS expects continued growth and expansion of services as more individuals become aware of their eligibility and request readjustment counseling services. To meet this projected increase in demand, RCS will continue to assess the need for additional staff to increase Vet Center services and support the multi-year planned expansion and relocation of Vet Center assets nationwide in high-demand and rural areas.

Collaboration with VA Medical Centers

While Vet Center organizational structure and authorities are separate from VA medical centers', there is collaborative connection through bi-directional referral, care coordination, and quality review that is consistent with Vet Center confidentiality. Every Vet Center is required to have both a local VA medical center clinical liaison and an administrative liaison.

- The clinical liaison assists Vet Centers with the following: making referrals and coordinating services for eligible individuals whose care is shared with the support VA medical facility; coordinating suicide prevention activities in conjunction with the VA medical facility Suicide Prevention Coordinator; assisting Vet Centers in conducting Mortality and Morbidity reviews for Vet Center clients; and providing supportive clinical assistance with eligible Veterans whose service needs go beyond the scope of readjustment counseling.
- The administrative liaison assists Vet Centers in connecting to administrative support such as acquisition, engineering service, and fleet management.

RCS national and field leaders are members of the national and Veterans Integrated Service Network Mental Health Integrated Clinical Community (ICC).. ICCs are Veteran-focused forums that are intended to create streamlined communication flows that amplify the voices of frontline employees and allow for efficient decision making. The goal of the ICC is to help identify variations, spread leading practices, and drive continuous improvement across VA to provide the highest quality of Veteran care.

In addition, the Office of Mental Health and Suicide Prevention has included a review of the role of the clinical and administrative liaisons in recent site visits that focus on evaluating mental health operations and service delivery at VA facilities. There is a

specific review that looks at whether required positions are filled per policy as well as opportunities for improvements in VA medical center and Vet Center partnerships.

Vet Center Eligibility Expansion

Section 402 of the *Support The Resiliency of Our Nation's Great (STRONG) Veterans Act of 2022* (Div. V of P.L 117-328) amended 38 U.S.C. § 1712A to make eligible for Vet Center services Veterans and members of the Armed Forces pursuing a course of education using certain educational assistance benefits. Section 403 of the same Act made family members of Veterans or members of the Armed Forces who died by suicide eligible for Vet Center services, to the degree that counseling furnished to such individual is found to aid in coping with the effects of suicide. VA completed interim policy to roll-out these new authorities on June 5, 2023, allowing RCS to begin services to these newly eligible groups while concurrently working to update VA's regulations. As of January 23, 2024, Vet Centers have provided readjustment counseling to approximately 250 student beneficiaries. Of those, approximately 170 were eligible solely because of their status as a student beneficiary using a qualifying educational benefit. Additionally, for the same time period, approximately 180 family members of a Veteran or member of the Armed Forces who died by suicide have received Vet Center services under the new authority granted by section 403 of the STRONG Veterans Act of 2022.

Vet Center Work Force Expansion

Section 102 of the STRONG Veterans Act of 2022 required VA to hire an additional 50 full-time equivalent employees for Vet Centers to bolster the workforce and expand mental health resources to Veterans, members of the Armed Forces, and families by December 29, 2023. RCS determined the locations for these additional 50 employees through extensive analysis of direct service, projection demand model data, caseloads, and unique geographical factors. RCS is holding ongoing weekly meetings to monitor statutory compliance and progress. As of December 31, 2023, RCS made selections for all 50 employees under this section.

Vet Center Scholarships

Section 502 of the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (*P.L. 116-171) required VA, as part of the Educational Assistance Program, to carry out the VA RCS Scholarship Program to provide scholarships to individuals seeking mental health-related advanced degrees in psychology, professional counseling (i.e., Licensed Professional Mental Health Counselor), marriage and family therapy (i.e., Marriage and Family Therapist), and social work (i.e., Master of Social Work). The individual is required to work at a Vet Center for six years after graduation. The award covers two years of all approved tuitions and fees, an annual book voucher of $1,200, and a monthly stipend of $1,200 while enrolled. Applications are being accepted and reviewed on a rolling basis with preference given to Veterans and ADSMs. VA has promoted the scholarship through

National press releases and media coverage, briefings to state directors of Veterans Affairs and Veterans Service Organizations, including Student Veterans of America. VA also targeted outreach to university department chairs and deans of students in communities that have experienced challenges in recruitment to include the Hopi and Navajo communities and the Northern Arizona University's Office of Indigenous Student Success. As of January 23, 2023, RCS awarded 46 scholarships, with 24 of the scholarships going to Veterans. In FY 2024, 12 mental health professionals are expected to graduate and transition to employment at a Vet Center. The first individual to graduate under this program completed their course of study and was placed at a Vet Center in December 2023. RCS anticipates six students to graduate in the spring 2024 semester and an additional five to graduate in the summer 2024 semester.

Pilot Programs

Travel cost reimbursement for accessing readjustment counseling services

Section 244 of the *Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022* (Cleland-Dole Act; Div. U. of P.L 117-328) requires VA to establish a 5-year pilot program within RCS to assess the feasibility and advisability of providing payment to cover or offset financial difficulties of an individual in accessing or using transportation to and from the nearest Vet Center service site providing the necessary readjustment counseling services for the individual's plan of service. VA must limit participation to individuals who are eligible for Vet Center services at participating locations and experiencing financial hardship. Participating Vet Centers include the four locations (Bangor, Maine; Kalispell, Montana; Santa Fe, New Mexico; and Spokane, Washington) providing payments and allowances for beneficiary travel under section 104 of the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 (P.L 112-154) and an additional 46 locations (total of 50 locations) serving individuals in rural, highly rural, or tribal areas (across all five RCS Districts).

VA has conducted a thorough review of the statutory requirements and developed implementation plans as a result. Based on this review, VA has determined that rulemaking is required to implement the pilot program required by section 244 of the Cleland-Dole Act. VA will need to define, through rulemaking, several elements, including—as required by section 244(b)(2)(B)—defining what constitutes financial hardship. VA will also likely need to address what is included under the phrase "payment to cover or offset financial difficulties of an individual in accessing or using transportation," among other provisions.

VA is committed to creating a robust pilot program. VA anticipates proposing regulations that would allow for implementation at approximately 50 Vet Centers. Location determinations would focus on equal distribution among qualifying locations across the country and increasing pilot use. VA is working expeditiously to publish and finalize regulations as soon as feasible.

Grant Program to Combat Food Insecurity Among Veterans and Family Members of Veterans

VA is fully committed to the successful implementation of the pilot program required by section 5126(f) of the *James M. Inhofe National Defense Authorization Act for FY 2023* (P.L. 117-263). VA is developing regulations to support a 3-year pilot program to award grants to eligible entities to support partnerships that address food insecurity among Veterans and family members of Veterans who receive services through Vet Centers or other VA facilities. This critical initiative represents a significant step forward in our commitment to ensuring the well-being of those who have served. The pilot program will not be limited in scope to Vet Centers so that VA can comprehensively address the issue of food insecurity among eligible Veterans and family members.

Native VetSuccess at Tribal Colleges and Universities

Section 211 of the Cleland-Dole Act requires VA to carry out a 5-year pilot program to assess the feasibility and advisability of expanding the VetSuccess on Campus program to additional tribal colleges and universities. The Veterans Benefits Administration's (VBA) Veteran Readiness and Employment Service (VR&E), in partnership with RCS, will provide culturally competent outreach and services to eligible students at tribal colleges and universities to close gaps in health care, education, and employment for Native American Veterans and their eligible dependents. VBA has identified three regional service areas and is currently evaluating colleges/universities in these areas to best serve eligible Tribal students. Evaluation includes degrees/trainings/certifications offered as well as proximity to VA facilities, including Vet Centers.

Enhancing Vet Center Services and Outreach

VA is grateful for independent reviews to improve vital Vet Center services and outreach through VA's Office of Inspector General (OIG) and the Government Accountability Office (GAO). The recently started annual OIG Vet Center Inspection Program focuses on suicide prevention, leadership and organization risks, consultation, supervision, training, environment of care, and outreach. GAO has also recently completed reviews related to RCS outreach activities, assessing barriers to care and awareness of services and potential staffing challenges in providing services. Additionally, GAO is actively conducting reviews in which RCS in included with focus areas concerning student Veterans' mental health, and the physical infrastructure of Vet Centers. At this time GAO Report 22-105039 "Opportunities Exist to Help Better Ensure Veterans' and Servicemembers' Readjustment Counseling Needs Are Met" is the only GAO report in which RCS has open recommendations. RCS received five recommendations in this report. One recommendation is complete and has been closed by GAO. RCS is on track for completion of action plans to address the remaining four open recommendations and collaborates with GAO for regular status updates on this progress. RCS stands ready to address any potential recommendations resulting from ongoing reviews.

Conclusion

VA is committed to providing quality readjustment counseling services and assisting Veterans, ADSMs, and their families toward a successful adjustment. We appreciate Congress' continued support and encouragement in this vital resource for Veterans. Chairman Tester, this concludes my testimony and I am prepared to answer any questions you may have.

Michael Fisher, MSW

Chief Readjustment Counseling Officer, Veterans Health Administration

Michael Fisher was appointed as the Chief Readjustment Counseling Officer of the Department of Veterans Affairs (VA) Readjustment Counseling Service (RCS) in May 2016. He has direct leadership and oversight of the 303 Vet Centers, 84 Mobile Vet Centers, numerous satellite locations, and the 24/7 Vet Center Call Center. Vet Centers have been proudly providing counseling, referral, and community engagement services to Veterans, service members, including members of the National Guard and Reserve, and their families since 1979. Vet Center assets are located in all 50 states, the District of Columbia, Puerto Rico, U.S. Virgin Islands, Guam, Commonwealth of the Northern Mariana Islands, and American Samoa. As Chief Officer, Mr. Fisher also advises the Under Secretary for Health in policy issues effecting the readjustment of Veterans and their families and issues surrounding the combat experience.

Mr. Fisher began his career with VA as an outreach specialist at the Baltimore Vet Center, ensuring increased access to care and services for his fellow Veterans. He progressed in responsibility at the local, regional and national level, culminating in his appointment as Chief Officer. Prior to his VA career, he served more than 10 years with the Pennsylvania National Guard and was deployed to Iraq as an infantry non-commissioned officer in 2005. Following this combat deployment, he was medically discharged from the military. He holds a Master of Social Work (MSW) from the Catholic University of America.

