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Report to the Chairman, Committee on Veterans' Affairs, U.S. Senate

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READJUSTMENT COUNSELING SERVICE

Vet Centers Address Multiple Client Problems, but Improvement Is Needed

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Health, Education, and
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The Honorable Alan K. Simpson
Chairman, Committee on Veterans' Affairs
United States Senate

Dear Senator Simpson:

The Department of Veterans Affairs (VA), through its Readjustment Counseling Service (RCS), operates 205 community-based facilities known as Vet Centers to help certain veterans make a successful transition from military to civilian life. This readjustment counseling program, initially established by the Congress in 1979 to assist Vietnam era veterans, has been expanded to cover veterans who served in all areas of military conflict since Vietnam, including Lebanon, Grenada, Panama, the Persian Gulf, and Somalia. Vet Centers also serve family members and significant others to the extent necessary to help 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 (PTSD).[1]

RCS is part of VA's Veterans Health Administration (VHA) and is subject to its budget and administrative review. However, within VHA, which also manages VA medical centers, RCS has its own organizational structure, manages its own resources, and evaluates its own program.

This report responds to your request for information about RCS' Vet Center program to assist in the Committee's evaluation of the appropriateness of the organizational structure of RCS and the effectiveness of its programs. It addresses the following areas:

- Who are the individuals that Vet Centers serve and what services are provided?
- How accurate is RCS' workload reporting system, and does it ensure that services reported are actually delivered?
- How adequate is VA's methodology to determine whether Vet Center services are appropriate and effective?
- Should RCS maintain an organizational structure within VHA that is separate from medical centers?

[1]PTSD is a condition caused by severely stressful or traumatic events such as military combat and may be chronic. Its symptoms include intense reliving of events, anxiety, sleep disturbance, depression, and social isolation.

In 1987, we reported on various aspects of VA's readjustment counseling program and made recommendations for improvement in some program areas.[2] Our report included observations on the accuracy of RCS' database, the need for RCS to better monitor Vet Center activities by making regional office site visits as required, and the need to better evaluate the quality of Vet Center care. This report recognizes RCS' efforts in these areas and identifies the need for further improvements.

In performing this review, we visited RCS' central office in Washington, D.C., four of RCS' seven regional offices,[3] and five Vet Centers.[4] At these locations we reviewed documentation, discussed program activities with officials, and at three of the Vet Centers we met with veterans to obtain their views on the program. We also obtained workload activity data for fiscal years 1993 through 1995 from 39 randomly selected Vet Centers that helped to describe clients and services provided. We also met with officials of several veteran service organizations to obtain their views on the program. We performed our work between June 1995 and April 1996 in accordance with generally accepted government auditing standards. (See app. I for a detailed description of our scope and methodology.)

Results in Brief

Vet Center counselors reported visiting with approximately 138,000 veterans during fiscal year 1995, 84,000 of whom were new to Vet Centers. Most veterans do not establish long-term relationships with Vet Center counselors; however, those who do represent a core group who use services over extended periods for serious psychological problems such as PTSD. Other veterans usually visit Vet Center counselors only once or twice for social concerns such as employment or benefit needs.

Although Vet Centers track their number of visits with clients, RCS' workload measurement system overcounts some activities and undercounts others. Also, the system does not track staff resources used during client visits and cannot distinguish between client visits requiring minimal staff time and visits that require extended periods of staff effort.

[2]Vietnam Veterans: A Profile of VA's Readjustment Counseling Program (GAO/HRD-87-63, Aug. 26, 1987).

[3]The RCS regional offices we visited are in Bay Pines, Florida; Hines, Illinois; Denver, Colorado; and Providence, Rhode Island.

[4]The Vet Centers we visited are in Cheyenne, Wyoming; Chicago, Illinois; Norwich, Connecticut; Tampa, Florida; and White River Junction, Vermont.

RCS has taken steps to help ensure that the services provided by Vet Center staff are appropriate. These steps include recurring consultation and records reviews by supervisory and clinical professionals within and external to Vet Centers, annual clinical reviews by RCS regional officials, and increased RCS emphasis on the credentials of its staff. However, problems exist with documenting client records, and RCS has not developed a systematic approach for measuring the effectiveness of Vet Center services in meeting clients' psychological needs.

