



# Department of Veterans Affairs Office of Inspector General

---

## Healthcare Inspection

### Readjustment Counseling Service Vet Center Report

**To Report Suspected Wrongdoing in VA Programs and Operations**

**Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time,  
Monday through Friday, excluding Federal holidays**

**E-Mail: [yaoighotline@va.gov](mailto:yaoighotline@va.gov)**

# Contents

	Page
<b>Executive Summary</b> .....	i
<b>Introduction</b> .....	1
Purpose.....	1
Background.....	1
Scope and Methodology .....	2
<b>Results and Conclusions</b> .....	3
A. Organizational Structure .....	3
B. FY 2008 Workload.....	6
C. Quality Management.....	10
D. Onsite Reviews .....	17
Conclusions and Recommendations .....	18
<b>Appendixes</b>	
A. Acting Under Secretary for Health Comments.....	21
B. List of Vet Centers Visited.....	26
C. OIG Contact and Staff Acknowledgments.....	27
D. Report Distribution .....	28

## Executive Summary

As requested in House Report 110-775, to accompany H.R. 6599, Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, fiscal year 2009, the VA Office of Inspector General (OIG), Office of Healthcare Inspection conducted a review of the Veterans Health Administration's (VHA's) Vet Center Program. The purpose of this review was to gather information on the operational procedures of Vet Centers.

The Readjustment Counseling Service (RCS) manages the Vet Centers and the provision of readjustment counseling. We found Vet Centers met their readjustment counseling responsibilities by providing both social and psychological services to veterans. Services provided by Vet Centers range from assistance with basic needs and benefits to therapeutic counseling for drug and alcohol abuse, sexual trauma, and post-traumatic stress disorder. Vet Centers provide a distinct service to combat veterans and their families.

We identified areas that required improvement. We found the documentation in client records was not always complete. Vet Center counseling records must contain specific elements to ensure that counselors properly document the care provided to veterans. We found that 19 (9 percent) of 203 Vet Centers did not have an External Clinical Consultant. External Clinical Consultants are required to perform at least 4 hours of monthly clinical consultation and help counselors to manage complex treatment issues. We also found that 52 Vet Centers did not have a seat on the support facility's Mental Health Council (MHC). A seat on the MHC could establish collaborative relationships and encourage mutual referrals and consults. Last, we found that the RCS policies were not always followed. The RCS Chief Officer stated they were in the process of updating many of their policies.

We recommended that:

- Vet Center counselors appropriately document in RCS client case files and that corrective action is taken when documentation problems are identified.
- All Vet Centers have an External Clinical Consultant.
- Each Vet Center has a seat and participates on the support facility's MHC.
- RCS comply with their existing policies or revise their policies to be consistent with present practice.



**DEPARTMENT OF VETERANS AFFAIRS**  
**Office of Inspector General**  
**Washington, DC 20420**

**TO:** Acting Under Secretary for Health (10)

**SUBJECT:** Healthcare Inspection – Readjustment Counseling Service Vet Center Report

### **Purpose**

As requested in House Report 110-775, to accompany H.R. 6599, Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, fiscal year (FY) 2009, the VA Office of Inspector General (OIG), Office of Healthcare Inspection (OHI) is undertaking a systematic review of the Veterans Health Administration's (VHA's) Vet Center program. The goal of the Vet Center program is to provide a broad range of counseling, outreach, and referral services to eligible veterans in order to help them make a satisfying post-war readjustment to civilian life. The purpose of this review is to gather information on the operational procedures of Vet Centers.

### **Background**

During the period 1969 through 1979, Congressional hearings were held which identified the presence of readjustment difficulties in some veterans returning from duty during the Vietnam era. In 1979, Congress passed legislation that required VA to provide readjustment counseling to eligible combat veterans.<sup>1</sup>

In response, the VHA established a nation-wide system of community-based programs separate from VA medical centers (VAMCs). The separation was based partially on the premise that many Vietnam era veterans were so distrustful and suspicious of government institutions that they would not go to a VAMC for care. Furthermore, readjustment services could be provided on an outpatient basis, regardless of the veteran's income, removing unnecessary barriers to care and honoring requests for counseling without delay and with minimal red tape. It was thought that providing mental health services at Vet Centers would remove the stigma.

---

<sup>1</sup> Public Law 96-22, Title I, § 103 (a)(1), 38 U.S.C. 1712A.

In 1981, VHA initiated a new organizational element, the Readjustment Counseling Service (RCS), to administer the Vet Centers and the provision of readjustment counseling. In April 1991, in response to the Persian Gulf War, Congress extended the eligibility to veterans who served during other periods of armed hostilities after the Vietnam era. On April 1, 2003, the Secretary of Veterans Affairs (Secretary) extended eligibility for Vet Center services to veterans of Operation Enduring Freedom (OEF) and on June 25, 2003, to veterans of Operation Iraqi Freedom (OIF) and subsequent operations within the Global War on Terrorism (GWOT). The family members of all veterans listed above are eligible for certain Vet Center services, including family, and marriage counseling.

On August 5, 2003, the Secretary authorized Vet Centers to furnish bereavement counseling services to surviving parents, spouses, children, and siblings of service members who died of any cause while on active duty, including federally activated Reserve and National Guard personnel.

In 1996, the Advisory Committee on the Adjustment of Veterans (Committee) was established<sup>2</sup> with the responsibility of reviewing the post-war readjustment needs of veterans and evaluating the availability and effectiveness of VA programs to meet these needs. Specific areas of concern were veterans' military-related social and psychological readjustment problems, including post-traumatic stress disorder (PTSD), alcoholism and other substance abuse, and benefit matters.

The Committee reviews and evaluates Vet Center workload data, program policies, and program standard of care and clinical guidelines. The Committee submits a report to the Secretary on the programs and activities of VA that relate to the readjustment of combat veterans to civilian life. Each report includes an assessment of the combat veterans' needs and makes recommendations for administrative or legislative action as the Committee considers appropriate. By law, the report must be submitted to the Secretary no later than March 31 of each year. At the time of this review, the Committee had completed its twelfth report.

## **Scope and Methodology**

We developed an internet-based OHI information request which was completed by each RCS Vet Center team leader (232). We reviewed the RCS Administrative and Clinical Quality Review reports completed during FY 2008, and we aggregated certain data elements from both reports. We met with the RCS Chief Officer and staff and conducted telephone interviews with the seven regional office managers. We did a statistically random selection of 14 Vet Centers,<sup>3</sup> which we visited December 2–12, 2008. During

---

<sup>2</sup> Public Law 104-262, § 333, 38 U.S.C. § 545.