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

STATEMENT OF JULIE KROVIAK, MD
PRINCIPAL DEPUTY ASSISTANT INSPECTOR GENERAL
FOR THE OFFICE OF HEALTHCARE INSPECTIONS
OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
US SENATE COMMITTEE ON VETERANS' AFFAIRS
HEARING ON
VET CENTERS: SUPPORTING THE MENTAL HEALTH NEEDS OF SERVICEMEMBERS, VETERANS, AND THEIR FAMILIES
JANUARY 31, 2024

Chairman Tester, Ranking Member Moran, and Committee Members, thank you for the opportunity to discuss the Office of Inspector General's (OIG) oversight of the Department of Veterans Affairs' (VA) vet centers. In 2020, the OIG's Office of Healthcare Inspections initiated the Vet Center Inspection Program (VCIP) to assess these centers' operations and processes. VCIP also reviews district and zone leaders' management and monitoring of vet centers. These cyclical inspections seek to ensure that vet center counseling services are provided in accordance with Veterans Health Administration (VHA) policy for safe and effective social and psychological services. Most importantly, the inspections help verify whether vet centers are appropriately identifying and engaging with the most high-risk veterans and collaborating with VHA facilities to ensure that any needed care is provided.

Three years into VCIP implementation, the OIG remains deeply committed to making certain that services provided in these settings are effectively and consistently meeting the needs of veterans and their families. Independent oversight provides an objective analysis of leaders' and frontline staff's adherence to VHA policy and their performance in meeting the mission to deliver critical counseling services. VCIP teams focus on evaluating a vet center's compliance with initiating and coordinating the critical clinical services required to support veterans deemed to be at high risk for suicide. The OIG has published nine VCIP reports from September 2021 through May 2023 (with others in development), covering all five districts and nine zones in the vet center system. These inspections and ongoing site visits provide evidence of frequent noncompliance with many required processes, most notably the procedures for assessing and documenting a veteran's suicide risk. Failing to consistently conduct and document these important evidence-based risk assessments undermines VA's attempts to reduce veteran suicide.

As with all OIG reports, VCIP recommendations are directed to VA leaders at inspection sites who can ensure that not only are responsive corrective action plans initiated, but improvements can be sustained.

These inspection reports are also effective road maps that can be used as a risk assessment tool by all vet center leaders across the system. While OIG teams repeatedly meet engaged and dedicated staff during these inspections, the limited progress demonstrated over the last three years, particularly as it pertains to suicide prevention activities, suggests barriers remain in improving and sustaining compliance with VA policies.

In particular, the OIG teams repeatedly found (1) noncompliance with required procedures documenting suicide risk and (2) lack of internal oversight to ensure staff are adequately trained to provide quality services and document their work in a timely manner.[1] Both deficiencies can have severe consequences for clients and their families.

The teams also identified three major contributing causes for the weaknesses:

1. Lack of clear and standardized Readjustment Counseling Service (RCS) policies
2. Challenges in staffing and workload
3. Deficiencies in RCSNet, the vet centers' electronic client record system

This statement addresses these barriers and highlights a meaningful example of the impact of deficient suicide risk assessments and the lack of strong leadership at a vet center in South Bend, Indiana.

BACKGROUND

Vet centers are administered by RCS, an autonomous entity in VHA. These community-based counseling centers are separate from VA medical facilities.[2] Since their inception in 1979, vet centers have focused on the readjustment needs of combat veterans. However, vet center eligibility, which differs from VHA medical care eligibility, has been expanded to include any service member who has experienced military sexual trauma (MST) and those who have served on active military duty in any combat theater or area of hostility, including National Guard and Reserve personnel.[3]

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[1] These findings are consistent with prior determinations disclosed to Congress. See Statement of Julie Kroviak, MD, Deputy Assistant Inspector General of Healthcare Inspections for the VA OIG, before the US House Veterans' Affairs Health Subcommittee, *Close to Home: Supporting Vet Centers in Meeting the Needs of Veterans and Military Personnel*, February 3, 2022, at www.vaoig.gov/sites/default/files/document/2023-08/VAOIG-statement-20220203-kroviak.pdf.

[2] Vet centers are organized into five districts, each with two to four zones. The leaders of the district and zones are responsible for providing management and oversight of their corresponding vet centers. Each zone has a range of 18 to 25 vet centers, each run by a vet center director who is responsible for all operations.

[3] Other individuals eligible for treatment at vet centers include those who provided mortuary services or direct emergent medical care to treat casualties of war while on active duty, performed as a member of an unmanned aerial vehicle crew that provided support to operations in a combat theater or area of hostility, responded to a national emergency or disaster or civil disorder while on active military duty, and participated in a drug interdiction as a former or current Coast Guard member. For more details on eligibility, see www.vetcenter.va.gov/Eligibility.asp.

Vet centers employ small multidisciplinary teams of at least four staff, including at least one VHA-qualified licensed mental health professional.[4] They focus on interventions for psychological and psychosocial readjustment problems when transitioning to civilian life that are related to various types of military service and deployment stressors, such as combat-related trauma and MST. Veterans are provided with counseling based on clinical diagnoses and have access to different treatment modalities, such as individual, group, and family therapy. Veterans who use vet center services are generally referred to as clients instead of patients.[5] Vet center records are kept separate from VHA and Department of Defense records and are not shared unless a client signs a release of information.[6] To support care, however, most vet centers have the capability of one-way viewing of VHA electronic health records. This separation supports vet center autonomy as well as client confidentiality.

THE OIG'S VET CENTER INSPECTION PROGRAM FOUND NONCOMPLIANCE WITH VA PROCEDURES

VCIP inspections examine a wide range of vet center activities and include an assessment of leaders engaged in overseeing and directing them. Specific focus areas are selected to help provide insight into a client's experience when they seek care or services. Current focus areas include leadership and organizational risks; quality reviews; suicide prevention; consultation, supervision, and training; and environment of care. The OIG's findings in VCIP reports are a snapshot of vet centers' performance within a geographic zone for the topic areas of focus. From the nine VCIP reports published to date (covering 36 vet centers), some common weaknesses emerged that are discussed below.[7]

Noncompliance with Required Procedures Documenting Suicide Risk

VA's *National Strategy for Preventing Veteran Suicide* embraces a comprehensive public health approach that looks beyond the individual to involve peers, family members, and the community.[8] VA

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[4] VHA Directive 1500(4), *Readjustment Counseling Service*, January 26, 2021, amended November 21, 2023.

[5] VHA Directive 1500(4).

[6] In FY 2003, the RCSNet web-based software system was implemented to collect client information and, in 2010, became the sole record-keeping system for vet center client services. RCSNet's independence from VA's and the Department of Defense's electronic health record systems allows vet centers to maintain secure and confidential records that will not be disclosed unless there is a signed release. VHA Directive 1500(4), 2021; 38 C.F.R. § 17.2000–816 (e).

[7] VA OIG, *Vet Center Inspection of Pacific District 5 Zone 1 and Selected Vet Centers*, September 30, 2021; *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, September 30, 2021; *Vet Center Inspection of Continental District 4 Zone 2 and Selected Vet Centers*, September 30, 2021; *Vet Center Inspection of Continental District 4 Zone 1 and Selected Vet Centers*, December 2, 2021; *Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers*, December 20, 2021; *Vet Center Inspection of Midwest District 3 Zone 3 and Selected Vet Centers*, January 12, 2023; *Vet Center Inspection of Midwest District 3 Zone 1 and Selected Vet Centers*, January 19, 2023; *Vet Center Inspection of North Atlantic District 1 Zone 4 and Selected Vet Centers*, May 25, 2023; *Vet Center Inspection of North Atlantic District 1 Zone 3 and Selected Vet Centers*, May 25, 2023.

[8] National Strategy for Preventing Veteran Suicide 2018–2028; U.S. Department of Veterans Affairs.

has identified RCS's efforts as an important part of VA's overall suicide prevention strategy and recognizes that the unique community-based setting of vet centers can enhance the clinical services provided to veterans under VHA care. These suicide prevention efforts are advanced by consistent and careful assessments. The VCIP suicide prevention review evaluated compliance across the zones and at selected vet centers for high-risk clients and found substantial noncompliance across all inspected vet centers.[9]

Suicide Risk Assessments, Safety Plans, and Consultations Were Not Completed According to Requirements

RCS provides guidance to vet centers for the assessment and management of individuals who are considered at risk for suicide. Vet center counselors are required to complete a suicide risk assessment for every client at the initial counseling visit and subsequently as indicated. For any client found to be at intermediate to high risk for suicide, counselors must then complete a safety plan, which should identify personalized coping strategies and supportive resources these clients may use to lower their risk of suicidal behavior. Over time, individuals can experience fluctuating levels of suicidality, and a safety plan is designed to break the cycle early, providing clients with tools to manage self-harm urges and suicidal thoughts. For individuals assessed to be at an intermediate to high risk for suicide, vet center counselors are also required to consult with the vet center director, associate district director for counseling, external clinical consultant, or other VA medical facility mental health professionals—including the suicide prevention coordinator. The OIG found that vet center counselors repeatedly did not comply with these three requirements. In addition, vet center staff did not meet with an external clinical consultant for the requisite four hours per month for professional consultation concerning the mental health care and services necessary to fully support clients' readjustment, particularly those at high risk for suicide. Taken together, these deficiencies limit the effectiveness of vet centers' suicide prevention efforts.

Vet Center Staff Do Not Regularly Participate in VA Medical Facility Mental Health Council Meetings

RCS requires licensed vet center counselors to participate in all support meetings with the VA medical facility mental health council. Participation is required to reinforce vet center and VA medical facility partnerships, assist with care coordination for clients receiving vet center and VA medical facility

[9] All VCIP report recommendations were directed to the chief officer of RCS and the pertinent district director. RCS and district leaders have concurred with and developed acceptable action plans for the OIG recommendations, with a few exceptions where they believe they have already met the intent of the recommendation. The OIG considers 42 of the 189 VCIP recommendations made from September 2021 to May 2023 to be currently open pending the submission of sufficient documentation that would support their closure. The OIG requests updates on the status of all open recommendations every 90 days and provides real-time updates on the recommendations dashboard found on the OIG website.

services, and aid in suicide prevention efforts. Although RCS requires participation, the OIG did not find a policy or guidance specifying how attendance was tracked and requested evidence of attendance. The OIG team found vet centers were consistently noncompliant with ensuring their staff attend mental health council meetings.

Deficiencies in District, Zone, and Vet Center Leaders' Oversight

The VCIP teams examined whether vet center staff members had completed their required suicide prevention and MST trainings.[10] Training is meant to provide the information and knowledge needed to intervene when clients are in crisis. In the nine published reports, the OIG found suicide prevention and MST trainings were not completed at most vet centers for all clinical staff and at more than half of vet centers for all nonclinical staff. Vet center directors explained that the trainings were not always correctly assigned in the internal tracking system and recognized there was a lack of oversight for the timely completion of staff training requirements.