VA is currently implementing a new health care services management structure known as the Veterans Integrated Service Networks (VISN) to coordinate and integrate health care resources within 22 local service networks. The VISN structure recognizes Vet Centers as a resource within each local network but continues RCS' organizational independence within VHA. Our work suggests that, at this time, RCS' independence is consistent with its mission of providing both social and psychological readjustment counseling services to veterans and the developing nature of the VISN structure. However, as VA completes implementation of the VISN structure for its health care services, reconsideration of RCS' organizational structure may be warranted.

Background

Under the Veterans' Health Care Amendments of 1979 (P.L. 96-22), the Congress authorized a temporary program of readjustment counseling services for Vietnam era veterans who served from August 5, 1964, to May 7, 1975, to assist them in the transition to postwar civilian life. At that time it was recognized that a veteran suffering from a "readjustment problem" might exhibit "a low-grade motivational or behavioral impairment" that interfered with interpersonal relationships, job or educational performance, or overall ability to cope with daily life. This condition, in combination with other symptoms, was later termed post-traumatic stress disorder (PTSD). At that time VA medical centers did not have special programs in place to treat these problems. Veterans who did go to VA medical centers for treatment were usually admitted to the general psychiatric service where these problems were not well understood.

PTSD is caused by severely stressful or traumatic events such as military combat, seeing people die, or incarceration as a prisoner of war. PTSD symptoms include intense reliving of the event in memory or dreams, anxiety, sleep disturbance, depression, social isolation, and an incapacity for intimate relations with others. PTSD may not be curable and can be a

chronic condition with symptoms that are stress-induced and effects that may increase with a person's age.

The readjustment counseling program was authorized as a community-based program separate from VA medical centers at least partially on the premise that many Vietnam era veterans were so distrustful and suspicious of government institutions that they would not come to VA's inpatient hospitals to seek care. It was also believed that providing mental health services in outpatient facilities would help to remove the stigma often associated with so-called "mental illness." The guiding principle was that readjustment services should be provided on an outpatient basis, regardless of the veteran's income, and that unnecessary barriers to care should be removed. In addition, requests for counseling should be speedily honored with a minimum of red tape.[5] In passing the authorizing legislation, the Congress recognized that Vet Centers would provide services to address not only psychological problems, but also other aspects of readjustment. Over the intervening 17 years, the Congress has expanded the program to include veterans who participated in all post-Vietnam military conflicts. The Congress also made the Vet Center program permanent and specifically authorized VA, supported by Vet Centers, to provide counseling to veterans who experienced sexual trauma while on active duty.

As currently configured, the Director of RCS reports to the Under Secretary for Health and is responsible for overall program oversight and direction. The Director is assisted in many management responsibilities by staff in seven regional offices.[6] Each regional office is headed by a regional manager who is responsible for monitoring Vet Center services, hiring and training Vet Center staff, enhancing relations with other VA facilities, and assessing program performance.

Two clinical field managers are responsible for monitoring the quality of clinical services provided by Vet Centers. One, based in Bay Pines, Florida, is responsible for all Vet Centers in the East and the other, in Denver, is responsible for western Vet Centers.

To meet clients' needs, Vet Centers provide easy, "hassle free" access to a variety of services, including individual, group, and family counseling;

[5]Veterans' Health Care Amendments of 1979, Report of the Committee on Veterans' Affairs, United States Senate, Report No. 96-100, pp. 27-31.

[6]RCS regional offices are in Baltimore, Maryland; Bay Pines, Florida; Benicia, California; Dallas, Texas; Denver, Colorado; Hines, Illinois; and Providence, Rhode Island.

referrals to other VA and community resources; and outreach activities to identify veterans needing assistance. Vet Centers are also authorized to provide services to family members and significant others to the extent necessary to help veterans who are being treated by program staff. In assisting clients, counselors draw from an array of psychosocial services.

Social services address problems such as basic needs, unemployment, and veterans benefits. Social services include coordinating with community providers for basic services, state representatives of Disabled Veteran Outreach Programs who work to match veterans with employment opportunities, and VA benefit offices who attempt to assist veterans with the benefits to which they are entitled. 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 VA medical centers.

During the first 16 years of the program, approximately 1.2 million veterans had about 7.3 million visits with Vet Center counselors. RCS currently operates 205 Vet Centers at an estimated fiscal year 1996 cost of about $64 million.[7] Vet Centers are generally located in community storefront facilities and staffed with counselors who are often veterans themselves. In general, each Vet Center has three to six staff members, including a team leader,[8] counselor(s), and an office manager. Ten of the 205 Vet Centers are also known as Veterans Resource Centers and may be staffed with as many as six counselors. Some Vet Centers contract with private mental health professionals in locations that are distant from the Vet Center or other VA providers. These contractors provide therapeutic services to veterans with psychological problems, such as PTSD.