<sup>3</sup> The 14 Vet Centers we visited are in Alabama, Arizona, California Florida, Illinois, Maryland, Massachusetts, New Mexico, Pennsylvania, Oregon, and Texas. The complete list is in Appendix B.

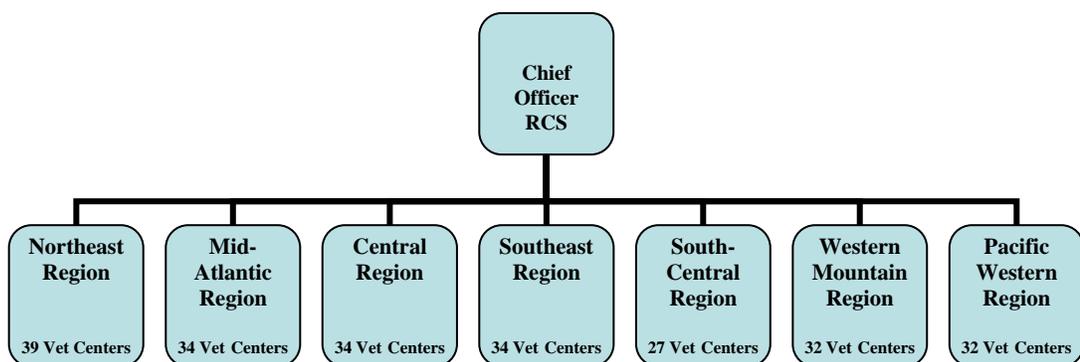
our site visits we inspected the Vet Centers' work areas; interviewed managers and employees; and reviewed staff-training, client, and administrative records.

This review evaluated the Vet Centers' compliance with VA policy and implementation of the applicable recommendations made by the Committee in their twelfth annual report (March 2008). Assessments of RCS' compliance with the Committee's recommendations are discussed in the appropriate section of this report. This review was conducted in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

## Results and Conclusions

### A. Organizational Structure

The RCS Chief Officer reports to the Under Secretary for Health and is responsible for overall program oversight and direction. The RCS Chief Officer supervises seven regional managers who are responsible for monitoring Vet Center services, hiring and training Vet Center staff, enhancing relations with other VA facilities, and assessing program performance of the Vet Centers assigned to their regions. Figure 1 demonstrates the seven regional offices and the number of Vet Centers assigned to each region.



**Figure 1. RCS Organizational Chart**

Each Vet Center is headed by a team leader and usually staffed with three to five staff members. Team leaders are responsible for the everyday management of their Vet Center and directly supervise staff in the provision of outreach, counseling, and referral services.

Sites for Vet Centers are determined from data provided by the Veteran Population (VetPop) Model.<sup>4</sup> VetPop generates the number of veterans by selected characteristics. Vet Centers are located in areas that serve the largest number of veterans with the least travel distances. The proximity to other VA facilities and non-VA organizations is also considered.

<sup>4</sup> This model use combined data from VA, Department of Defense (DoD), and Bureau of the Census to provide the official estimates and projections of the veteran population.

The Committee recommended the addition of 23 Vet Centers to its program by the end of FY 2008. As of September 30, 2007, there were 209 Vet Centers in operation.<sup>5</sup> During our review, there were 232 Vet Centers located in all 50 states and the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands. RCS has plans to open 39 additional Vet Centers by the end of FY 2009, bringing the total number of Vet Centers to 271.

Although located apart from established VA facilities, each Vet Center is administratively assigned to a VA support facility, usually a VAMC that provides services such as purchasing supplies, paying bills, and maintaining the payroll. According to RCS policy,<sup>6</sup> the Director of each supporting VAMC or VA outpatient clinic designates one or more Vet Center liaison officers. Liaison officers' duties include ensuring timely and effective Vet Center administrative support as well as ensuring a close professional collaboration between Vet Center and VAMC professional staff.

We found five liaison officers who said they were not the liaison assigned to the Vet Centers, even though one of the five liaison officers was assigned to three separate Vet Centers. The liaison later acknowledged his role with the Vet Centers. On our site visits, we were informed by some team leaders that they did not have a close working relationship with their support VA facility.