RCS requires an annual clinical and administrative quality review of care at each vet center, conducted by zone leaders, to advance compliance with RCS policies and procedures. The vet center director, with the help of zone leaders, is required to develop a remediation plan and resolve any deficiencies identified during the quality review.[11] The OIG found most vet centers completed annual clinical and administrative quality reviews as required; however, the VCIP teams could not determine when deficiencies from clinical reviews were resolved because of missing or incomplete documentation. During some inspections, the teams were told some elements were verified only through verbal confirmation, and there is no follow-up to verify deficiency resolution. There is no requirement to provide or maintain documentation of when or how identified problems are addressed, resulting in an inadequate recordkeeping system for remediation plans.

Finally, RCS guidance requires vet center leaders to conduct monthly client chart audits on 10 percent of each counselor's clinical caseload as part of their quality oversight for care.[12] These audits are designed to evaluate completion of required clinical documentation and provide feedback to the counselors. The OIG could not find sufficient evidence that the required 10 percent chart audits were completed by the directors at any of the vet centers inspected. Acknowledging this requirement may not have been met, the vet center leaders interviewed by the OIG attributed the lack of audits to factors that included competing priorities, inaccuracies within RCSNet, and vet center director miscalculations of the number of audits required. Although the inspection teams noted that the report that was supposed to be used in

[10] In 1992, vet center eligibility was expanded to include veterans who experienced MST, and vet center counselors are required to complete MST training to effectively meet the counseling needs of those clients.

[11] According to RCS guidance in VHA Directive 1500(2) dated 2021, within 30 days of receiving the quality review report, the vet center's director develops a remediation plan with target dates for deficiencies to be corrected and submits it to zone leaders for approval. Within 60 days of the approval date, the vet center director is responsible for resolving all deficiencies.

[12] VHA Directive 1500(4), 2021.

RCSNet was consistently inaccurate and vet center leaders were sometimes completing chart audits using their own tracking mechanisms. This is significant because the RCSNet report is used to track audit completions by district leaders.

UNDERLYING CAUSES THAT CONTRIBUTE TO VET CENTER DEFICIENCIES

The OIG's VCIP reviews have found multiple opportunities for RCS to better support its staff to consistently provide high-quality and safe care and improve monitoring of that care and collaborations. The OIG has found some recurring themes from its inspections that, taken together, appear to be limiting RCS' ability to make the necessary improvements across the vet center system. Until each of these areas is addressed, vet center clients remain at risk of receiving inadequate assessment, care coordination, and services.

Lack of Clear and Standardized RCS Policies

The delivery of consistent high-quality care across vet centers is reliant on clear and consistent policies to guide frontline staff. OIG inspections have found the varying applications of policies is often due to their misinterpretation caused by vague, confusing, or conflicting language, or cumbersome processes.

For example, the RCS established a High Risk for Suicide Flag SharePoint site in May 2020 to easily identify and anticipate the needs of vet center clients identified as high risk or potentially high risk for suicide by the VHA medical facility. However, during OIG interviews with RCS staff, many reported lacking an understanding of the purpose and requirements of the site, difficulty using the site, and inaccuracies in its data. While RCS leaders report that they are working to address the inaccuracies, these issues impede efforts to identify and meet the needs of high-risk clients.

The OIG has also found a lack of clarity regarding timeframe requirements within RCS policy. For example, RCS policy does not include a timeframe for when staff are to have a consultation about individuals assessed at an intermediate to high risk for suicide, leaving staff unclear of how to meet the requirement and making internal compliance monitoring challenging. Further, the lack of clear metrics inhibits the OIG's ability to perform oversight and ensure vet center staff are meeting the intent of the policy.

Previously, RCS directed vet center directors to provide one hour of weekly supervision to their counselors; however, this requirement was updated to simply mandate supervision on a "regular and ongoing basis." This is another example of an unclear metric making it more difficult to define expectations and evaluate compliance.

In addition, prior versions of the RCS directive required the completion of morbidity and mortality reviews for client deaths by suicide as well as when a client has engaged in a serious suicide attempt.[13] The intent of a morbidity and mortality review is to evaluate the facts of the event and clinical services

[13] VHA Directive 1500(3), *Readjustment Counseling Service*, January 26, 2021, amended June 5, 2023.

provided, identify opportunities for improvement and best practices, and determine if any additional actions may have resulted in a different outcome. However, leaders across the five districts used different and inconsistent processes to determine if a suicide attempt warranted a morbidity and mortality review. That led to an OIG recommendation in January 2023 that RCS define "serious suicide attempt." RCS revised the policy and now require a peer review anytime a suicide attempt is reported, making the procedure less ambiguous for vet center staff.[14] However, this highlights another example of vet center staff process challenges and confusion identified during previous OIG reviews.

Challenges in Staffing and Workload

Through interviews and surveys of RCS staff, the OIG gathered consistent reports that noncompetitive salaries and vet center positions with low grade levels on the General Schedule pay scale contribute to vacancies. While these staffing challenges have been recognized by vet center and district leaders, many OIG inspections have found that leaders in acting positions have limited authority that further hinders their ability to fully address these challenges. The OIG is aware of recent VA initiatives to encourage and incentivize vet center hiring, but the impact of these initiatives has not yet been assessed.

Additionally, OIG teams have been told that it is a challenge for the small zone leadership teams to oversee the large number of vet centers in each zone. Many of the deficiencies the OIG has identified—such as the completion of training, chart audits, and suicide risk assessments—may be improved with more focused zone oversight. RCS leaders have stated that this is an area for which changes are under consideration, but specific plans have not yet been shared with VCIP inspection teams.

Deficiencies in RCSNet

Many areas of VCIP-identified noncompliance were impacted by the limitations of RCSNet, the electronic recordkeeping system used by the vet center staff. OIG inspection teams observed that RCSNet did not have a function to easily determine when required documentation for specific assessments had been completed. This limitation has made it difficult for RCS leaders to conduct quality oversight and hampered the OIG's ability to make timely determinations regarding the quality of services and care provided. Additionally, RCSNet lacks the ability to alert care providers to clinical reminders as well as client behavior or suicide flags. Functionality is also insufficient for collaborative or supervisory staff to cosign notes, for limiting system users' permissions that could compromise the integrity of the record, and for viewing scanned records alongside other documentation in a client's record. RCS staff responses and opinions shared with OIG inspectors related to RCSNet's capabilities were consistently negative.

The types of deficiencies identified through OIG inspections can have significant consequences. The following is an example from a South Bend, Indiana, vet center.

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[14] VHA Directive 1500(4), 2023.

DEFICIENCIES IN SUICIDE RISK ASSESSMENTS AND LEADERSHIP EXAMPLE

A January 2023 OIG report illustrated the impact of failed leadership and lack of adherence to the processes meant to ensure high-risk veterans are appropriately assessed and clinical services coordinated for clients deemed as high risk for suicide.[15]

The OIG substantiated allegations that staff at the South Bend Vet Center inaccurately assessed three clients' level of risk for suicide, including one client who subsequently died by suicide. The vet center director, counselors, and a former counseling intern were aware of and documented risk factors that may contribute to suicide for the clients they had assessed. They failed, however, to properly assign each client's risk level for suicide. The OIG determined the suicide risk assessments were rated lower than clinically indicated. Consequently, the three clients did not have measures such as personalized safety plans, clinical consultations, and heightened contact protocols in place. One client died by suicide and the other two clients were both subsequently hospitalized with suicidal ideations with suicide risk rated as high acute and high chronic.

Multiple factors contributed to the inaccurate ratings, including the vet center director's informal guidance and practice of keeping ratings low to avoid RCS leader involvement, staff's lack of understanding on how to evaluate and manage clients' risk of suicide, and the vet center director's lack of competent clinical and leadership practices.

Additionally, the vet center director failed to provide adequate oversight and instruction to a counseling intern and failed to facilitate a time-sensitive transition of care for a high-risk client. Further, RCS leaders failed to report the director's clinical deficiencies to the state licensing board; RCS guidance lacked a clear reporting process.

The OIG made three recommendations to the chief readjustment counseling officer related to adverse events, intern oversight, and state licensing boards. The OIG made five recommendations to the Midwest District 3 director related to assessing and mitigating suicide risk, continuity of care, adverse events, and state licensing board reporting. All eight report recommendations have been closed as implemented after reviewing RCS's responsive actions.

CONCLUSION

Vet centers are uniquely positioned to partner with VHA clinical services to support the needs of veterans and contribute to VHA's highest priority of suicide prevention. The OIG recognizes and appreciates the additional support services provided to veterans, active-duty members, and their families. The commendable motivation and dedication of vet center staff alone, however, are insufficient

[15] VA OIG, *Deficiencies in Suicide Risk Assessments, Continuity of Care, and Leadership at the South Bend Vet Center in Indiana*, January 19, 2023.

to achieve their mission. Staff need clear policy and direction to consistently meet requirements essential to clients' welfare. Leaders must prioritize removing barriers that prevent frontline staff from providing and coordinating services that clients and their families need. The OIG report on the South Bend Vet Center underscores the need for leadership engagement and continuous oversight of the activities their staff perform every day, particularly for veterans at high risk for suicide. The OIG will continue reviewing vet centers on a cyclical basis, building on the lessons learned in earlier reviews and will not only increase its focus on leaders' oversight but will also evaluate vet center outreach plans and activities, as well as mobile vet center use. Outreach activities are critical to engaging those veterans living in underserved areas who have not previously accessed RCS services. This testimony highlights critical findings that require immediate and sustained interventions to ensure the safety and quality of services provided to clients across the system.

Chairman Tester, Ranking Member Moran, and members of the Committee, this concludes my statement. I would be happy to answer any questions you may have.

United States Government Accountability Office

Testimony
Before the Committee on Veterans' Affairs, U.S. Senate

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VETERANS HEALTH CARE

VHA Has Taken Steps towards Improving Vet Centers

Statement of Sharon M. Silas, Director,
Health Care

GAO-24-107170

GAO Highlights

Highlights of GAO-24-107170, a testimony before the Committee on Veterans' Affairs, U.S. Senate

Why GAO Did This Study

Some veterans and servicemembers experience challenges, such as mental illness, when readjusting to civilian life or continued military service. This can be due to trauma experienced during military service. VHA's Vet Centers provide services to eligible veterans, servicemembers, and their families.

This statement describes the findings from GAO's May 2022 report, GAO-22-105039, which examined VHA's efforts to assess Vet Center clients' needs, tailor outreach activities and assess their effectiveness, and identify and address barriers to care. This statement also describes the status of VHA's efforts to implement GAO's recommendations. For this statement, GAO reviewed VHA's reports of steps RCS has taken to address GAO's recommendations.

What GAO Recommends

GAO made five recommendations in the May 2022 report to VHA to improve Vet Center processes. VHA concurred with GAO's recommendations and has implemented one of the recommendations. As of January 2024, VHA had taken steps to implement the remaining four, which remain open.

View GAO-24-107170. For more information, contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov.