Although located apart from established VA facilities, each Vet Center is administratively assigned to a VA support facility (usually a VA medical center) that provides services such as purchasing supplies, paying bills, and maintaining the payroll.

[7]See app. II for a list of all Vet Center locations.

[8]The team leader directly supervises and oversees the performance of Vet Center staff in the provision of outreach, counseling, and referral services. Duties include selecting and evaluating staff, administering the budget, collaborating with staff in the supporting VA medical facility, and providing direct clinical services.

Currently many medical centers have their own inpatient and outpatient programs specifically to address PTSD-related problems. In some cases, veterans need inpatient care to address debilitating symptoms while others may need medications to treat symptoms but only on an outpatient basis. Today there are 61 inpatient and 93 outpatient specialized medical center programs for veterans who are diagnosed as having PTSD.

Over the life of the Vet Center program, questions have been raised about the continued need for readjustment counseling services, whether, organizationally, RCS should be more closely connected with VA medical centers, and what program management improvements could be made. A number of studies have addressed these questions, including our 1987 report on the readjustment counseling program. These studies have consistently recommended the continuation of readjustment counseling services and RCS' organizational independence within VHA. (See the bibliography for a list of major studies and reports related to RCS' Vet Center program and the diagnosis and treatment of PTSD.)

Many Veterans Are Served, but Few Require Extended Vet Center Services

Approximately 138,000 veterans visited with Vet Center staff during fiscal year 1995,[9] of which about 84,000 were new veterans to the program.[10] (See app. III for RCS' fiscal year 1995 Service Activity Reporting System (SARS) data.) Most veterans do not remain in contact with counselors over extended periods. Nevertheless, veterans who have more serious psychological problems, such as PTSD, represent a core group who visit with Vet Center staff, on average, more often than veterans with social concerns such as the need for employment or veterans' benefits.

While RCS reports that a large number of veterans are seen each year, most do not establish long-term relationships with Vet Center counselors. RCS reported that nearly 283,000 new veteran clients visited Vet Centers during fiscal years 1993 through 1995. Of these veterans, we estimate based on our sample[11] that 59 percent had only one visit with Vet Center staff, 80 percent had three or fewer visits, and 90 percent had seven or fewer staff visits during the 3-year period. The remaining 10 percent of Vet

[9]For the purpose of our analysis, Vet Center visits include face-to-face and substantive telephone contacts between Vet Center counselors and clients.

[10]A veteran who has never had an open/active record at a particular Vet Center is defined by RCS as a "new veteran."

[11]With RCS assistance, we obtained workload measurement data from a sample of 39 Vet Centers for fiscal years 1993 through 1995. The data from these centers provide a national estimate based on the sample.

Center clients visited eight or more times.[12] The 17 counselors and team leaders we met with at five Vet Centers each had an average clinical caseload of about 26 clients.

New veterans with psychological problems such as PTSD and sub-PTSD[13] were seen more often by Vet Center counselors. For example, veterans with PTSD averaged 5 visits and those with sub-PTSD averaged 4.3 Vet Center staff visits during fiscal year 1995. Over a 3-year period, veterans with these problems averaged 9.4 and 6.4 Vet Center staff visits, respectively. Conversely, veterans who had social concerns, such as employment and VA benefit needs, averaged 1.9 and 1.5 visits during fiscal years 1993 through 1995.[14]

A relatively small percentage or core group of veterans are long-term users of the Vet Center program. For example, of the veterans who first visited with a Vet Center counselor before fiscal year 1993, 20 percent were seen 13 or more times through fiscal year 1995; 10 percent had 32 or more visits in that period. In addition, during our visits with 50 clients (veterans and family members) at three Vet Centers, some of the veterans and spouses commented that the Vet Center staff were responsible for saving these veterans' lives and they very much needed the Vet Center program. These veterans also stated that they preferred to obtain services at Vet Centers rather than VA medical centers. As a result, many of these veterans now, and in the foreseeable future, are likely to continue to use the counseling services provided by this community-based program.

