STATEMENT OF JULIE KROVIAK, MD
DEPUTY ASSISTANT INSPECTOR GENERAL
OFFICE OF HEALTHCARE INSPECTIONS
OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS
HEARING ON
CLOSE TO HOME: SUPPORTING VET CENTERS IN MEETING THE NEEDS
OF VETERANS AND MILITARY PERSONNEL
FEBRUARY 3, 2022

Chairwoman Brownley, Ranking Member Bergman, and Subcommittee Members, thank you for the opportunity to discuss the Office of Inspector General's (OIG) oversight of the Department of Veterans Affairs' Vet Centers program. The OIG's Office of Healthcare Inspections recently initiated a new line of inspections that examines vet centers' operations and processes. These cyclical inspections seek to ensure that services are provided in accordance with Veterans Health Administration (VHA) guidance for safe and effective mental health treatment and, most importantly, that vet centers collaborate with VHA facilities as required for high-risk veterans with complex mental health conditions.

The OIG's interest in inspecting vet centers results from years of experience in conducting oversight of the services provided by VHA, particularly to those veterans in need of mental health care. As community-based counselors, vet center staff play an integral role in how many veterans and service members receive mental health services and readjustment counseling. Since their founding in 1979, vet centers have evolved and expanded services to include many evidence-based treatments targeting posttraumatic stress disorder and other mental health diagnoses. Many OIG publications, including individual inspections, national reviews, and comprehensive healthcare inspection program reports, have addressed concerns regarding access to quality mental health care for high-risk veterans.

The five OIG inspections involving 20 vet centers that have been published to date have underscored the value of independent oversight of care received in these settings to help VA make continuous improvements. These recent inspections have found the quality of vet centers' services relies heavily on engaged leaders at all levels. Overall, the OIG determined that leaders and staff at the districts, zones, and vet centers were engaged and expressed interest in wanting to make quality improvements,

suggesting a commitment to a veteran- and service member-centric culture.[1] Suicide prevention remains VA's top clinical priority, and vet centers are critical partners in reducing the risk of suicide for those who seek their services. Vet center leaders must be as attentive as their VHA clinical counterparts to ensure staff are ready and able to meet the needs of those high-risk veterans. To that end, the OIG's findings show that immediate attention is needed in several critical areas that will ultimately support their suicide prevention efforts. These include greater attention to overseeing staff training, internal quality reviews of care, and coordination of care with VHA medical facilities. Addressing these issues will also help VA ensure consistent, quality care is being delivered in these settings.

BACKGROUND

The vet centers' history provides insight into their role in caring for today's veterans, service members, and their families. Since their inception, 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 several times to include any servicemember 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.

Vet centers are administered by the Readjustment Counseling Services (RCS), an autonomous organizational element in VHA, and these centers are separate from VA medical facilities.[2] Vet centers employ small multidisciplinary teams of at least four staff, each with at least one VHA-qualified licensed mental health professional.[3] They focus on interventions for psychological and psychosocial readjustment problems related to various types of military service and deployment stressors, such as combat-related trauma, MST, or other service-related traumas. Veterans are provided with therapies based on clinical diagnoses and have access to different treatment modalities, such as individual, group, and family therapy. Their users are generally not referred to as patients—but rather, as clients.[4] Vet center records are kept separate from VHA and the Department of Defense records and are not shared unless a client signs a release of information. To support treatment, most vet centers have the capability of viewing VHA electronic health records. This separation supports vet center autonomy and veteran confidentiality when receiving care at a vet center.

[1] The vet centers are organized into five districts, each with two to four zones. 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.

[2] RCS manages the Vet Center program, which is comprised of 300 vet centers, 80 mobile vet centers, 18 outstations, and the Vet Center Call Center.