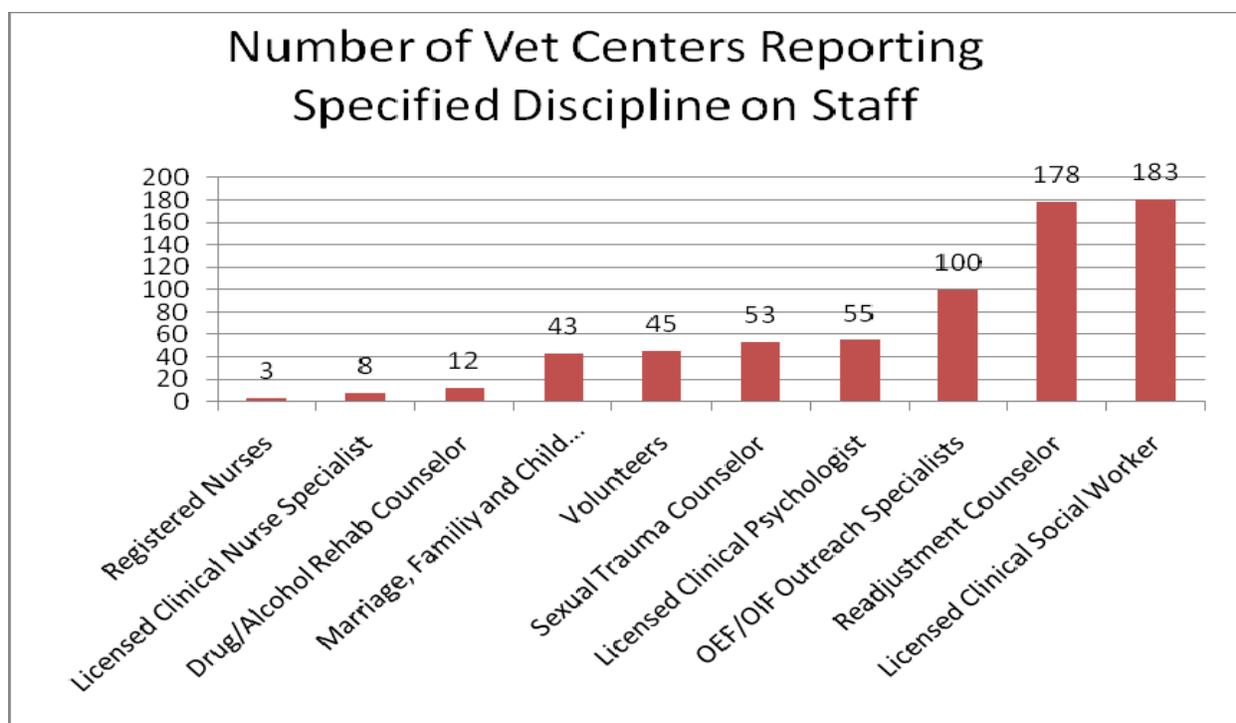
### *Vet Center Staffing*

Each Vet Center team leader was asked what types of professional disciplines they employed. They were also asked to provide total number of full-time equivalent employees (FTE) for each discipline selected. Figure 2 shows the Vet Centers' clinical staff mix for FY 2008 according to the OHI information request. The totals designate the number of Vet Centers that report that particular discipline employed at their Vet Center.

---

<sup>5</sup> Sources – Veterans Health Administration (VHA) System Tracking System.

<sup>6</sup> VHA Manual M-12, *Readjustment Counseling Service Vet Centers Part I*, Chapter 2, *Administrative Organization*, July 6, 1993.



**Figure 2. FY 2008 RCS Vet Center Staff Mix**  
**Source: OHI Information Request**

FY 2008 staffing totaled 1,316 FTE, a 14 percent increase from FY 2007 (1,156). RCS estimates a 16 percent increase in FY 2009, for a total FTE of 1,526.

We reviewed the OHI information request results for the educational background of the RCS Vet Center team leaders and found that 216 of 232 (93 percent) had a master's or doctoral degree. Only 6 (2.5 percent) of the remaining 16 team leaders had less than a baccalaureate degree. The majority (128/232, 55 percent) of team leaders were master's degree social workers.

#### Background Regarding Disciplines Employed in Vet Centers

Using FY 2008 pay period 20 – PAID system data, Vet Centers reported the number of staff in different disciplines totaling 904 positions; 396 (44 percent) of these were social workers. Throughout VHA, a social work position requires a master's degree in social work from a school accredited by the Council on Social Work Education and a license or certification at the master's level to independently practice social work in a state. Requirements for a professionally accredited degree and state license are similar for other health care disciplines, such as registered nurses, licensed clinical nurse specialists, and – at the doctoral level – for psychiatrists and licensed clinical psychologists.

Requirements for a number of the other positions, such as readjustment counselor, sexual trauma counselor, and OEF/OIF outreach specialist are less structured and are dependent

on the grade level (General Schedule (GS) level) at which the position is described on USAJOBS,<sup>7</sup> the Office of Personnel Management (OPM) website. For example:

- A sexual trauma counselor provides counseling services to women and men who have been sexually traumatized during their military service, with a goal of reducing the effects of the trauma and helping the veteran readjust into civilian life.
- An outreach counselor's role is to be the bridge for returning OIF/OEF veterans and their access to Vet Centers, the VA, and other community resources.
- Some readjustment counselors establish outreach services with military installations, Reserve, and National Guard facilities and provide transitional assistance program briefings to personnel transitioning from active duty, along with developing working relationships with a network of service provision agencies and individuals relevant to returning veterans.
- Other readjustment counseling therapists do interviews and counseling with clients and families, psychological assessment and treatment, involves issues of post traumatic stress disorder and related psychological difficulties, marital and family issues, substance abuse, employment, homelessness, and other issues impacting upon a veteran's ability to successfully re-enter civilian society.

The qualification requirement for a GS-5 entry level job is a "4-year course of study in an accredited college or university, which meets all of that institution's requirements for a bachelor's degree in a behavior or social science, or a major field of study directly related to the position (transcript required) OR a combination of education and experience that provided the applicant with a knowledge of one or more of the behavioral or social sciences equivalent to major in the field."<sup>8</sup>

Generally speaking, entry level requirements are a GS-5 for a bachelor's degree, a GS-9 for a master's degree, and a GS-11 for a Ph.D. degree. OPM states that "Equivalent combinations of education and experience are qualifying for all grade levels for which both education and experience are acceptable."

## **B. FY 2008 Workload**

RCS provides psychosocial and psychological assistance to eligible veterans and their families. The social services address problems such as basic needs, unemployment, and veterans benefits. They coordinate with community providers for basic services, state representatives of Disabled Veteran Outreach Programs to match veterans with employment opportunities, and VA benefit offices that attempt to assist veterans with the benefits to which they are entitled.

---

<sup>7</sup> <http://www.usajobs.gov/>.

<sup>8</sup> Requirements as cited on <http://jobsearch.usajobs.gov/>.

The psychological services address issues such as PTSD, drug and alcohol abuse, and sexual trauma. Vet Center staff may either directly provide the psychological care needed or refer the veterans to other sources of treatment. For example, veterans who need medications or inpatient care for PTSD are generally referred to the VAMC.

In FY 2008, RCS reported that Vet Centers provided services to 167,034 unique<sup>9</sup> veterans; 97,124 (58 percent) of these were OEF/OIF veterans. RCS also reported that 67,334 of the 167,034 (40 percent) of the veterans seen in FY 2008 were not seen at any other VA health care facility in FY 2008. The total number of veteran visits was 1,059,755. They also serviced 12,517 unique family members for a total of 53,064 family visits.

### Services

Vet Centers assist war-zone veterans and their families through various services they provide. Client services provided by Vet Centers include:

- Psychological counseling and psychotherapy (individual and groups).
- Screening and treatment PTSD.
- Substance abuse screening and counseling.
- Employment/educational counseling.
- Bereavement counseling.
- Military sexual trauma counseling.
- Marital and family counseling.
- Referrals (VA benefits, community agencies, and substance abuse).

Veterans' social concerns are usually addressed in a few visits. Vet Center staff may refer clients to other VA and non-VA programs, thus limiting the number of visits needed. Veterans with psychological problems such as PTSD require multiple visits for ongoing counseling. Over 40,000 veterans were counseled for PTSD at Vet Centers, and approximately 4,000 clients were seen for other clinical issues according to the OHI information request results.