January 31, 2024

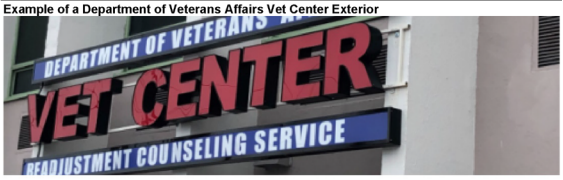
VETERANS HEALTH CARE

VHA Has Taken Steps towards Improving Vet Centers

What GAO Found

The Veterans Health Administration's (VHA) Readjustment Counseling Service (RCS) provides counseling to individuals, groups, couples, and families through 303 Vet Centers nationwide. In fiscal year 2023, RCS data show that Vet Centers provided about 1.3 million counseling visits to more than 104,000 clients.

Example of a Department of Veterans Affairs Vet Center Exterior



Source: Department of Veterans Affairs. | GAO-24-107170

In its May 2022 report, GAO found that VHA lacked processes that would help it better assess Vet Center activities. Specifically,

- **VHA did not collectively assess whether Vet Centers were meeting clients' needs.** GAO found that RCS and Vet Centers used assessments and feedback surveys to assess each individual client's needs. However, RCS had not assessed the extent to which Vet Centers were meeting the needs of client subpopulations, like those with traumatic brain injury, that may experience different readjustment challenges.
- **VHA lacked data to tailor outreach and assess its effectiveness.** GAO found that Vet Centers used data from outreach activities, such as the number of contacts made, to try to assess their effectiveness. However, there were limitations to using these data because not all outreach activities resulted in contacts, according to officials from RCS and Vet Centers.
- **VHA did not identify whether its actions were minimizing barriers to Vet Center care.** GAO found that RCS and Vet Center officials identified barriers to Vet Center care, such as lack of awareness of Vet Center services. Officials also identified steps they have taken to address barriers. However, RCS officials did not know the extent to which barriers to Vet Center care remained because RCS did not have an assessment process.

Based on these findings, GAO made five recommendations in its May 2022 report. As of January 2024, VHA had implemented one of GAO's recommendations by assessing the extent to which Vet Centers were meeting the needs of their clients collectively. VHA has taken some steps towards implementing the other four recommendations. Continued attention to these recommendations will help ensure veterans and servicemembers are receiving the help they need readjusting to civilian life or to continued military service.

Chairman Tester, Ranking Member Moran, and Members of the Committee:

Thank you for the opportunity today to discuss the Department of Veterans Affairs' (VA) efforts to meet the mental health needs of veterans and military personnel through Vet Centers.

Vet Centers play a pivotal role in helping veterans and servicemembers readjust to civilian life or to continued military service. Although many of them readjust without major difficulties, others experience challenges, such as mental illness and substance abuse, which can increase their risk of suicide. Vet Centers are community based, and are separate from VA's medical centers and its community-based outpatient clinics.[1] They provide social and psychological services—including individual, group, marriage, and family counseling to veterans and active duty servicemembers who have served in any combat theater or area of hostility, as well as their family members.[2] The Veterans Health Administration's (VHA) Readjustment Counseling Service (RCS) operates the Vet Centers.

In May 2022, we issued a report that examined VHA's efforts to assess Vet Center clients' needs, tailor outreach activities and assess their effectiveness, and identify and address barriers to care, as provided in by the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019.[3] My testimony today describes that report's findings and VHA's actions to implement the five recommendations we made in the report.

For our May 2022 report, we reviewed RCS's policies and requirements related to Vet Centers. We also interviewed officials from RCS, its five regional districts, and five Vet Centers, selected for variation in the

[1]Congress established Vet Centers as part of VA in 1979, recognizing that a significant number of Vietnam era veterans were experiencing readjustment problems. Pub. L. No. 96-22, tit. I, § 103(a), 93 Stat. 47, 48 (1979), codified, as amended, at 38 U.S.C. § 1712A.

[2]In October 2020, eligibility for Vet Centers was expanded to include, among other groups, members of reserve components who served on active service in response to a national emergency or major disaster declared by the President. See 38 U.S.C. § 1712A(a)(1)(C) for currently eligible veterans and servicemembers and their families.

[3]See GAO, *VA Vet Centers: Opportunities Exist to Help Better Ensure Veterans' and Servicemembers' Readjustment Counseling Needs Are Met*, GAO-22-105039 (Washington, D.C.: May 17, 2022).

Pub. L. No. 116-171, Tit. V, § 503, 134 Stat. 778, 818-819 (2020).

presence of satellite counseling locations, and in geographic location—including Vet Centers from both urban and rural locations, and one Vet Center from each of the five regional districts.[4] Our May 2022 report includes a full description of our scope and methodology.[5] In addition, we reviewed information on VHA's efforts to implement the recommendations from our May 2022 report. The work on which this statement is based was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Vet Center Services and Locations

Vet Centers' services and structure are separate from health care provided at VA medical facilities to ensure privacy and confidentiality. Vet Centers have separate staff and maintain separate medical records. However, VA medical facilities are required to align with nearby Vet Centers to provide clinical and administrative support.[6] For example, VA medical facilities provide clinical consultations for Vet Center counselors to discuss appropriate treatment for complex cases.

In fiscal year 2023, there were 303 Vet Centers located in all 50 states, as well as the District of Columbia, Puerto Rico, American Samoa, and Guam. Vet Centers expand their geographic reach in local communities in several ways:

- RCS maintains a fleet of 84 Mobile Vet Centers, vehicles that individual Vet Center staff operate to provide outreach and counseling in the community.[7] (See fig. 1.)

[4]Districts are responsible for overseeing the implementation of VA and VHA policies for RCS and for supervising clinical and administrative staff at each of the Vet Centers within their region, among other things.

[5]See GAO-22-105039.

[6]See Department of Veterans Affairs, *Veterans Health Administration Readjustment Counseling Service*, VHA Directive 1500(3) (Washington, D.C.: June 5, 2023).

[7]One specific use of the Mobile Vet Centers is to provide outreach and direct readjustment counseling at active military, Reserve, and National Guard demobilization activities. As part of VA's "Fourth Mission" to respond to natural disasters and emergencies, RCS deployed Mobile Vet Centers to several cities in response to the COVID-19 pandemic.

- Vet Center staff also provide services at satellite locations, including both outstations (typically in leased spaces) and community access points (located in donated spaces, such as college campuses).[8]

Figure 1: Examples of a Department of Veterans Affairs Vet Center Exterior and a Mobile Vet Center

Source: Department of Veterans Affairs and GAO. | GAO-24-107170

In fiscal year 2023, RCS data show that Vet Centers provided about 1.3 million counseling visits to more than 104,000 clients. Based on our analyses of RCS's data, 2.1 percent of these clients had not received services from any Vet Center in the previous 2 years.

Vet Centers also conduct outreach to contact and engage local eligible individuals and bring them into Vet Centers for services. Outreach efforts may include contacting eligible individuals and family members, contacting local service providers and civic leaders, and building referral networks with community providers. Vet Centers conducted 30,758 outreach activities in fiscal year 2022, and 30,020 activities in fiscal year 2023, according to RCS data.

RCS and Vet Center Organizational Structure

VHA's RCS oversees Vet Centers, and is led by a Chief Officer. The RCS Chief Officer reports directly to VA's Under Secretary for Health and maintains direct authority over all Vet Center staff. RCS's Vet Centers are organized into five regional districts, led by district directors. Each of the

[8]Vet Center services are also augmented by the Vet Center Call Center, which is a 24-hour, confidential national call center staffed by combat veterans.

five district directors oversees the implementation of VA and VHA policies for RCS in their respective districts.[9]

Each Vet Center is managed by a Vet Center director, who is responsible for the day-to-day oversight of the Vet Center's staff. According to RCS, Vet Centers have an average of six to seven staff members, consisting of at least one counselor, a program support assistant, and an outreach specialist.[10] Vet Center counselors are multi-disciplinary and have various professional licensures. The counselors can include psychologists, social workers, licensed professional counselors, or marriage and family therapists.

VHA Has Taken Steps to Implement Recommendations for Strengthening Vet Center Processes

In our May 2022 report, we found that VHA lacked processes that would help it better assess Vet Center activities. Specifically, VHA (1) did not assess the extent to which Vet Centers are providing services that meet the needs of their clients collectively; (2) lacked data that would help them better tailor their outreach activities and guidance to assess that outreach's effectiveness; and (3) had not identified the extent to which their actions minimized barriers to Vet Center care.

VHA did not collectively assess whether Vet Centers were meeting clients' needs. We found that RCS and Vet Centers used psychosocial assessments to identify areas of focus, such as post-traumatic stress disorder, and feedback surveys to assess individual client needs and whether those needs are being met. However, RCS did not assess the extent to which Vet Centers were meeting the needs of clients collectively, including client subpopulations that may experience different readjustment challenges. For example, RCS had not analyzed information from psychosocial assessments or feedback surveys to assess what proportion of Vet Center clients were making progress. Similarly, we found that RCS had not assessed the extent to which there are differences in the progress being made among different client subpopulations, such as those that experienced a traumatic brain injury or military sexual trauma during military service, or veterans of more recent conflicts (e.g., Afghanistan and Iraq post-9/11).

[9]See Veterans Health Administration *VHA Directive 1500(3)*, amended June 5, 2023.

[10]See Department of Veterans Affairs, *Memorandum: Readjustment Counseling Service (RCS) Asset Change Process.* (Jan. 8, 2018.)

VHA lacked data to tailor outreach and assess its effectiveness. We also found that Vet Centers used data from outreach activities, such as the number of contacts made, to try to assess their effectiveness. However, there were limitations in using these data for that purpose, according to officials from RCS and Vet Centers. These officials told us the number of outreach contacts may not be an appropriate way to assess the effectiveness of outreach activities that do not generate a lot of contacts, such as those tailored to specific communities (e.g., Native Americans) with which it can take time to develop trust. Vet Center officials told us it would be helpful if RCS provided them with guidance that includes metrics and targets for assessing the effectiveness of their outreach activities.

We also found that Vet Centers may have obtained some data on the veterans in their service area, such as the total number of veterans at the county-level from the U.S. Census Bureau. However, district and Vet Center officials told us that these data are not sufficient to allow them to tailor their outreach. Data available to Vet Centers did not include information on veterans that are eligible for Vet Center services, such as how many recently transitioned back to civilian life.

VHA did not identify whether their actions were minimizing barriers to Vet Center care. As described in our May 2022 report, RCS and Vet Center officials identified barriers to accessing Vet Center care, such as a lack of awareness of Vet Center services. Officials also identified steps they have taken to address barriers, such as offering care during evening hours and via telehealth to increase access. However, we found that RCS did not know the extent to which barriers to Vet Center care remained because RCS does not have an assessment process. For example, RCS did not know how many veterans experience challenges getting to Vet Centers during their hours of operation.