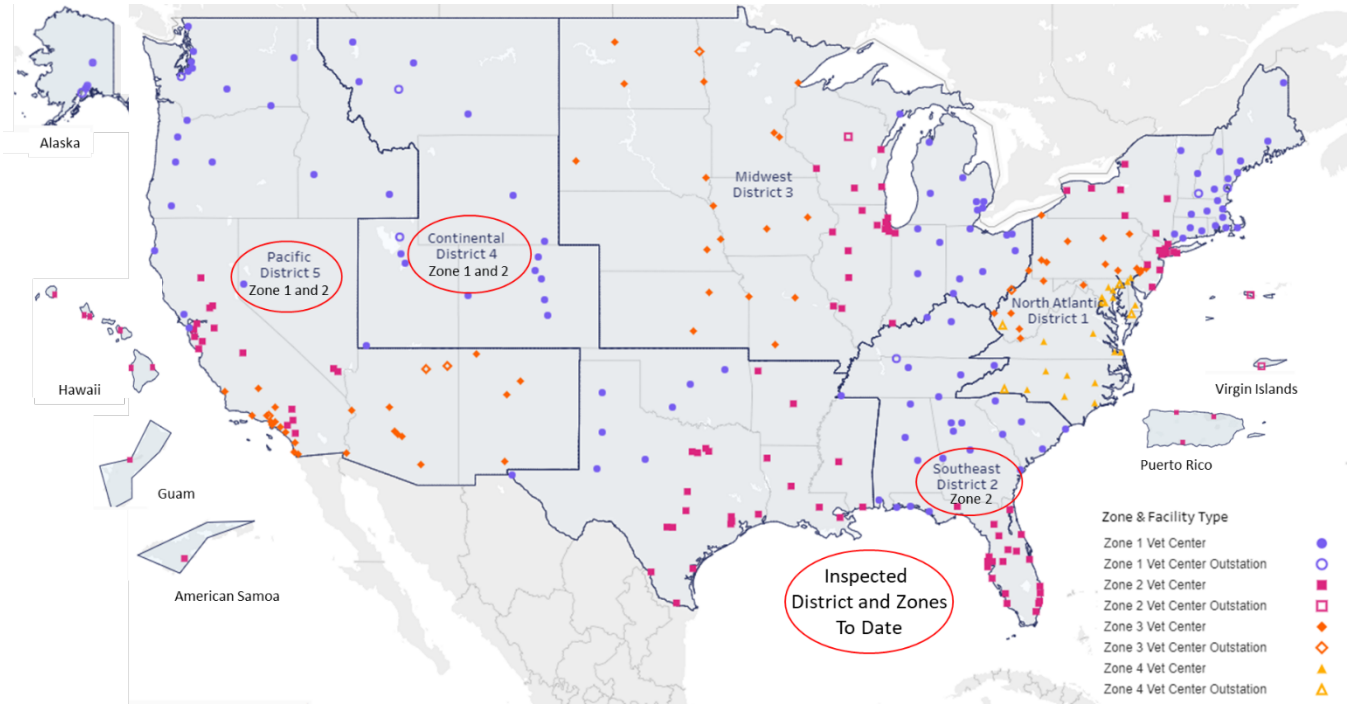
[3] VHA Directive 1500(2), Readjustment Counseling Service, 2021-01-26, (amended 2021-12-30).

[4] VHA Directive 1500(2), 2021.

THE OIG'S VET CENTER INSPECTION PROGRAM

In fiscal year (FY) 2021, the OIG developed inspection protocols to review vet center operations and services to ensure there is routine oversight of the quality of care being delivered. The OIG findings in Vet Center Inspection Program (VCIP) reports are a snapshot of vet centers' performance within a geographic zone for identified topic areas of focus. To date, the OIG has published five VCIP reports covering 20 vet center inspections in Districts 2, 4, and 5.[5] Figure 1 shows a map of the districts, zones, and vet centers, with the districts and zones inspected so far notated.

Figure 1.



The placement of Alaska, American Samoa, Hawaii, Guam, Puerto Rico, and the Virgin Islands is not representative of their actual geographical locations.

VCIP inspections are designed to be wide-ranging and include an assessment of leaders engaged in overseeing and directing vet center activities. The focus areas examined are selected to help provide insight into a client's experience when they seek care or services.

[5] *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; and *Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers*, December 20, 2021.