Figure 3 shows the total number of visits by service for FY 2008. We received the data from the RCS Service Activity Reporting System (SARS) database.<sup>10</sup>

---

<sup>9</sup> Unique patients are counted by the number of individual Social Security numbers extracted from VA patient files.

<sup>10</sup> SARS contains Vet Center workload data.

Services Provided	Total number of visits
PTSD	719,401
Psych/Other	140,943
Marital/Family	117,750
Outreach	93,282
Benefits	81,951
Other <sup>11</sup>	53,262
Medical	49,842
Drug/Alcohol	27,985
Sexual Trauma	26,940
Employment	19,361
Basic Needs	17,341
Legal	7,068
Homeless	5,090
Bereavement	1,396
Crisis	806

**Figure 3. FY 2008 Visits/Service**

### Outreach

Outreach defines the activities the Vet Center team uses toward locating and engaging veterans to provide them with information regarding readjustment counseling services. Vet Center staff members encounter and educate veterans about VA services and benefits at numerous outreach related events such as meetings, forums, fairs, and Post Deployment Health Reassessment (PDHRA) events.

The Committee recommended that Vet Centers ensure the continuation of the more traditional methods of community outreach in addition to the GWOT outreach performed at demobilization sites. The Committee also recommended that Vet Centers continue its current practice of participating in 100 percent of PDHRA events.

In 2004, the VA authorized the RCS Vet Center program to hire 50 OEF/OIF veterans to conduct outreach services. In 2005, VA authorized another 50 positions to be hired and positioned in all 50 states, the District of Columbia, and Puerto Rico. We found that 100 (43 percent) out of 232 Vet Centers had an OEF/OIF Outreach Specialist on staff during FY 2008.

<sup>11</sup> "Other" encompasses any service not listed. RCS does not aggregate the other category; therefore, they do not know if a service needs to be added to the services they routinely provide.

Vet Centers receive a listing from the regional offices of all PDHRA events scheduled in their areas. Most Vet Centers participated in 100 percent of PDHRA events; however, we found five Vet Centers that were unable to meet this requirement either because of staff vacancies or because there were no PDHRA events scheduled in the area.

The Committee also recommended that the Vet Centers provide outreach through association with community emergency responders, educational presentations at community mental health and social service agencies, and other forms of community education. According to the OHI information request results, we found that Vet Centers were participating in various community outreach activities as described by the Committee. Vet Centers developed liaisons with:

- Veterans Service Organizations and other federal agencies.
- Colleges (city, community, and universities).
- Police and Fire Departments.
- Local churches, hospitals, and the American Red Cross.
- Prisons.
- VA-sponsored Stand Downs.
- Personal briefings (done with active service members, Reserves, and National Guards).

### Referrals

According to VA policy,<sup>12</sup> Vet Centers are to make referrals when it is determined that the client's presenting problems are beyond the scope of the Vet Center's team services or expertise.

The OHI information request results disclosed that Vet Centers were referring clients for various types of services. Vet Centers made referrals for benefits assistance, substance abuse, and community education. Other referrals included medication and medical care at VAMCs, food and shelter, job counseling and placement, legal assistance, and military sexual trauma.

We were informed by the RCS staff that a Vet Center referral procedure was not in place; therefore, they were unable to capture the total number of referrals made by the Vet Centers. The Committee reported it was their understanding that Vet Centers made far more referrals to VAMCs than VAMCs made to Vet Centers. Therefore, the Committee recommended that VHA Mental Health establish a standardized referral procedure to Vet Centers. VHA concurred with the recommendation in principle but cited lack of access to electronic medical records at some Vet Centers made it difficult to track such referrals.

---

<sup>12</sup> VHA Manual, M-12, Part II, Chapter 4, *Operational Procedures*, April 21, 1992.

However, local collaboration between VAMCs and Vet Centers did facilitate frequent referrals on an informal basis.

### **C. Quality Management**

VHA policy<sup>13</sup> requires that RCS manifest measurable quality management program components in each Vet Center. Quality measures address the unique Vet Center features of outreach and a combination of professional and peer counseling. The major components of the quality management program include:

- Ensuring at least one qualified VHA mental health professional on staff at each Vet Center.
- Privileging of all Vet Center professional staff.
- Background check of academic and clinical credentials.
- A critical event plan for responding to emergencies.
- Regular external clinical consultation for review of cases.
- Formal mortality and morbidity review of all suicides.
- Standards for Vet Center clinical records.
- Formal site visit reviews by RCS management.

#### Qualified Mental Health Professional

Each Vet Center must have at least one VHA qualified mental health professional (Psychologist, Licensed Clinical Social Worker, Clinical Nurse Specialist) on staff. Data from FY 2008 RCS internal quality reviews reported that 7 (3.4 percent) of 203 Vet Centers did not have this required employee. During our inspections of 14 statistically randomly selected Vet Centers, we found all Vet Centers had a mental health professional on staff.

#### Professional Staff Privileging

M-12, Part I, dated July 1993, requires that Vet Center professional staffs be privileged through the supporting VAMC's Clinical Executive Board. RCS informed us they were drafting a revision to this policy. The Director of C&P told us that the counseling services provided at the Vet Centers are not considered medical care; therefore, required privileging for licensed independent practitioners, as described in VHA policy,<sup>14</sup> does not apply to Vet Center professional staff. Nonetheless, we found several Vet Center staff who were privileged. Figure 4 shows the results of the OHI information request

---

<sup>13</sup> VHA Manual, M-12, Part I, Chapter 5, *Quality Management*, July 6, 1993.

<sup>14</sup> VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007.

regarding the privileging of licensed professional staff who provided psychotherapy at Vet Centers.

Professional Staff	Vet Centers with a Licensed Professional	Licensed Professionals Privileged
Psychologist	55	18
Social Worker	183	33
Clinical Nurse Specialist	8	1

**Figure 4. Privileged Professionals**

### Credentialing and Background Checks

RCS policy<sup>15</sup> states team leaders are to ensure all Vet Center staffs are properly credentialed. Vet Center staffs are credentialed through VetPro<sup>16</sup> by the supporting VAMC staff. Credentialing is the systematic process of reviewing the qualifications of applicants for appointment to ensure they possess the required education, training, experience, and skills to fulfill the requirements of the position.

During our site visits we reviewed 45 providers' credentialing information. We found the following:

- 15 (78 percent) had a full, active, current, and unrestricted license.
- 33 (73 percent) had their license verified.
- 37 (82 percent) had their education verified.
- 34 (76 percent) had their training and experience verified.