We also found that some Vet Center counselors have experienced barriers in receiving clinical consultations to discuss care for complex cases, according to RCS and Vet Center officials. According to VHA policy, Vet Center counselors are to work with an external consultant for at least 4 hours each month to discuss care or coordinate support needed for their complex cases. The external consultant is required to be a qualified mental health professional assigned by the VHA medical facility aligned with the

Vet Center. RCS and Vet Center officials told us that, in some cases, Vet Center counselors experienced delays in receiving, or did not receive at all, the required hours of consultations each month. RCS and Vet Center officials told us this occurred, for example, because the medical facility's staff were unavailable to provide the consultation hours.

In our May 2022 report, we made five recommendations to VHA. VHA concurred with each of these recommendations. As of January 2024, VHA had implemented one of our recommendations and taken steps to implement the remaining four. See table 1 for these five recommendations and their implementation status.

Table 1: GAO Recommendations to Improve Vet Center Activities and Status of Veterans Health Administration Actions to Address Them, as of January 2024

GAO recommendation	Implementation status
The RCS Chief Officer should develop and implement a process to periodically assess the extent to which Vet Centers are meeting the needs of their clients collectively, including subpopulations of clients that may experience different challenges readjusting to civilian life or to continued military service. Such client subpopulations could include those who experienced trauma during military service and those who served in different conflicts.	**Implemented.** In May 2023, RCS officials provided documentation of their plan to use RCS's Vet Center client feedback survey to periodically analyze how well Vet Centers are meeting the needs of individuals served, both collectively across the organization and for subpopulations of clients. RCS also analyzed the results of its client feedback survey, including results for clients collectively and for subpopulations of clients, such as for those who served in different military branches. These actions will help improve RCS's understanding of how effective Vet Centers are in meeting the needs of their clients.
The RCS Chief Officer should ensure that Vet Centers have data on eligible individuals in their service area that they can use to tailor their outreach activities. These data could include information on veterans who have recently transitioned back from military service and veterans' demographic characteristics (e.g., age, gender, race, and ethnicity).	**Not implemented.** As of January 2024, RCS officials said that RCS had taken steps to address this recommendation. Specifically, RCS officials stated that they are working with VA's Office of Information Technology to develop a software solution to access the Veterans Affairs/Department of Defense Identity Repository, which contains the demographic information on veterans who recently transitioned from active service by zip code. RCS officials also noted their ongoing participation in outside partnerships that facilitate outreach services, such as the Department of Defense, Intervention, Prevention, and Outreach forum that RCS joined in fiscal year 2020. RCS officials reported a planned implementation date of March 2024 for the software solution.
The RCS Chief Officer should provide Vet Centers with guidance for assessing the effectiveness of their outreach activities. This guidance should include metrics for the outreach activities and targets against which to assess those metrics to determine effectiveness.	**Not Implemented.** As of January 2024, RCS officials said that RCS had taken steps to address this recommendation. Specifically, RCS officials said that the RCS Governance Board's Stakeholder Relations Council identified the need to pilot new outreach measurement processes in response to our recommendation. A 6-month pilot at a selection of sites is estimated to be completed by September 2024. The council then plans to evaluate the results of the pilot and any changes needed to policy or measurement methodology.

GAO recommendation	Implementation status
The RCS Chief Officer should develop and implement a process to periodically assess the extent of identified barriers eligible veterans and servicemembers may experience to obtaining services, including a lack of awareness about Vet Centers and challenges accessing Vet Center services.	**Not Implemented.** As of January 2024, RCS officials said that RCS had taken steps to address this recommendation Specifically, RCS officials reported that they will use results from RCS's Vet Center client feedback survey to understand barriers eligible individuals experience when accessing Vet Center services. To gauge awareness of Vet Center services and barriers to access for eligible individuals who are not already engaged with Vet Centers, RCS reported working with a contractor to develop a national survey to periodically assess eligible individuals' awareness of Vet Center services and any barriers. RCS launched the survey in September 2023 and plans to obtain results by February 2024.
The RCS Chief Officer should develop and implement a process to periodically assess the extent of identified barriers Vet Center staff may encounter to providing services, including challenges obtaining clinical consultations for complex cases.	**Not Implemented.** In January 2024, RCS officials reported that they launched a survey of Vet Center staff in December 2023. The James M. Inhofe National Defense Authorization Act for 2023 also included a requirement for RCS to collect systematic feedback from Vet Center staff; officials plan to use this survey to satisfy these requirements and our recommendation. RCS officials reported that they intend to develop a plan for periodic re-assessment based on the survey results and complete this work by the end of January 2024.

Source: GAO-22-105039 and GAO analysis of Department of Veterans Affairs (VA) Readjustment Counseling Service (RCS) information. | GAO-24-107170

We will continue to follow up with RCS officials on their progress in implementing these recommendations. When RCS completes these activities, we will evaluate the extent to which it has addressed our recommendations. In addition, we have ongoing work examining the physical infrastructure of VA's Vet Centers and future investments, which we plan to issue in the summer of 2024.[11] We also have planned work that we will begin in 2024 in response to a provision in the James M. Inhofe National Defense Authorization Act for Fiscal Year 2023 to assess the feedback VA obtains from its evaluation of Vet Center counselor productivity expectations.

In closing, VHA's RCS has implemented one recommendation and taken steps to address the four remaining open recommendations from our May 2022 report. Implementing these recommendations will help ensure veterans and servicemembers are receiving the assistance they need from Vet Centers to help meet the serious challenges many face readjusting to civilian life or to continued military service.

[11]James M. Inhofe National Defense Authorization Act for Fiscal Year 2023, Pub. L. No. 117-263, § 5126(e), 136 Stat. 2395, 3216 (2022).

Chairman Tester, Ranking Member Moran, and Members of the Committee, this concludes my statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made contributions to this testimony include Malissa G. Winograd (Assistant Director), Margot Bolon (Analyst-In-Charge), Jacquelyn Hamilton, Drew Long, Ethiene Salgado-Rodriguez, and Kelly Turner.

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GAO Highlights

Highlights of GAO-24-107170, a testimony before the Committee on Veterans' Affairs, U.S. Senate

Why GAO Did This Study

Some veterans and servicemembers experience challenges, such as mental illness, when readjusting to civilian life or continued military service. This can be due to trauma experienced during military service. VHA's Vet Centers provide services to eligible veterans, servicemembers, and their families.

This statement describes the findings from GAO's May 2022 report, GAO-22-105039, which examined VHA's efforts to assess Vet Center clients' needs, tailor outreach activities and assess their effectiveness, and identify and address barriers to care. This statement also describes the status of VHA's efforts to implement GAO's recommendations. For this statement, GAO reviewed VHA's reports of steps RCS has taken to address GAO's recommendations.

What GAO Recommends

GAO made five recommendations in the May 2022 report to VHA to improve Vet Center processes. VHA concurred with GAO's recommendations and has implemented one of the recommendations. As of January 2024, VHA had taken steps to implement the remaining four, which remain open.

View GAO-24-107170. For more information, contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov.

January 31, 2024

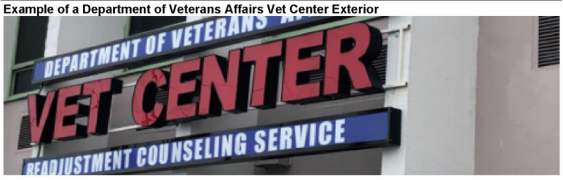
VETERANS HEALTH CARE

VHA Has Taken Steps towards Improving Vet Centers

What GAO Found

The Veterans Health Administration's (VHA) Readjustment Counseling Service (RCS) provides counseling to individuals, groups, couples, and families through 303 Vet Centers nationwide. In fiscal year 2023, RCS data show that Vet Centers provided about 1.3 million counseling visits to more than 104,000 clients.

Example of a Department of Veterans Affairs Vet Center Exterior



Source: Department of Veterans Affairs. | GAO-24-107170

In its May 2022 report, GAO found that VHA lacked processes that would help it better assess Vet Center activities. Specifically,

- **VHA did not collectively assess whether Vet Centers were meeting clients' needs.** GAO found that RCS and Vet Centers used assessments and feedback surveys to assess each individual client's needs. However, RCS had not assessed the extent to which Vet Centers were meeting the needs of client subpopulations, like those with traumatic brain injury, that may experience different readjustment challenges.
- **VHA lacked data to tailor outreach and assess its effectiveness.** GAO found that Vet Centers used data from outreach activities, such as the number of contacts made, to try to assess their effectiveness. However, there were limitations to using these data because not all outreach activities resulted in contacts, according to officials from RCS and Vet Centers.
- **VHA did not identify whether its actions were minimizing barriers to Vet Center care.** GAO found that RCS and Vet Center officials identified barriers to Vet Center care, such as lack of awareness of Vet Center services. Officials also identified steps they have taken to address barriers. However, RCS officials did not know the extent to which barriers to Vet Center care remained because RCS did not have an assessment process.

Based on these findings, GAO made five recommendations in its May 2022 report. As of January 2024, VHA had implemented one of GAO's recommendations by assessing the extent to which Vet Centers were meeting the needs of their clients collectively. VHA has taken some steps towards implementing the other four recommendations. Continued attention to these recommendations will help ensure veterans and servicemembers are receiving the help they need readjusting to civilian life or to continued military service.

Questions for the Record

Department of Veterans Affairs (VA)
Questions for the Record
Committee on Veterans' Affairs
United States Senate
Hearing on Vet Centers: Supporting the Mental Health Needs of Service Members, Veterans, and their Families

January 31, 2024

Question for the Record from Senator John Tester:

Question 1: Okay. And then the last question is, what kind of use are you seeing from the physically disabled veterans' groups? That is data that we don't have. And that's something that we can take back for the record and be able to answer that more effectively.

VA Response: Vet Centers do not capture information regarding individual physical disabilities in a way that can be easily reported or aggregated. This information is collected (where applicable) in text fields as a part of the eligible individual's intake assessment and is used in the creation of an individualized counseling plan. Vet Centers work with Veteran Service Organizations (VSOs) to ensure clients have ample opportunities to participate in activities catered toward physically disabled Veterans. For example, the Kalispell Vet Center recently attended a DREAM Adaptive Ski Trip at Whitefish Mountain Resort. This partner generously provides Veterans from all over the country with opportunities to participate in Alpine and Nordic skiing throughout this winter season.

Questions for the Record from Senator Thomas R. Tillis:

Question 1: According to OIG's testimony, RCS has had challenges with staffing within the Vet Centers. Please provide the vacancy rate and what initiatives is the VA pursuing to increasing hiring at Vet Centers.