To examine risks or potential risks to clients, the inspections during FY 2021 focused on six areas that influence the quality of client care and service delivery at vet centers:

- **Leadership and organizational risks** – an evaluation of district leadership stability, quality improvement activities, employee and vet center user survey results, and leadership and organizational risk questionnaire results.
- **Quality reviews** – a determination of district oversight of the vet centers' self-administered clinical and administrative quality reviews and critical-incident quality reviews.
- **COVID-19 response** – an examination of emergency planning, communication and field guidance, supplies and infrastructure, access, and client care (including telework and telehealth, and client screening).
- **Suicide prevention** – an evaluation of compliance in psychosocial and lethality risk assessments, access, care coordination and collaboration with VA medical facility, high-risk suicide flag client disposition, crisis plans, and root cause analysis and feedback.
- **Consultation, supervision, and training** – a review of clinical liaison and external clinical consultation, the VHA-qualified mental health professional on staff, supervision, and staff training.
- **Environment of care** – an evaluation of the physical environment, general safety, and privacy.

VCIP Reports' Findings, Consistent Themes, and Recommendations

Vet centers provide invaluable services to veterans, active-duty personnel, National Guard members, reservists, and their families. OIG oversight has consistently found that the quality of the services provided to veterans relies heavily on engaged leaders at all levels. Overall, leaders at the district, zone, and vet center levels were engaged and interested in improving services, signifying a commitment to a client-focused culture. Vet centers leaders indicated they had adequate supplies and instituted and maintained appropriate COVID-19 safety protocols. Additionally, all vet centers inspected maintained a welcoming and noninstitutional environment, containing veteran-centric displays, art, and memorabilia.

To fully realize their potential to reduce risk and occurrence of suicide, vet centers' success relies on the commitment of properly trained staff coordinating and collaborating with VHA clinical services personnel to care for the most vulnerable and high-risk veterans and service members. VCIP reviews found multiple opportunities for RCS to better prepare their staff to consistently provide high-quality and safe care and improve monitoring of that care and collaborations. The results of the first five inspections have revealed some consistent findings of insufficiencies in three key areas: (1) training, (2) internal controls and reviews, and (3) suicide prevention.

Training

During VCIP reviews, the inspection teams examined whether vet center staff members had completed their required suicide prevention training. This training helps ensure they have the information and

knowledge needed to intervene when clients are in crisis. At the 20 sites inspected, the OIG found suicide prevention training was only completed at four vet centers for all clinical staff and at 12 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 the lack of oversight for the timely completion of training requirements for staff. The OIG teams also reviewed whether clinical staff were completing the required MST training. 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. The OIG teams found that MST training was only completed for all clinical staff at four of the 20 vet centers inspected.[6] Vet center directors explained that this was due to training not being assigned or being assigned incorrectly.

Internal Controls and Reviews

RCS requires an annual clinical and administrative quality review of care at each vet center, conducted by zone leaders, to ensure 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.[7] To confirm the required quality oversight occurred, the OIG team examined clinical and administrative quality review documentation and evidence of the resolution of identified deficiencies. The OIG found most vet centers completed annual clinical and administrative quality reviews as required; however, the teams could not determine when deficiencies from on-site clinical reviews were resolved because of missing or incomplete documentation. For example, remediation plans for the clinical quality reviews did not include documentation of the zone-level approval and approval date, as required.

District and zone leaders are also required to conduct a morbidity and mortality (M&M) review to evaluate clinical care and identify opportunities to improve care when a serious suicide attempt or death by suicide has occurred. M&M reviews follow psychological autopsy protocols to evaluate the actions taken and to make recommendations for improvement. These reviews are completed by a panel that includes a mental health professional from a nearby VA medical facility.

The OIG evaluated whether these required M&M reviews were completed for serious suicide attempts and deaths by suicide for active vet center clients and determined whether identified process improvements were implemented. The five VCIP reports found a total of 53 critical incidents required a review, yet only 23 were completed by the zones inspected. The OIG found most of the five zones completed the required M&M review for *a death by suicide*. However, only one of the five zones

[6] The four vet centers that were compliant with suicide prevention training were not the same four vet centers that were compliant with MST training.

[7] According to RCS guidance in VHA Directive 1500(2), 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.

inspected completed M&M reviews for *serious suicide attempts*, as required. The OIG found four of five zones lacked processes to identify when a suicide attempt was considered serious or to complete an M&M review if criteria were met. This deficiency significantly limited opportunities across RCS to improve suicide prevention efforts.