VA<sup>17</sup> and VHA policy<sup>18</sup> requires agencies to conduct appropriate background screenings of individuals, both employees and non-employees, who have access to sensitive information. Background screenings were initiated as per policy; however, we found one team leader's background screening had been judged unacceptable almost 20 years ago. We contacted the supporting VAMC's Human Resources Department, which immediately initiated another background screening for this individual.

### Critical Events Plan

Critical events plans described a method for addressing a crisis situation such as suicide threats. The plans are aimed to reduce the severity and likelihood of a crisis at a Vet Center. The plans assist staff to identify clients at risk of dangerous behavior and to provide them with the means of handling their situation. Our aggregated data of RCS'

<sup>15</sup> RCS Policy Memorandum No. 3-8, *Verification of Clinical Staff Credentials*, October 2002.

<sup>16</sup> VetPro was implemented by VHA in March 2001 as VA's Credentials Data Bank, to be used by all health care providers who hold a license, national certification, or registration.

<sup>17</sup> VA Directive 0710, *Personnel Suitability and Security Program*, September 10, 2004.

<sup>18</sup> VHA Directive 0710, *Personnel Security and Suitability Program*, May 18, 2007.

quality reports demonstrated that 197 (97 percent) out of 203 Vet Centers reported having an active crisis plan in place and that all staffs were familiar with the crisis procedures. All the Vet Centers inspected during our site visits had comprehensive crisis intervention plans or guidelines.

### Formal Mortality and Morbidity Reviews

VHA policy<sup>19</sup> requires that a mortality and morbidity (M&M) review should be completed in cases of homicides and/or suicides by active<sup>20</sup> clients and that all cases are to be reported to the Office of the Medical Inspector (OMI).

According to the RCS Chief Officer, Vet Centers followed VHA policy and reported all known suicides to the VHA Patient Safety Office, which would then assign the respective medical centers to do a root cause analysis (RCA).<sup>21</sup> The RCS Chief Officer stated that suicides and/or homicides are only reported to the VHA's OMI upon OMI's request.

In FY 2008, there were no known or reported homicide cases involving active Vet Center clients. However, Vet Centers reported five known suicide cases including three active clients and two closed cases. Three veterans were of the OEF/OIF era, with one each from the Gulf War and Vietnam eras. All the cases were reviewed either by RCA (three cases), Suicide Committee review, or M&M review (initiated by RCS).

In four of the five suicides, a VAMC was the primary provider with the Vet Center providing auxiliary services to the physician, usually a psychiatrist. VHA performed the analysis of the suicides when they were the primary provider. Vet Center staff were involved in the suicide analyses either through participating as a team member or by providing testimony. The Vet Centers reported that they did not receive the outcomes of these reviews.

RCS conducted the M&M review, even though the suicide occurred 6 months after their last contact with the veteran. The Vet Center's external clinical consultant, a psychiatrist, headed the board and reviewed the case. The purpose of the M&M review was to determine whether care was appropriate and adequate, whether other steps and interventions might have altered the outcome, and whether the Vet Center practices were adequate.

Regardless of the type of review used to analyze the suicides, we found that most reviews concluded that the collaboration and sharing of patient information between VAMCs and Vet Centers needed strengthening.

---

<sup>19</sup> VHA Manual, M-12, Part II, Chapter 4, *Operational Procedures*, April 21, 1992.

<sup>20</sup> A veteran is considered inactive if not seen within 90 days of their last visit.

<sup>21</sup> RCA is a focused review process for identifying the basic or contributing causal factors that underlie variations in performance associated with Adverse Events or Close Calls.

*Clinical Record Standards*

RCS had established standards for Vet Center counseling records. Counseling records must contain specific elements to ensure that counselors properly document the care provided to veterans. RCS policy requires recurring consultation and record review by supervisory and clinical professionals within and external to Vet Centers.

RCS regional office staff conduct annual clinical reviews of Vet Centers within their regions. To monitor RCS self-assessment of the quality of services and treatment provided to veterans, we reviewed the FY 2008 Clinical Quality Review reports. Regional managers reported various deficiencies in record keeping, to include inadequate documentation of treatment plans, military histories, and progress notes. Other problems identified by RCS were the lack of team leader record reviews and missing closing summaries. A summary of issues with Vet Centers' record keeping is listed in Figure 5.

<i><b>FY 2008 Aggregated Quality of Record Keeping Data - N = 203</b></i>		
<b>Deficiency cited</b>	<b>Number of Vet Centers with deficiencies</b>	<b>Percentage with deficiencies</b>
Treatment plans are current, measurable, and relate to identified focus areas.	56	<b>27.6</b>
Evidence of Team Leader reviews of clinical records.	23	<b>11.3</b>
Course of treatment reflected in Progress Notes.	28	<b>13.8</b>
Psychological, sexual trauma, & military history data are complete and appropriate.	32	<b>15.8</b>
Closing Summaries.	29	<b>14.3</b>
Eligibility verification.	7	<b>3.4</b>

**Figure 5. RCS Record Keeping**

RCS policy<sup>22</sup> states that team leaders are required to conduct monthly reviews of 10 randomly selected counseling folders per full-time counselor. RCS managers developed a form that included the “minimal clinical notations” requirements. We utilized this form to perform our review of their clients’ records. We reviewed 140 client records (4 non-psychological counseling<sup>23</sup> and 136 counseling records<sup>24</sup>). A summary of our findings are listed in Figure 6. RCS managers acknowledged that problems continue to exist with the client records.

<b>Review of Counseling Records:</b>		<b>N=136</b>
<b>Criterion</b>	<b>Number of Deficiencies</b>	<b>Percentage of Deficiencies</b>
<b>Documented by 1<sup>st</sup> visit to Vet Center</b>		
1. Demographic information	1/136	<b>0.7</b>
2. Mental status assessed	18/136	<b>13.2</b>
3. Health history	23/136	<b>16.9</b>
<b>Documented by 3<sup>rd</sup> visit to Vet Center</b>		
4. Global Assessment of Function (GAF) score	39/133	<b>29.3</b>
5. Psycho-Social Focus Severity Rating (PSFSR) score	41/133	<b>30.8</b>
6. Patient received Rights & Responsibility	59/136	<b>42.9</b>
<b>Documented by 5<sup>th</sup> visit to Vet Center</b>		
7. Military History		
7a. Entry/Training	33/129	<b>25.5</b>
7b. War Zone – Circumstances of assignment to war zone	32/129	<b>24.8</b>
7c. Trauma/Sex Trauma Events	32/129	<b>24.8</b>
7d. Homecoming (Describe homecoming)	36/129	<b>27.9</b>
7e. Impact of military experience	36/129	<b>27.9</b>
<b>Other Elements</b>		
8. Treatment plans completed	30/131	<b>22.9</b>
9. Closing summaries (within 90 days of last visit)	33/84	<b>30.3</b>
10. Review of record by team leader (signed/dated)	38/136	<b>27.1</b>

**Figure 6. Onsite Counseling Record Reviews**

Note: The denominator changed based on the criterion evaluated.