VA Response: As of February 11, 2024, the Readjustment Counseling Service (RCS) had a vacancy rate of 17%. RCS uses a variety of different initiatives to increase hiring at Vet Centers:

Relocation, Recruitment, and Retention (3R) Incentives: These incentives are for highly qualified candidates and employees to support hiring and retention of employees in hard-to- fill communities, which can include rural and tribal areas. RCS typically offers 3R incentives up to 25% basic pay (salary) in exchange for a service agreement. In cases of critical need, VA has authority to offer up to 50% of base pay. During FY 2023, 53 individuals received a 3R incentive.

Special Salary Rates (SSRs): In April 2022, RCS conducted an analysis into programs that are available in making RCS salary more competitive with other Federal and non-Federal employers. Through this analysis, RCS identified several occupations in various locations that were eligible to be added to existing VA SSRs. SSRs also may be authorized when recruitment or retention problems are anticipated due to high non-Federal rates of pay in the community. RCS currently has 699 RCS employees receiving an SSR. RCS continues to analyze other locations and occupations where SSRs may be beneficial and are eligible for new SSRs. Nearly 60% of current RCS counseling staff now are receiving an SSR.

Education Debt Reduction Program (EDRP): The EDRP provides a tax-free payment reimbursement of up to $200,000 over 5 years for direct service Hybrid Title 38 employees in hard to recruit or retain locations. In FY 2023, RCS used 50 EDRP allocations. Since inception in FY 2020, RCS has used 147 EDRP allocations.

Student Loan Repayment Program (SLRP): This program provides a flexibility where the agency may repay Federally insured student loans as a recruitment or retention incentive. VA may pay $40,000 per year and up to $100,000 lifetime for a Title 5 and Hybrid Title 38 employees in exchange for a minimum 3-year service commitment. In FY 2023, RCS awarded 30 SLRP incentives. Since inception in FY 2019, RCS has awarded 159 SLRP incentives. Of note, these higher limitations derive from Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act authority codified in 38 U.S.C. § 706(e), which sunsets on September 30, 2027. Without the authority in the PACT Act, the limitation is $10,000 per year and $60,000 per employee.

Employee Incentive Scholarship Program (EISP): This program authorizes VA to award scholarships to employees pursuing degrees or training in healthcare occupations where the recruitment and retention of qualified personnel is difficult such as Title 38/Hybrid Title 38 occupations in exchange for a service obligation of 1 to 3 years. Since inception in FY 2022, there have been 20 EISP scholarships awarded.

Question 2: According to a GAO report, they recommended that RCS conduct a pilot, tracking the effectiveness of outreach. Can you describe what tools are going to be used for measuring the outreach? Can you also provide a full outline of the pilot?

VA Response: A full outline of the pilot program will be available by June 2024 provided successful completion of union bargaining requirements. RCS is developing a pilot project to evaluate effective outreach using different measures of tracking outreach performance and effectiveness. This project includes future testing of a pipeline model, commonly used in the private sector, which looks at conversion rates of outreach into direct services. This pilot will be used to make recommendations on appropriate target percentages for individual Vet Center communities. Thirty Vet Center locations across all RCS districts were selected.

Question 3: [Mr. Fisher Response: Also on your comment about the website, we have recently implemented websites for every Vet Center that includes up-to-date information on the type of services we provide at those locations. We will also take that other item back to look for some inefficiencies.] Why does the VA locator work the way it does?

VA Response: The Facility Locator was designed to be used by Veterans and other beneficiaries. Through research, we've learned that Veterans use the tool to find facilities near their current location or near a location where they will be in the future. As such, they tend to search using a city or zip code, rather than looking for every facility within a state.

The search applies a radius from an initial point representing the center of the geographic parameter entered by the user to return the most convenient locations based on proximity. This search logic supports Veterans in small states or living near state borders because the closest location may be across the state line. The need to find these locations was underscored in 2019 for Community Care Pharmacy Benefits under the Maintaining Internal Systems and Strengthening Integrated Outside Networks Act (known as the MISSION Act). Finding these locations in a state-based search would require the Veteran to perform a second search for the neighboring state. State-level searches may not be practical for residents of large states, such as Montana, California, or Texas, because many locations returned will not be within a reasonable distance.

Question 4: If it cannot be changed, why not?

VA Response: The application can be modified to include this type of search. However, this feature has not been developed yet because Veterans have not expressed (through our research and feedback mechanisms) that such a search feature is a needed or high-priority feature.

Question 5: To which office in VA could his office request a change to the site?

VA Response: The Office of the Chief Technology Officer is the appropriate office to contact.

Question for the Record from Senator Richard Blumenthal:

Question 1: Can a former Coast Guard Academy Cadet who did not complete the requirements to commission, and withdrew from the Academy as a result of military sexual trauma, receive counseling at a Vet Center? If so, is this entitlement available to all cadets or midshipmen at West Point, Annapolis, or the Air Academy who withdrew under similar circumstances?

VA Response: Eligibility to receive Vet Center services for conditions related to sexual assault or sexual harassment during military service (Military Sexual Trauma or MST) requires only two basic service history requirements: (1) service on active military,

naval, air, or space service (as defined under 38 U.S.C. § 101(24)) and (2) a discharge therefrom that is not dishonorable or otherwise subject to a statutory bar to VA benefits under 38 U.S.C. § 5303 or other applicable statutes, to include 1720I(b).

The term "active military, naval, air or space service" is defined to include the term "active duty." See 38 U.S.C. § 101(24)(A). Service as a cadet at the U.S. Military, Air Force, or Coast Guard Academy, or as a midshipman at the U.S. Naval Academy, qualifies as active duty under 38 U.S.C. § 101(21)(D) and thus meets the active military, naval, air, or space service requirement for VA benefits purposes. Of note, 38 U.S.C. § 5303A imposes a minimum active-duty service requirement for VA benefits, with limited exceptions. MST-related care is exempt from the minimum active-duty service requirement because it is considered an exception as a service provided "for or in connection with a service-connected disability, condition, or death" under § 5303A(b)(3)(D). Therefore, a cadet/midshipman who withdrew from an academy prior to the completion of the minimum active-duty service requirement could still be eligible for MST-related care, even if not eligible for other VA health care services, subject to any statutory bar to benefits, to include a disqualifying discharge.

With MST, it doesn't matter where a former service-member was physically or what they were doing when the sexual trauma occurred; it only matters that they were currently in a duty status as an enrolled cadet or midshipman. An individual who served at least 1 day of full-time active duty as a Coast Guard Academy cadet could be eligible for VA MST-related care.

Questions for the Record from Senator Kyrsten Sinema:

Question 1: My office has been hearing from Arizona veterans and VA staff regarding concerns about unmanageable counselors' workloads, which leads to staff burnout, high turnover, and impacts the quality of care that veterans are receiving. Is Readjustment Counseling Service (RCS) still following the 1.5 visits per hour policy, and how are Vet Centers managing the demand for mental health services while ensuring the quality of care is not impacted?

VA Response: RCS sets performance expectations within employee performance plans. For readjustment counselors, fully successful performance includes a comprehensive mix of individual, couples, family, and group counseling and outreach services. The expectation is that 50% of worked duty time (time associated with leave, training, and certain types of clinical supervision is removed) is spent in combination of direct client care, outreach, and associated travel. Of this 50% of worked duty time, the expectation is to have 1.25 visits for each direct service or outreach hour. This metric of 1.25 visits for each direct service or outreach hour is calculated through the number of individuals attending group counseling, family sessions, outreach, and traditional individual sessions. To monitor quality of care, RCS uses VSignals, which is a real-time customer feedback platform, to provide tools to analyze how the needs of individuals served are being met through Vet Center services.

Staffing levels are determined in part by the RCS Staffing Model that incorporates service demand projections and analysis of the service delivery provided to each Vet Center to help guide leadership in determining where additional staffing may be needed. Directors who assess their Vet Center as needing additional support, based on workload, capacity, and local demand, can request additional employees through consulting with their District and submitting a streamlined asset request process.

In Arizona, specifically in the prior 14 months, counselors had an average direct service percentage of approximately 50% indicating that they spent half of their available time providing counseling services, engaging in outreach activities, and potentially traveling to client appointments.

Question 2: Does the VHA have plans to improve its recruitment and retention policy for quality counselors, including for locations in rural and tribal areas?

VA Response: While RCS does not have a specific policy for retention and recruitment, in FY 2023 RCS made improvements to recruitment and retention of quality counselors throughout RCS, to include locations in rural and tribal areas. Some of the ways in which RCS uses strategies to recruit and retain quality employees include the following, which align with current strategic staffing plans across VHA:

Relocation, Recruitment, and Retention (3R) Incentives: These incentives are for highly qualified candidates and employees to support hiring and retention of employees in hard-to- fill communities, which can include rural and tribal areas. RCS typically offers 3R incentives up to 25% basic pay (salary) in exchange for a service agreement. In cases of critical need, VA has authority to offer up to 50% of base pay. During FY 2023, 53 individuals received a 3R incentive.

Special Salary Rates (SSRs): In April 2022, RCS conducted an analysis into programs that are available in making RCS salary more competitive with other Federal and non-Federal employers. Through this analysis, RCS identified several occupations in various locations that were eligible to be added to existing VA SSRs. SSRs also may be authorized when recruitment or retention problems are anticipated due to high non-Federal rates of pay in the community. RCS currently has 699 RCS employees receiving an SSR. RCS continues to analyze other locations and occupations where SSRs may be beneficial and are eligible for new SSRs. Nearly 60% of current RCS counseling staff now are receiving an SSR.

Education Debt Reduction Program (EDRP): The EDRP provides a tax-free payment reimbursement of up to $200,000 over 5 years for direct service Hybrid Title 38 employees in hard to recruit or retain locations. In FY 2023, RCS used 50 EDRP allocations. Since inception in FY 2020, RCS has used 147 EDRP allocations.

Student Loan Repayment Program (SLRP): This program provides a flexibility where the agency may repay Federally insured student loans as a recruitment or retention incentive. VA may pay $40,000 per year and up to $100,000 lifetime for a Title 5 and

Hybrid Title 38 employees in exchange for a minimum 3-year service commitment. In FY 2023, RCS awarded 30 SLRP incentives. Since inception in FY 2019, RCS has awarded 159 SLRP incentives. Of note, these higher limitations derive from Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act authority codified in 38 U.S.C. § 706(e), which sunsets on September 30, 2027. Without the PACT Act authority, the limitation is $10,000 per year and $60,000 per employee.

Employee Incentive Scholarship Program (EISP): This program authorizes VA to award scholarships to employees pursuing degrees or training in healthcare occupations where the recruitment and retention of qualified personnel is difficult such as Title 38/Hybrid Title 38 occupations in exchange for a service obligation of 1 to 3 years. Since inception in FY 2022, there have been 20 EISP scholarships awarded.

Question 3: With which incentive program have you seen the most success with onboarding quality Vet Center employees, and how are Vet Centers supporting current staff to reduce attrition rates and help the staff manage increasing demand for services?