Family members and significant others constitute about 8 percent of the total number of visits. We found that these clients, on average, have fewer visits with Vet Center counselors than veterans in all areas, except for marriage and family problems, where significant other and family member visits with Vet Center staff exceeded those of veterans over our 3-year period of review. Table 1 shows the average and median number of visits by new veterans and family and significant others by problem areas addressed for fiscal year 1995. Table 2 shows data for the 3-year study period, fiscal years 1993 through 1995.

[12]In our sample, the highest number of visits was 236.

[13]Sub-PTSD is a clinical diagnosis for someone found to have been exposed to a traumatic event but who fails to meet all of the criteria to support a diagnosis of PTSD.

[14]Vet Center staff are responsible for reporting the problems addressed during each client's visits, and counselors can report up to three problems per visit. For each subsequent client visit, Vet Center staff record problems in the same manner except that the problems addressed may be different, with the exception of PTSD. Once a veteran is identified with PTSD, it is automatically counted as one of the problems addressed in all future contacts.

Table 1: FY 1995 Visits by New Veterans and Family and Significant Others, by Problem Addressed

	New veterans		Family and significant others	
Problem addressed	Average visits	Median visits	Average visits	Median visits
Sexual trauma	6.7	3.0	2.8	2.0
PTSD	5.0	2.0	2.7	1.0
Sub-PTSD	4.3	2.0	2.7	1.0
Marital/family	3.1	1.0	2.8	1.0
Psych/other	3.0	1.0	1.9	1.0
Legal	2.4	1.0	1.3	1.0
Drug/alcohol	2.4	1.0	1.3	1.0
Homeless	1.8	1.0	1.0	1.0
Employment	1.6	1.0	1.1	1.0
Basic needs	1.6	1.0	1.1	1.0
Other	1.5	1.0	1.1	1.0
Medical	1.4	1.0	1.2	1.0
Benefits	1.3	1.0	1.2	1.0

Source: GAO analysis of SARS data.

Table 2: FY 1993-95 Visits by New Veterans and Family and Significant Others, by Problem Addressed

	New veterans		Family and significant others	
Problem addressed	Average visits	Median visits	Average visits	Median visits
Sexual trauma	11.2	4.0	4.8	2.0
PTSD	9.4	3.0	4.1	1.0
Sub-PTSD	6.4	2.0	3.6	1.0
Marital/family	4.5	2.0	4.8	2.0
Psych/other	3.8	1.0	2.8	1.0
Drug/alcohol	3.0	1.0	1.5	1.0
Homeless	2.5	1.0	1.1	1.0
Legal	2.2	1.0	1.4	1.0
Other	2.1	1.0	1.2	1.0
Employment	1.9	1.0	1.2	1.0
Basic needs	1.7	1.0	1.2	1.0
Medical	1.6	1.0	1.4	1.0
Benefits	1.5	1.0	1.3	1.0

Source: GAO analysis of SARS data.

We found two reasons that partially explain why most veterans do not continue to use Vet Centers after a few visits. First, many veterans have social concerns that can be addressed in three or fewer visits with staff. These visits might include helping clients with basic needs, legal problems, employment matters, and homelessness issues. Vet Center staff may draw on their own resources to assist with these problems or may refer clients to other VA and non-VA programs, thus limiting the number of visits needed.

Second, RCS restricts veterans from World War II, the Korean War, and noncombat veterans from conflicts other than Vietnam to three visits with Vet Center counselors. In fiscal year 1995, RCS reported that almost one-fourth of the new veteran clients were from these eras.

Vet Center Workload Reporting System Needs Improvement

SARS is RCS' primary means for collecting productivity data from its Vet Centers. In our review of 40 records in four Vet Centers, we found that data on client visits were, for the most part, accurately entered in the SARS database. However, refinements are needed to make the information more useful. SARS, as currently designed, produces data that emphasize the quantitative rather than the qualitative aspects of the Vet Center program. For example, it does not accurately describe Vet Center operations or distinguish between client visits requiring minimal staff time and visits that require extended periods of staff effort. As a result, the core group of veterans who use the largest portion of Vet Centers' staff resources are not readily identifiable, and managers and supervisors may lack information needed to oversee the program and monitor staff activities.