<sup>22</sup> RCS Policy Memorandum No. 3-10, *Review of Clinical Records*, October 2002.

<sup>23</sup> Record contains client demographics and DAP (Data, Assessment, Plan) note about the purpose and outcome of the visit to include readjustment counseling services, such as employment and educational counseling, job finding assistance, benefit, etc.

<sup>24</sup> Six distinct and separate sections 1) demographic, 2) counseling intake, 3) individual case notes, 4) closing summary, 5) group counseling notes, and 6) medical problem list VA Form 10-1415.

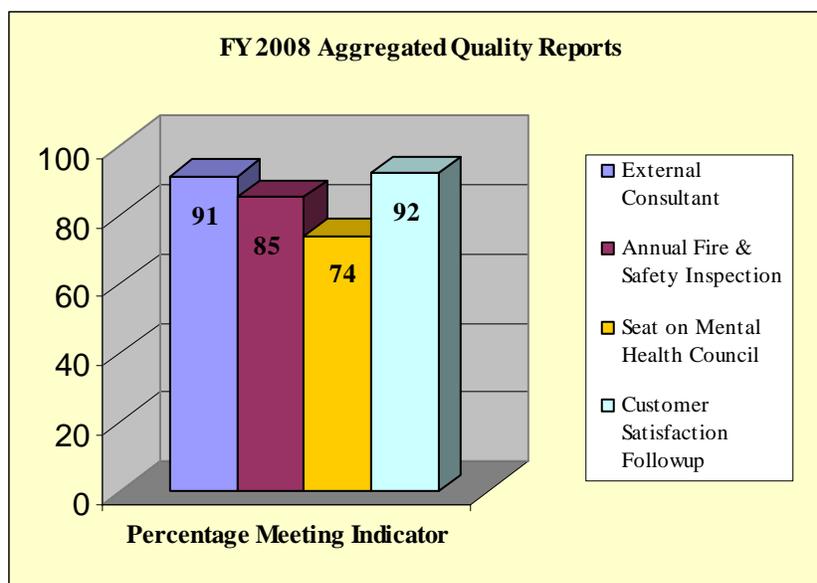
### RCS Onsite Quality Reviews

The RCS had two internal quality reviews (administrative and clinical) to evaluate the operations at the Vet Centers. The Administrative Quality Review examined the following areas, with examples listed for each:

- Facility Operations – building lease, location of site, equipment inventory.
- Administrative Operation – hours of operations, memorandum of understanding with other agencies, performance appraisals, RCS policies.
- Clinical Services – outreach plan, SARS data entry, provider workload data.
- Quality Management – seat on mental health council at support facility, custom satisfaction follow-up, crisis plan developed.
- Fiscal Management – average cost per visit, purchase cards.
- Special Programs/Services – all contracts for contract fee providers, homeless and women veterans' coordinator, research and telemedicine.

While Clinical Quality Reviews assessed some of the same issues, they focused on the efficient use of clinical services, including types of services delivered and the quality of counseling services identified through the quality of the client's chart.

We obtained the quality reports from RCS. In FY 2008, they completed 211 administrative and 224 clinical reviews. We selected various data elements from both quality reports to identify any trends among the Vet Centers. We found that two regional offices used different review forms for their administrative review, and the questions did not correspond consistently to the other sites. Therefore, our sample size may differ for various questions we analyzed. Figure 7 shows the aggregated findings of the quality reports not already discussed in this report.



**Figure 7. FY 2008 Administrative and Clinical Quality Reports**

### External Clinical Consultant

We found that 19 (9 percent) of 203 Vet Centers did not have an External Clinical Consultant. External Clinical Consultants are required to perform at least 4 hours of monthly clinical consultation. During these sessions, the consultant reviews the counselor's assessments and treatment plans for all active clients. External Clinical Consultants were also utilized to help counselors manage volatile cases (suicidal ideation or behavior) or existing cases where there are complex treatment issues present. Review of these reports did not disclose the reason for the lack of an External Clinical Consultant.

### Annual Fire and Safety Inspections

According to the results from the RCS administrative reviews, 29 (14 percent) of 203 Vet Centers had not had their annual fire and safety inspections. On our site inspections, we found all the fire inspections were up to date.

### Seat on Mental Health Council

The regional managers determined that 150 (74 percent) of 203 Vet Centers had a seat on the support facility's Mental Health Council (MHC), 6 (3 percent) did not, and 47 (23 percent) were coded non-applicable. The regional managers scored the 47 Vet Centers as non-applicable because they believed the support facility did not have a MHC. We contacted the liaison officers at the support facilities<sup>25</sup> to confirm whether or not this was correct. Fifty-two of the 53 support facilities we contacted stated they had a MHC. When the regional managers were interviewed further, three reported the travel distance

<sup>25</sup> We contacted the 47 support facilities coded as non-applicable and the 6 coded as not having a MHC.

to the support facility made it difficult to attend the meetings and one of three also stated that the MHC did not offer them a seat due to the material discussed in the meeting. Of the 14 Vet Centers we inspected, 8 (57 percent) stated they did not have a seat on their support facility's MHC.

#### Customer Satisfaction Follow-Up

RCS quality reports indicate that 187 (92 percent) of 203 Vet Centers have a process in place to assess their clients' satisfaction with the services they receive. However, we found that only 7 (50 percent) of the 14 Vet Centers we inspected were conducting customer satisfaction follow-up as required by RCS procedure.

#### **D. Onsite Reviews**

While onsite, we conducted environment of care rounds to determine if the Vet Centers were 1) located in safe neighborhoods, 2) clean and had a non institutional feel, 3) handicap accessible, and 4) securing the client records. We also examined the staff training records.