Finally, RCS guidance requires vet center leaders to conduct monthly client chart audits on 10 percent of each counselor's clinical case load as part of their quality oversight for care.[8] 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 any of the vet centers inspected. The vet center leaders interviewed by the OIG attributed the lack of audits to factors that included competing priorities and inaccuracies within RCSNet, their electronic client record system.[9] Although the inspection team noted vet center leaders were often completing chart audits using their own tracking mechanisms, the report that was supposed to be used in RCSNet was consistently inaccurate. This is significant because that report is used to track audit completions.

Suicide Prevention

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.[10] They also recognize vet centers as an important collaborator in their overall suicide prevention efforts. The distinct nature of vet centers located in communities close to its clients increases opportunities to connect with veterans at risk of suicide and can help improve clinical outcomes for veterans both under VHA care and those who are not engaged.[11]

These efforts are advanced by consistent and careful assessments. Recognizing the clinical importance of early assessments and identifying risk factors, RCS is required to perform a psychosocial assessment of veteran clients to collect relevant background information and assess their suicide risk factors.[12] The psychosocial assessment is an integrated product that documents the individual client's perception of life stressors and the vet center counselor's professional perspective.[13] The OIG looked at required clinical

---

[8] VHA Directive 1500(2), 2021.

[9] In FY 2003, a web-based software system called RCSNet was implemented to collect client information; in 2010, RCSNet became the sole record keeping system for client services. RCSNet's independence from VA medical facilities and Department of Defense's electronic health record systems allows vet centers to maintain secure and confidential records that will not be disclosed to VA medical facilities, VA clinics, or the Department of Defense unless there is a signed release of information. VHA Directive 1500(2), 2021; 38 C.F.R. § 17.2000–816 (e).

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

[11] Deputy Under Secretary for Health for Operations and Management (10N), "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services." November 13, 2017.

[12] The psychosocial assessment includes the intake and military history. The suicide risk assessment is performed separately.

[13] Comprehensive Suicide Risk Assessment and Safety Plan Application Guide for Readjustment Counseling Services (RCSNet), September 19, 2020.

assessment documentation, such as intake, military history, and suicide risk assessments. The team's electronic health record review found substantial noncompliance for the completion of these assessments across all inspected vet centers. Noncompliance was related to incomplete documentation and limitations within RCSNet. During the OIG's FY 2021 inspections, RCSNet did not have a function to determine when documentation has been completed, making it difficult for RCS to conduct quality oversight and limiting the OIG's ability to make determinations.

Another focus of the OIG's vet center inspections is the communication and collaboration between vet center staff and their local VA medical facility's suicide prevention coordinator for individuals determined to be at an elevated risk for suicide. Accurate, timely information regarding an individual's risk level is critical to ensure treatment planning and coordination meet the client's clinical needs. Vet center clinical staff are required to consult and coordinate care with the support of VA medical facility personnel for all clients who are at high risk for suicide, and to provide timely notification to suicide prevention coordinators when clients pose a significant safety risk.[14] While most vet centers had informal processes for collaboration and reported good relationships with the suicide prevention coordinator, only three of the 20 vet centers had a standardized communication process.

The OIG reviewed requirements for sharing VHA lists of veterans flagged as high risk for suicide with vet center staff. The inspection team evaluated if vet centers were receiving the high-risk suicide flag lists from their local VA medical facilities as required. The OIG initially found high risk for suicide lists were not routinely received. In an effort to improve access to this information, RCS created a SharePoint site accessible to vet center directors that houses an updated high-risk suicide flag list. That list is updated with VHA-identified veterans flagged as high risk who have been seen at a vet center in the past 12 months. Since its creation, vet center directors are expected to perform monthly reviews of the SharePoint site and the client case list to determine what interventions or support are needed, and then document the disposition of the review on the SharePoint site.[15] The OIG inspections found that 15 of the 20 vet centers completed the RCS SharePoint review.