VA Response: As outlined in the previous question, RCS has broadly used incentive programs to retain and recruit quality staff. Programs, like EDRP, offer a high dollar value reimbursement for loan payments in exchange for service in a Vet Center. This program has the greatest financial benefit to the employee, while SLRP directly pays the employee's student loans and can be used for employees in all Vet Center professions, including non-counseling staff. As noted, RCS used 53 3R incentives in FY 2023, which brought equity in recruiting and retention of high-quality employees to Vet Centers across the country. In addition, EISP provides RCS with the ability to place new graduates into Vet Centers where recruitment and retention is often a challenge, which may include rural and tribal communities, if appropriate.

With regard to areas where there is an increased demand for services, all employees in the organization have a pathway to submit requests for additional staffing. The RCS Staffing Model incorporates service demand projections and analysis of the service delivery provided to each Vet Center, which helps guide leadership in determining where additional staffing may be needed. If a Vet Center Director's assessment of workload, capacity, and local demand for their Vet Center indicates need for additional support, they can consult with their District to submit a streamlined asset request process, which includes an expedited review and approval of staffing requests.

Question 4: The Tucson Vet Center recently shared concerns with my team regarding their electronic client record system slowing down the delivery of provider care. The Vet Center staff reported that the system is decades out of date and contains redundant steps for documenting patient and family interactions. What steps are the VA taking to ensure Vet Centers receive more effective and up-to-date IT systems for clinical staff? As the VA transitions to the Electronic Health Record system, how are you ensuring that you reduce friction

for Vet Center staff with read-only access to veterans' records? How is RCS ensuring that the fixes for RCSNet are not "band-aid" fixes, but sustainable solutions?

VA Response: RCS maintains an electronic health record system that is separate from VA medical facilities records. RCS staff is granted read-only access to the VA medical facilities' electronic health record system to support effective care coordination. RCS District Office teams work with our Vet Center teams to ensure they have read-only access and are trained on how to navigate the read-only access. In addition, RCS staff is provided with training on how to use RCS' internal electronic health record system. RCS currently is exploring options for modernization of RCS electronic records. This process is being done through a formal intake process and National Service Request with the Veterans Health Administration (VHA) Office of Information Technology. The next steps will involve defining business requirement through this process. In addition, RCS is implementing the Vet Center Outreach Application, which was custom created for RCS using the Salesforce platform. This process will significantly modernize outreach documentation and processes and will be integrated with the current RCS electronic record (RCSNet).

Question 5: What outreach efforts are Vet Centers pursuing with military installations to ensure transitioning service members are aware of the services that Vet Centers provide?

VA Response: In partnership with the VA Office of Outreach, Transition, and Economic Development, RCS created a comprehensive overview of Vet Center services in the VA benefits and services training within the mental health services section. This training includes an instructor manual for Transition Assistance Program (TAP) contractors teaching the class. The guide is also available on the TAP website. A separate training module is also made available for TAP's Military Life Cycle initiative ensuring Service members and their families are aware of Vet Centers before transitioning out of the military. Vet Center team members occasionally provide the TAP briefing themselves or are offered an outreach table to speak with Service members during breaks. This process is dependent on the individual relationships and agreements with the local bases or units.

The organization maintains Memorandums of Understanding with the U. S. Marine Corps and the National Guard Bureau to open pathways for individuals to seek Vet Center services. These partnerships have proven to be successful in improving collaboration efforts to target current and transitioning Service members.

The Vet Center Outreach Application allows RCS to reach out to and track outreach contact attempts with separating Service members in a more systematic manner. The application retrieves data on separating Service members and expands targeted outreach to individuals transitioning from the military. This tool allows RCS to engage with Service members and Veterans earlier and at the local level.

Question 6: Can you speak to the status of the pilot program for travel cost reimbursement in support of RCS access and its implications for future expansion opportunities?

VA Response: Section 244 of the Cleland-Dole Act (P.L. 117-328) requires VA to implement a 5-year pilot program to assess the feasibility and advisability of providing payment to cover or offset financial difficulties of an individual in accessing or using transportation to and from the nearest Vet Center service site providing the necessary readjustment counseling services for the individual's plan of service.

VA has conducted a thorough review of the statutory requirements and developed implementation plans as a result. Based on this review, VA has determined that rulemaking is required to implement the pilot program required by section 244 of the Cleland-Dole Act.

VA is committed to creating a robust pilot program and, once regulations are complete and effective (an estimated 18 – 24 month process), VA is projecting implementation at approximately 50 Vet Centers equally distributed across the country to increase pilot utilization.

Question 7: What specific efforts are Vet Centers implementing to connect with vulnerable veteran communities, such as homeless, geographically isolated, Native American, women veterans, and others?

VA Response: Vet Centers develop strategic outreach plans to target eligible populations within each community, including outreach to vulnerable Veteran communities, such as homeless, geographically isolated, Native American, and women Veterans. Teams use Mobile Vet Centers and develop community partnerships to further support the needs of underserved populations. For example, Vet Centers partner with VA medical centers annually to co-host Homeless Veteran Standdowns and referrals to VA and community housing programs to access housing vouchers. Vet Centers foster strong working relationships with tribal communities and conduct outreach and direct services on tribal nations. For example, in FY 2023, the San Luis Obispo Vet Center in California developed a satellite location in Santa Maria, California, to meet the identified needs of Veterans from the Santa Ynez Band of Chumash Indians.

Questions for the Record from Senator Joe Manchin:

Question 1: Mental Health Services for Rural Veterans Through the Deployment of Mobile Vet Centers: there are 83 mobile vet centers that the Readjustment Counseling Services (RCS) currently own, that provide unique access to vet service even to those veterans who live in rural states and areas. Are veterans aware of these mobile vet centers and the services they can provide? Can these mobile vet centers fill in gaps where veterans are unable to travel hours to a VAMC or those vets who opt to not use telehealth appointments to receive mental

health care? Does the VA take in account the desire and frequency that mobile vet centers are deployed in rural locations in their decision to expand brick and mortar vet center locations? I ask because I want to ensure rural veteran populations in West Virginia are not overlooked if they do not live close to larger cities who do have vet centers. Are veterans aware of these mobile vet centers and the services they can provide? Can these mobile vet centers fill in gaps where veterans are unable to travel hours to a VAMC or those vets who opt to not use telehealth appointments to receive mental health care? Does the VA take in account the desire and frequency that mobile vet centers are deployed in rural locations in their decision to expand brick and mortar vet center locations?

VA Response: With regard to mental health care, RCS is authorized to provide psychosocial counseling designed to assist eligible individuals in overcoming barriers to achieving a successful readjustment. Readjustment counseling consists of individual, group, and family counseling, as well as community outreach to promote access and referral services to coordinate care between the Vet Centers, VA medical facilities, and other community providers. Mobile Vet Centers (MVCs) are meant to operate in communities distant from physical Vet Center locations. Their purpose is to extend direct counseling, outreach, and referral into communities to fill gaps where physical RCS assets do not exist. MVCs also participate in local events like fairs, festivals, parades, special community events, and respond at times of disaster depending on the needs of the community. In emergency situations resulting from disaster response or augmenting Veteran service needs where VA facilities normal operations are curtailed, Mobile Vet Centers (MVCs) have been used as office space to support VA mental health personnel in providing mental health services to Veterans.

RCS has invested in expanding the MVC fleet, and in FY 2023 modernized the fleet to include updated vehicle wraps that provide Vet Center branding and messaging related to the Vet Center mission and who Vet Centers serve. The purpose of this messaging is to ensure eligible individuals are aware of the MVC in places that they are likely to frequent.

MVCs are intended to be used as demand developers in communities that are rural or distant from Vet Center locations in that Vet Centers use MVCs to establish private and confidential counseling space anywhere with a parking lot. Depending on the vehicle model, a MVC offers 1 to 2 private counseling areas and a bathroom. Every MVC is capable of being powered by an on-board generator, making it ideal for those rural environments with limited infrastructure.

As service provision increases in a given community, RCS seeks to establish Community Access Points (CAPs) that use donated space within the community of need. This space can be at any variety of locations, including but not limited to local Veterans service organizations, community behavioral health providers, faith-based spaces, or educational institutions. Vet Center teams provide counseling from these donated spaces at a frequency dictated by the demand for services. As demand rises, RCS considers additional opportunities for more permeant space like an Outstation or a

standalone Vet Center. This plan is a cost-effective way for RCS to provide services in more remote locations where demands for service exist.

Vet Center teams are intentional in the outreach they provide to Veterans, Service members, and family members in their local communities. They participate in events that Veterans and Service members are likely to attend ranging from events at a Veterans service organization to larger community events like professional and minor league sporting events.

In FY 2023, MVCs provided readjustment counseling services (outreach and direct counseling) to 25,334 Veterans across the country, including 1,148 Veterans and Service members from West Virginia-based MVCs in Huntington and Beckley.

Question 2: The Relocation, Recruitment, Retention Incentive Program (3Rs): I understand that one of the incentives the VA offers to get and keep staff at vet centers where they are badly needed is the "Relocation, Recruitment and Retention" program. Can you tell me where some of these most hard to fill communities tend to be? How successful would you say this program is? How successful would you say the "relocation" part of this program is at bringing talent to rural areas, such as the state of West Virginia?

VA Response: RCS successfully uses 3R incentives for highly qualified candidates and employees to incentivize hiring and retention of employees in hard-to-fill communities. RCS generally uses 3R incentives up to 25% basic pay (salary) in exchange for a service agreement. In circumstances of critical need, VA has the authority to approve incentives up to 50% of the employee's base pay. During FY 2023, 53 individuals were awarded a 3R incentive. The following table outlines the type and location of these incentives. This program has been successfully used to build equity by incentivizing qualified staff to serve in locations with vacancies are that often difficult to fill.

3R Incentive Types, Number, and Locations.

Type of Incentive	Number of Incentives Used	Locations
Recruitment	18	Princeton, WV Naples, FL Knoxville, TN Fargo, ND Midland, TX Fort Collins, CO Oklahoma City, OK Grand Junction, CO Great Falls, MT Boulder, CO San Francisco, CA Temecula, CA Chico, CA San Jose, CA

Type of Incentive	Number of Incentives Used	Locations
		Yamika, WA Lihue, HI Prescott, AZ Lakewood, CO
Retention	27	Chico, CA Concord, CA (x3) Naples, FL (x4) Berlin, NH Albuquerque, NM Santa Fe, NM Bismarck, ND Fargo, ND Erie, PA Austin, TX South Burlington, VT Martinsburg, WV Georgetown, DE Dundalk, MD Rapid City, SD Corona, CA Federal Way, WA (x3) Temecula, CA (x2) Springvale, ME
Relocation	8	Lowell, MA Hyannis, MA Fargo, ND Grand Forks, CO Fort Collins, CO Corpus Christi, TX Kailua-Kona, HI San Jose, CA

Question 3: Can you tell me where some of these most hard to fill communities tend to be?