#### Environment

All the Vet Centers with the exception of one were located in safe neighborhoods. The team leader reported they were in the process of relocating this Vet Center. Two Vet Centers were not handicap accessible. Both sites did not have automatic entrance doors. At one of the sites, the interior design (narrow hallways), furnishings, and the heating and cooling system needed improvement. This Vet Center was also in the process of relocating.

We also found two Vet Centers which did not secure the client records. At one of the Vet Centers, we observed the client records were in an unlocked cabinet and the door to the file room was unlocked. These files were located near public traffic. We questioned the staff each time we encountered this discrepancy. The Vet Center staff acknowledged the need to keep the door and cabinet closed when no staff were in the room.

#### Staff Training

We reviewed 66 staff training records and found that most had completed mandatory VA training (Cyber Security, VA Privacy, Prevention of Sexual Harassment, and No Fear Act). We examined the training records for specific training on PTSD, military sexual trauma, counseling techniques, and other areas specific to the services Vet Centers provide.<sup>26</sup> We did not find documentation of this training for several staff. Figure 8 displays our findings on staff training.

---

<sup>26</sup> RCS Policy 3-14, *RCS Training Guidelines*, October 2002.

<i>New Staff Training Required (N = 13 New Staff)</i>	<i>Number Not Receiving Training</i>	<i>Percentage</i>
<i>Assessment and counseling for PTSD</i>	7/13	54
<i>Assessment and counseling for sexual trauma</i>	9/13	69
<i>Clinical record keeping</i>	13/13	100
<i>Needs of special groups (i.e., minority, women, and disabled)</i>	8/13	62
<i>Vet Center outreach techniques</i>	7/13	54
<i>Crisis intervention</i>	7/13	54
<i>Individual group and family counseling and psychotherapy techniques</i>	8/13	62
<i>VA benefits and discharge upgrade process</i>	13/13	100
<i>Experienced Staff Training Required (N = 49 Experienced Staff)<sup>27</sup></i>		
<i>Assessment</i>	11/49	22
<i>Benefits counseling</i>	25/49	51
<i>Clinical supervision/consultation</i>	15/49	31
<i>Outreach</i>	13/49	27
<i>Sexual trauma</i>	16/49	33
<i>Stressors of wars and conflicts</i>	11/49	22
<i>VA benefits and discharge upgrade process</i>	28/49	57
<i>Counseling/therapy processes and techniques</i>	12/49	24
<i>PTSD and co-morbid disorders (depression, substance abuse, etc.)</i>	11/49	22

Figure 8. Staff Education

## Conclusions and Recommendations

Vet Centers meet their readjustment counseling responsibilities by providing both social and psychological services to veterans. Services provided by Vet Centers range from assistance with basic needs and benefits to therapeutic counseling for drug and alcohol abuse, sexual trauma, and PTSD. Although the Vet Center PTSD treatment is similar to the outpatient PTSD care provided by some medical centers, the two types of facilities generally focus on different clients and missions. Vet Centers provide a distinct service to our combat veterans and their families. RCS reports that over 67,000 (40 percent) of veterans seen in FY 2008 were seen only at Vet Centers and at no other VA facility.

<sup>27</sup> Of the 66 employee training records selected, 13 were new. Of the other 53 employees in the sample, 3 were administrative or work study staff and were counted as Not Applicable to the training and did not receive the training, and 1 staff member's training was not identified. Therefore N = 49 for this evaluation.

We identified areas that required improvement. The documentation in client records was not always complete. Although RCS had procedures that detailed required documentation in the client record, record reviews by supervisory and clinical professionals along with annual clinical review by RCS regional managers disclosed this was not consistently occurring. RCS' review of the psychological counseling records demonstrated deficiencies in various areas. The deficiencies included inadequate documentation of treatment plans, military histories, missing closing summaries, and progress notes. Another problem identified was the lack of record review by the team leader. Our review of 136 client records disclosed similar findings.

Nine percent of Vet Centers did not have an External Clinical Consultant; therefore, routine clinical assessment and consultation was not occurring at these Vet Centers. Since External Clinical Consultants are required to perform at least 4 hours of monthly clinical consultation and help counselors to manage complex treatment issues, the need for an External Clinical Consultant is essential. The RCS regional office managers reported that some positions had been recently vacated and others were difficult to fill due to the site location.

The relationship between the Vet Centers and support facilities needs to be strengthened. The high percentage of Vet Centers that did not have a seat on the support facility's MHC and the reported lack of feedback of suicide analysis are examples of a fragmented process between Vet Centers and VAMCs. Regional managers reported that some medical centers did not extend an invitation to the MHC due to the content of the meeting; while others reported the distance to the medical center as an impediment (a travel time of 3 to 4 hours). A seat on the MHC could establish collaborative relationships and encourage mutual referrals and consults. Regardless of the reason, a cohesive working relationship between the Vet Center and the support facility is essential to meet the needs of the veterans.

We also found several RCS and VHA policies that were not consistently followed. These policies include but are not limited to:

- Having a seat on the support facility's MHC.
- Privileging Vet Center professional staffs.
- Completing a M&M review in cases of homicides and/or suicides and providing a copy of the M&M review to the OMI.

The RCS Chief Officer stated they were in the process of updating many of their policies.

**Recommendation 1:** We recommended that the Acting Under Secretary for Health ensure that RCS Vet Center counselors appropriately document in RCS client case files and that corrective action is taken when documentation problems are identified.

**Recommendation 2:** We recommended that the Acting Under Secretary for Health ensure that all Vet Centers have an External Clinical Consultant.

**Recommendation 3:** We recommended that the Acting Under Secretary for Health takes steps to ensure that each Vet Center has a seat and participates on the support facility's MHC.

**Recommendation 4:** We recommended that the Acting Under Secretary for Health have RCS comply with their existing policies or revise their policies to be consistent with present practice.

## Comments

The Acting Under Secretary for Health concurred with the findings and recommendations. The implementation plan is acceptable, and we will follow up until all actions are complete.