VCIP Report Recommendations

All VCIP report recommendations were directed to the chief officer of RCS and the pertinent district director.[16] Appendix A provides a view of VCIP recommendations for the topic areas discussed in this testimony. 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 all recommendations currently open pending the submission of

[14] Deputy Under Secretary for Health for Operations and Management (10N), "Memorandum of Understanding between Office of Mental Health and Suicide Prevention and Readjustment Counseling Services." November 13, 2017.

[15] RCS Memoranda RCS-CLI-006, High Risk Suicide Flag Outreach, April 27, 2020.

[16] Three recommendations in the topic area of suicide prevention were made to the undersecretary of health in the first report and referenced in the consecutive reports, as the findings were relevant in all inspections.

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.

The inspection teams will continue reviewing vet centers on a cyclical basis. Although the review areas may change or expand to address emerging concerns, the resulting reports will provide findings and recommendations that all vet center leaders or oversight personnel can use to make improvements at their own sites. The recommendations in appendix A suggest that many of the review areas with consistent findings across the five published VCIP reports are likely issues at many other vet centers that have yet to be reviewed.

CONCLUSION

Vet centers are uniquely positioned to partner with VHA clinical services to support the needs of veterans, particularly those considered at high risk for suicide. The evolution of vet center services are evidence of the commitment and connection that these centers have developed with the veterans they serve. The OIG met enthusiastic and dedicated staff members who are committed to improving the quality of care provided to clients. While the OIG recognizes and appreciates the differences between vet centers and VHA mental health clinical services, the reality remains that high-risk veterans will utilize vet centers but will also require higher levels of care that vet centers are not equipped to provide. The coordination between RCS and VHA must therefore be seamless and efficient with every client, every time. This will require continued leadership engagement and greater attention to training, internal controls, and oversight.

Chairwoman Brownley, Ranking Member Bergman, and members of the Subcommittee, this concludes my statement. I would be happy to answer any questions you may have.

APPENDIX A: SUMMARY OF RECOMMENDATIONS DISCUSSED IN TESTIMONY FROM PUBLISHED VET CENTER INSPECTION PROGRAM REPORTS

		VCIP Report Location				
Review Area	**Recommendation Language***	Southeast District 2 Zone 2	Continental District 4 Zone 1	Continental District 4 Zone 2	Pacific District 5 Zone 1	Pacific District 5 Zone 2
Consultation, Supervision, and Training	The District Director determines reasons for noncompliance with the appointment of a clinical liaison at the vet center(s), ensures assignment of a liaison, and monitors compliance.				■	
	The District Director determines reasons an external clinical consultant was not assigned as required at the vet center(s) and ensures compliance.		■			
	The District Director determines reasons for noncompliance with processes for completing and tracking four hours of external clinical consultation per month at the vet center(s), ensures that vet center directors implement processes, and monitors compliance.	■	■	■	■	■
	The District Director determines reasons for noncompliance with staff supervision provided by vet center directors at the vet center(s), ensures staff supervision occurs as required, and monitors compliance.	■	■	■	■	■
	The District Director verifies and determines reasons for noncompliance with monthly RCSnet chart audits at the vet center(s), ensures chart audits are completed as required, and monitors compliance.	■	■	■	■	■
	The District Director determines reasons for errors in training assignments and why completed trainings are not being recorded for employees at the vet center(s), ensures all staff complete mandatory trainings as required, and monitors compliance.	■	■	■	■	■
Quality Reviews	The District Director determines reasons quality reviews were not completed and monitors compliance.	■		■		■
	The District Director determines reasons for missing and incomplete quality reviews, remediation plans, and resolution of deficiencies; ensures completion; and monitors compliance.					■
	The District Director evaluates the quality review report approval process to determine if a timeliness measure is needed and takes action as indicated.	■	■			
	The District Director determines reasons quality review remediation plans were not completed, ensures completion, and monitors compliance.	■			■	
	The District Director determines the reasons quality review remediation plans do not include the Deputy District Director's approval and date of approval as required and ensures compliance.		■	■		
	The District Director evaluates the quality review process for resolution of quality review deficiencies and initiates action steps as necessary.	■		■	■	■
	The District Director determines reasons for noncompliance with critical incident quality review (currently known as morbidity and mortality review) of a death by suicide, ensures completion includes an evaluation of vet center services to determine if actions are needed to improve the effectiveness of vet center suicide prevention activities, and monitors compliance.	■				
	The District Director determines reasons for noncompliance with critical incident quality reviews (currently known as morbidity and mortality reviews) for serious suicide attempts, ensures completion, and monitors compliance.	■	■	■	■	