VA Response: In places where RCS has challenges filling vacant positions, RCS District Leaders use 3R incentives. As displayed in the previous table, RCS uses 3R incentives across the United States in communities that serve rural and urban environments. Many of the locations are in more remote locations, but all locations have had historical challenges in recruiting and retaining quality counselors. In FY 2023, RCS used multiple 3R incentives for retention in four separate Vet Centers, including four in Naples, Florida, three in Federal Way, Washington, and three in Concord, California.

Question 4: How successful would you say this program is?

VA Response: As stated previously herein, RCS used 53 3R incentives in FY 2023, which brought equity in recruiting and retention of high-quality employees to Vet Centers across the country. RCS views the program as successful, particularly in these locations with historic challenges in recruitment and retention. Frequent turnover disrupts counseling progress, and so RCS views continuity in staff members to be integral in the success of the Veterans, Service members, and families that we serve.

Question 5: How successful would you say the "relocation" part of this program is at bringing talent to rural areas, such as the state of West Virginia?

VA Response: RCS used a recruitment incentive in Princeton, West Virginia, and a retention incentive in Martinsburg, West Virginia, which were successful in recruiting one Social Worker and retaining another, who remain in service to Veterans in those locations. RCS has used 3R incentives in remote areas—like Fargo, North Dakota; Grand Junction, Colorado; Yakima, Washington; and Great Falls, Montana—to assist in recruiting and retaining quality staff. These incentives are valuable in maintaining high-quality care in the more rural areas that Vet Centers serve.

Question 6: S.3650 Combat Veterans Pre-enrollment Act: This January, Senators King, Cramer, Rounds and myself introduced the bipartisan "Combat Veterans Pre-enrollment Act", which would allow combat veterans to pre-enroll in the VA healthcare system 6 months before their date of separation from the military. I understand that common issue that veterans face their first time walking into a vet center is that they need to be registered for care at the VA before receiving services at a vet center. If it passes, the "Combat Veterans Pre-enrollment Act", should allow separating servicemembers to receive vet center services as soon as they are as they pre-enroll with the Department of VA. Were you aware of this bill? Would you agree that this bill could be helpful to ensure veterans are able to receive mental health care immediately at a vet center than potentially being turned away if they were unaware that they need to register with the VA first?

VA Response: VA does not require additional statutory authority to provide Vet Center services to eligible Service members prior to their separation from the military. Current RCS eligibility is inclusive of active-duty Service members provided they meet at least one of the following eligibility criteria listed. In addition, eligibility for Vet Center services is separate and independent from eligibility for VHA Healthcare. Individuals are not required to enroll in VHA Healthcare to use Vet Center services and may directly engage with Vet Centers regardless of their status related to service connection or enrollment with a local VA medical center. There are no additional registration requirements for Vet Center services.

Per 38 U.S.C. § 1712A, members of the Armed Forces, including members of a Reserve Component, who are eligible for Vet Center services include, but are not limited to, those who served on active duty in a theater of combat operations or in an

area with hostilities, who provided emergency medical or mental health care or mortuary services to casualties of combat operations or hostilities while located outside such areas, who engaged in combat with an enemy of the United States or against an opposing military force in a theater of combat operations or an area with hostilities by operating a remote-controlled unmanned aerial vehicle, or who served on active service in response to a national emergency or major natural disaster declared by the President.

Per the provisions of 38 U.S.C. § 1720D, VA shall provide military sexual trauma (MST) counseling to former members of the Armed Forces who experienced sexual assault or harassment while serving on active military duty in any theater of service. VA also is authorized to provide such counseling to Service members under § 1720D(a)(2). Readjustment counseling at Vet Centers includes military sexual trauma counseling and referral per 38 C.F.R. § 17.2000(d). Vet Centers provide MST counseling to Veterans and Service members who experienced sexual trauma or harassment, as described in § 1720D, while on active duty in any theater of service per paragraph 1, 2.o, 3.d. of VHA Directive 1500(4), Readjustment Counseling Service, dated January 26, 2021 (amended November 21, 2023).

Per the provisions of 38 U.S.C. § 1783, VA may provide bereavement services at Vet Centers for eligible family members and caregivers who were actively receiving counseling and other services described in 38 U.S.C. § 1782 at the time of the Veteran's death if the death was unexpected or occurred while the Veteran was receiving hospice or similar care, and to immediate family members, including parents, of Service members who died in the line of duty not due to the person's own misconduct.

Question for the Record from Senator Bill Cassidy:

Question 1: I mean, we're talking suicide, you see what I'm saying? So is there a stepwise plan that you could send the two of us and we could look at it and we say, "Oh, this is reasonable. They're addressing it." And we could actually go someplace and see it being implemented, and we say it's actually being implemented. Because I'm hearing from Dr. Kroviak that that's not the case. She didn't say it precisely, but implicit in what she's saying is that it's not happening.

[Mr. Fisher's Response: Yes, sir. There is a plan in place and in locations that that finding happens. That district office creates an action plan to improve those concerns, and we can provide that.]

VA Response: The Vet Center Inspection Program (VCIP) is a randomized inspection process initiated by OIG. After OIG inspects identified Vet Centers within a given RCS District/Zone, a draft report is issued by OIG with recommendations. Local and District leadership work in consultation with RCS national leadership to form responses and create local action plans based on the recommendations. District leadership is responsible for the implementation of action plans. OIG determines when the

recommendation has been successfully implemented and then closes the recommendation based on evidence of mitigation.

Suicide prevention processes include formal risk assessment conducted on the first counseling visit, monthly case audits, and annual clinical site visits, all of which are requirements in VHA Directive 1500(4). In addition, individuals with oversight responsibilities have access to a real-time data quality assurance report to measure local compliance of suicide risk assessments.

Question for the Record from Senator Sherrod Brown:

Question 1: So, thank you. My state's 12 million people. We have centers in some big cities, Toledo, Columbus, and then we have centers in a medium sized city, Canton. And then we have centers in sort of suburban areas of big cities, Kettering near Dayton, Norwood near Cincinnati, Oakwood near Dayton, Parma Heights near Cleveland. Should there be more to serve 12 million -- well, serve 700,000 plus veterans? Should there be more of these? Should they be staffed at higher rates? You talked about falling short on outreach. What's the problem, Mr. Fisher?

VA Response: RCS strives to provide the appropriate level of services for eligible Veterans, Service members, and their families based on the demand for services within the communities. To accomplish this, RCS leaders use several different assets (see the following outline) and resources to meet the local need, which may include using a Mobile Vet Center, creating a Vet Center CAP, Vet Center Outstation, or a full "brick and mortar" Vet Center:

Community Access Point (CAP): CAPs are typically located in donated space established in conjunction with a community partner for the purpose of providing readjustment counseling services to a small number of eligible Veterans, Service members, and their families. These may be staffed ranging from 1 day per month to several times per week. Typically, the workload does not support a fulltime employee 5 days per week. The number in of these locations fluctuate given local demand.

Vet Center Outstation: Outstations are established in leased space as an adjunct to an existing Vet Center. Historically, Outstations were located within a rural community with an underserved population scattered over a large geographical area. These locations are generally staffed with a minimum of one to two counselors and like CAPs are designed to increase access to services by taking the services to the communities where eligible Veterans, Service members, and their families live.

Vet Center: Vet Centers are in leased spaced in the community outside of the larger VA medical facilities and are staffed with an average of six staff, which includes supervisory, counseling, outreach, and administrative staff. The placement of a Vet Center within the community makes every effort to maximize access for local eligible

Veterans, Service members, and their families via all modes of transportation, such as public, private vehicle, and/or pedestrian traffic.

Mobile Vet Center (MVC): MVCs are used to take services to communities that are distant from a Vet Center, Outstation, or CAP. Staffing for these vehicles may include readjustment counselors or outreach specialists. MVCs can provide direct readjustment counseling, access to services offered at Vet Centers, assistance with benefits, and rapid response to crisis situations. MVCs attempt to take advantage of community events where large gatherings of eligible individuals may be.

The following table represents Vet Center assets in Ohio that have associated counseling services in FY 2024. RCS District Leadership regularly assess the need for additional assets and resources:

VET Center Assets in Ohio.

Type	Name of Asset	City	State
Vet Center	Cincinnati Vet Center	Norwood	OH
Vet Center	Cleveland Vet Center	Oakwood Village	OH
Vet Center	Columbus Vet Center	Columbus	OH
Vet Center	Dayton Vet Center	Kettering	OH
Vet Center	Parma Vet Center	Parma Heights	OH
Vet Center	Stark County Vet Center	Canton	OH
Vet Center	Toledo Vet Center	Toledo	OH
MVC	Dayton Mobile Vet Center	Kettering	OH
MVC	Stark County Mobile Vet Center	Canton	OH
CAP	Butler County Veteran Service Office	Hamilton	OH
CAP	University of Cincinnati at Blue Ash	Blue Ash	OH
CAP	Summit County Veteran Service Commission	Akron	OH
CAP	Geauga County Veterans Service Commission	Chardon	OH
CAP	Lake County Veteran Service Commission	Painesville	OH
CAP	Mahoning County Veteran Service Commission	Youngstown	OH
CAP	American Legion Post 584	Marion	OH
CAP	Licking County Veterans Service Commission	Newark	OH

Type	Name of Asset	City	State
CAP	American Legion Post 96 - Allen County	Lima	OH
CAP	Veterans Service Office - Shelby County	Sidney	OH
CAP	Veterans Service Office - Clark County	Springfield	OH
CAP	Veterans Service Office - Auglaize County	Wapakoneta	OH
CAP	Immanuel Church (Kurt Bush)	Hamler	OH
CAP	Richland County Veteran Service Center	Mansfield	OH
CAP	Tuscarawas County Veteran Service Center	New Philadelphia	OH
CAP	Holmes County Veteran Services	Millersburg	OH

Department of Veteran Affairs
March 2024

Senator Thom Tillis
Questions for the Record
Senate Veterans' Affairs Committee
Vet Centers
January 31, 2023

Questions for [Dr. Kroviak]

1. Dr. Kroviak, many of us represent highly rural states, and we appreciate the efforts VHA is putting in to reach those underserved populations. Has the OIG inspections looked at these smaller outstations and mobile vet centers? Are they properly resourced?

OIG RESPONSE:

For each Readjustment Counseling Service district reviewed by the OIG's Vet Center Inspection Program, the team reviews information and a sample of client charts that incorporates data from rural vet centers, community access points, and mobile vet centers. Our ongoing inspections also evaluate vet center outreach plans and activities, as well as mobile vet center use. We have incorporated these areas into our inspection program because we recognize they are critical to engaging those veterans living in underserved areas who have not previously accessed vet center services.

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