*(original signed by:)*  
JOHN D. DAIGH, JR., M.D.  
Assistant Inspector General for  
Healthcare Inspections

## Acting Under Secretary for Health Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** July 7, 2009

**From:** Acting Under Secretary for Health (10)

**Subject: Healthcare Inspection – Readjustment Counseling Service Vet Center Report**

**To:** Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report, and I concur with the report and recommendations. Vet Centers provide readjustment counseling and outreach services to combat Veterans and are an important resource for Veterans. Your report will help to improve the relationship between Vet Centers and support facilities in meeting the needs of Veterans.
2. The community-based Vet Centers are a key component of VA's mental health program, providing Veterans with mental health screening and post-traumatic stress disorder counseling, along with help for family members dealing with bereavement. Although 74 percent of Vet Centers already have a seat on their support facility's Mental Health Council (MHC) as encouraged in the Handbook on Uniform Mental Health Services, participation of *all* Vet Centers will help to ensure care coordination and continuity of care for Veterans served through both the Vet Centers and VHA's health care system. Consequently, VHA Handbook 1160.01, "Uniform Mental Health Services in VA Medical Centers and Clinics," dated September 11, 2008, will be revised to require Vet Center participation on VHA Mental Health Councils.
3. To further facilitate care coordination between Vet Centers and support facilities, all RCS Regional Managers will be tasked with ensuring compliance with the established quality management procedure for external clinical consultation for all Vet Centers. Regional Managers will intervene with the VAMC support facility for those Vet Centers without an assigned external clinical consultant, and pursue the services in the private sector when a VAMC professional is not logistically feasible. Further, Regional Managers will also

be tasked with promoting full compliance of standards for clinical case recording and quality reviews of Vet Center client files. RCS is in the process of updating applicable policies and operational procedures so that current practices among Vet Centers are consistent with existing policy.

4. Thank you for the opportunity to review the draft report. A detailed action plan to implement all report recommendations is attached. If you have any questions, please contact Margaret M. Seleski, Director, Management Review Service (10B5) at (202) 461-7245.

*(original signed by:)*

Gerald M. Cross, MD, FAAFP

Attachment

## **Acting Under Secretary for Health Comments to Office of Inspector General's Report**

The following Acting Under Secretary for Health's comments are submitted in response to the recommendations in the Office of Inspector General's report:

### **OIG Recommendations**

The Acting Under Secretary for Health will:

**Recommendation 1:** We recommended that the Acting Under Secretary for Health ensure that RCS Vet Center counselors appropriately document in RCS client case files and that corrective action is taken when documentation problems are identified.

Concur

Standards for clinical case recording and quality reviews of Vet Center client files are established quality management procedures at Vet Centers. To promote full compliance with this standard, Readjustment Counseling Service (RCS) leadership will task all RCS Regional Managers to review all completed site visit reports for their respective Vet Centers for FY 2009 and document actions taken to correct noted deficiencies within 90 days after the end of the fiscal year.

In process

December 31, 2009

**Recommendation 2:** We recommended that the Acting Under Secretary for Health ensure that all Vet Centers have an External Clinical Consultant.

Concur

Professional external clinical consultation is an established Readjustment Counseling Service (RCS) quality management procedure required for all Vet Centers. The external clinical consultant provides peer case review and guidance in the clinical treatment of complex and emergent veteran cases. The Team Leader is responsible for the selection of external clinical

consultants with the approval of the RCS Regional Manager. External consultants must be VHA qualified mental health professionals who are licensed in a state and appropriately credentialed through the VAMC. A staff member and mental health professional at a VAMC support facility is preferred for selection as a clinical consultant. All RCS Regional Managers will be tasked with ensuring compliance with this standard by intervening with the VAMC support facility leadership for those Vet Centers without an assigned external clinical consultant. Regional managers will pursue the services of a private sector professional in situations where a VAMC professional is logistically not feasible.

In process

September 30, 2009

**Recommendation 3:** We recommended that the Acting Under Secretary for Health take steps to ensure that each Vet Center has a seat and participates on the support facility's MHC.

Concur

The Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) will also work with the Readjustment Counseling Service (RCS) to address the relationship between VHA facilities and Vet Centers, with focus on ensuring that Vet Centers have a seat and participate on the support facility's mental health council, reporting of suicides, privileging of professional staff and completing mobility and mortality reviews, by August 31, 2009.

In addition, VHA Handbook 1160.01, "Uniform Mental Health Services in VA Medical Centers and Clinics", dated September 11, 2008, will be revised to change the policy encouraging Vet Center participation on VHA Mental Health Councils to a requirement. Once the Handbook is revised, the Office of Patient Care Services (PCS) will widely announce the update to this policy on Chief Medical Officer and Chief of Staff conference calls. The DUSHOM, RCS, and PCS will also collaborate in drafting a memorandum to VHA facilities that will provide guidance on the report findings and recommendations.

In process

December 2009

**Recommendation 4:** We recommended that the Acting Under Secretary for Health have RCS comply with their existing policies or revise their policies to be consistent with present practice.

Concur

The Readjustment Counseling Service (RCS) is in the process of updating its policies and operational procedures in a new VHA Directive and Handbook. This update is in the final draft stage and will soon be in internal VHA concurrence, with an anticipated issue date of September 30, 2009.

## List of Vet Centers Visited

Vet Center 103, Springfield, MA  
Vet Center 125, Lowell, MA  
Vet Center 201, Baltimore, MD  
Vet Center 229, Scranton, PA  
Vet Center 313, Mobile, AL  
Vet Center 332, Melbourne, FL  
Vet Center 407, Chicago Heights, IL  
Vet Center 421, Springfield, IL  
Vet Center 518, Prescott, AZ  
Vet Center 520, Santa Fe, NM  
Vet Center 611, Corona, CA  
Vet Center 626, Eugene, OR  
Vet Center 706, Dallas, TX  
Vet Center 708, Forth Worth, TX

## OIG Contact and Staff Acknowledgments

---

OIG Contact	Marisa Casado, Director CBOC/Vet Center Program Review (727) 395-2416
Acknowledgments	Wachita Haywood, Associate Director Lin Clegg, Ph.D. Marnette Dhooghe Jeff Joppie Nancy Albaladejo Stephanie Hensel Deborah Howard Cathleen King Audrey Collins-Mack Karen Moore Reba B. Ransom Mary Toy Marilyn Walls

---

## Report Distribution

### **VA Distribution**

Office of the Secretary  
Veterans Health Administration  
Assistant Secretaries  
General Counsel  
Readjustment Counseling Service Chief Officer (0015)

### **Non-VA Distribution**

House Committee on Veterans' Affairs  
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and  
Related Agencies  
House Committee on Oversight and Government Reform  
Senate Committee on Veterans' Affairs  
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and  
Related Agencies  
Senate Committee on Homeland Security and Governmental Affairs  
National Veterans Service Organizations  
Government Accountability Office  
Office of Management and Budget

This report is available at <http://www.va.gov/oig/publications/reports-list.asp>.