*Recommendation language may differ in actual VCIP report

Legend:

☐ No issue identified

■ Issue identified

APPENDIX A (CONTINUED)

Review Area	Recommendation Language*	VCIP Report Location				
		Southeast District 2 Zone 2	Continental District 4 Zone 1	Continental District 4 Zone 2	Pacific District 5 Zone 1	Pacific District 5 Zone 2
Suicide Prevention (Zone-wide)	The District Director ensures the intake assessment portion of the psychosocial assessment is completed and monitors compliance across all zone vet centers.	■	■	■	■	■
	The District Director ensures military histories are completed and monitors compliance across all zone vet centers.	■			■	
	The District Director ensures lethality risk assessments are completed and monitors compliance across all zone vet centers.	■	■	■	■	■
	The District Director ensures clinical staff consult and coordinate care with the support Veterans Affairs medical facility for shared clients flagged as high risk for suicide and monitors compliance across all zone vet centers.		■	■	■	■
	The District Director ensures clinical staff follow confidentiality requirements when consulting and coordinating care with shared support Veterans Affairs medical facility for shared clients who are flagged as high risk for suicide and monitors compliance across all zone vet centers.		■	■	■	■
	The District Director confirms clinical staff make timely notification to the suicide prevention coordinator at the support Veterans Affairs medical facility for clients with significant safety risks and monitors compliance across all zone vet centers.				■	
	The District Director ensures clinical staff consult with the vet center director, external clinical consultant, or suicide prevention coordinator following a lethality status change as required and monitors compliance across all zone vet centers.		■	■	■	■
	The District Director ensures clinical staff complete crisis reports as required and monitors compliance across all zone vet centers.		■	■	■	■
Suicide Prevention (Vet Center)	The District Director, in collaboration with Readjustment Counseling Service Central Office, evaluates the limitations of current tools and tracking methods, including reasons completion dates are unavailable in RCSnet, and ensures compliance with standards for timely completion of intake assessments and military histories.	■	■	■	■	■
	The District Director determines reasons the vet center(s) did not have nontraditional hours as required and ensures compliance.	■				
	The District Director, in collaboration with the support VA medical facility clinical or administrative liaisons, determines the reasons for noncompliance with the vet center(s) staff participation on mental health councils, and takes action as indicated to ensure compliance with Readjustment Counseling Service requirements.	■	■	■	■	■
	The Under Secretary for Health ensures that the Chief Officer collaborates with the Office of Mental Health and Suicide Prevention to determine reasons for noncompliance with vet centers' receipt of the monthly Office of Mental Health and Suicide Prevention list of clients with an increased predictive risk for suicide, ensures coordination of care with VA medical facilities for vet center clients on the list, and monitors compliance.	■				
	The Under Secretary for Health ensures that the Chief Officer collaborates with the Office of Mental Health and Suicide Prevention to determine the reasons updated lists of clients designated as high risk for suicide were not received by vet centers, and ensures a process for vet centers' receipt of the list in accordance with the Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding.	■				
	The Under Secretary for Health ensures that the Chief Officer collaborates with the Office of Mental Health and Suicide Prevention to determine reasons for noncompliance with a standardized communication and collaboration process between suicide prevention coordinators and vet centers in accordance with the Office of Mental Health and Suicide Prevention and RCS Memorandum of Understanding, and initiates action as necessary.	■				
	The District Director determines reasons for noncompliance with high risk for suicide flag SharePoint site requirements and the tracking of continuity of care for clients with a high-risk suicide flag at the vet center(s), takes action to ensure requirement is met, and monitors compliance.	■			■	
	The District Director determines reasons the vet center(s) did not have a written crisis plan, ensures requirements related to crisis plans are met, and monitors compliance.				■	

*Recommendation language may differ in actual VCIP report

Legend:

- ☐ No issue identified
- ■ Issue identified