DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

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OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS
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HEARING ON
VET CENTERS: SUPPORTING THE MENTAL HEALTH NEEDS OF SERVICEMEMBERS, VETERANS, AND THEIR FAMILIES
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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

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[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

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[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

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[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.