Client Visits Are Generally Recorded Accurately in RCS' Workload Reporting System

Client visits were accurately recorded at three of the four Vet Centers where we compared our sample of client records with information in the SARS database. All Vet Center staff are required to maintain handwritten daily activity log sheets that record each of their client contacts throughout the day. These daily activity logs are the original documents from which SARS data are entered. To test the accuracy of the SARS database, we compared the SARS data, daily activity logs, and 40 client records to determine whether information about client visits was consistent among the three sources. We found the information was correctly recorded at three of the four Vet Centers we visited and, in total, was accurate in 95 percent (38 of 40) of the cases. At one Vet Center, the client visits were shown in the progress notes in two of the client records we reviewed but not in the daily logs or SARS.

Workload System Does Not Adequately Report Staff Activities

The workload reporting system does not provide adequate information about the activities conducted by Vet Center staff. For example, when reporting activities in SARS, staff in some Vet Centers count meetings they conduct with active duty personnel in the Transitional Assistance Program (TAP).[15] These meetings may include 10 to 100 people, each of whom may be counted in SARS as an individual client visit.

Our analysis of the data from 39 Vet Centers showed that visits with active duty personnel accounted for more than 21 percent of the outreach visits performed in 5 of the 39 Vet Centers during fiscal year 1995. Moreover, in three of the five Vet Centers, active duty personnel accounted for over two-thirds of the total number of outreach visits.

While contacting military personnel who are about to be separated from active duty is a legitimate Vet Center outreach activity, recording group meetings as individual client visits makes them appear to be the same as visits that involve extended counseling. This method of counting and recording Vet Center visits inflates productivity data.

Vet Center staff also told us that several services and activities they provide or participate in are not recorded in the workload reporting system. We were told, for example, that staff help clients through crisis situations, such as suicidal periods, provide assistance with support groups for family members of active duty personnel who have been deployed for an overseas mission, and participate in community events during holidays such as Veterans Day. These and similar types of actions are not recorded in the workload reporting system, which contributes to understating the activities performed by Vet Center staff.

Furthermore, the workload reporting system does not collect information to determine how Vet Center staff resources are used. Through fiscal year 1992, time spent with clients was recorded by Vet Center staff; however, this information is no longer included in SARS. The time spent by counselors to help clients can vary dramatically. In some instances, counselors may spend 15 minutes and make only one or two phone calls to provide the assistance their clients need. In other situations, counselors may spend all day helping clients cope with serious situations and more complex issues. Without information on how time is spent, supervisors cannot (1) readily identify the core group of clients who use the largest portion of staff resources, (2) measure how staff allocate their time over a

[15]TAP was established to provide active duty personnel nearing separation from military service with employment and training information. Vet Center counselors meet with them to describe the services eligible veterans can get from the centers.

given period, or (3) determine whether the time spent with certain clients is appropriate.

Processes and Staffing in Place, but Documentation of Records and Program Effectiveness Need to Be Addressed

RCS has taken steps to ensure that Vet Center services are appropriate, but problems exist with documenting client records and demonstrating, on a systematic basis, that these services are effective. Activities to ensure that the services provided by Vet Center staff are appropriate include recurring consultation and records reviews by supervisory and clinical professionals within and external to Vet Centers, annual clinical reviews by RCS regional officials, and increased RCS emphasis on the credentials of its staff. However, some clients' records are not well documented, and RCS has not developed a systematic approach for demonstrating that the Vet Center program is effective, on a continuing basis, in meeting the psychological needs of its clients.

Processes in Place to Review the Appropriateness of Vet Center Services

Since our 1987 report, RCS has instituted processes to ensure that services provided to its clients are appropriate. RCS has established standards for Vet Center clinical records and case reviews by supervisory and clinical staff. During the required evaluations, Vet Center team leaders, regional office staff, and clinical coordinators review current client cases to determine whether (1) records are adequately documented, (2) treatment plans are being followed and progress made toward the treatment goals, and (3) treatment services are appropriate. Table 3 summarizes these activities.

Table 3: Summary of Activities to Ensure the Appropriateness of Vet Center Services

Activity	Performed by	Description
Clinical reviews of client records	Vet Center staff	Monthly reviews of client records are performed by team leaders with clinical backgrounds and/or the clinical coordinator on staff at each Vet Center to evaluate case documentation, appropriateness of care, and progress toward treatment goals.
Site reviews	Regional office staff	Annual clinical reviews are conducted at all Vet Centers. A sample of client records is reviewed for documentation and appropriateness of care.
External clinical reviews	VA medical center or contract staff	All Vet Centers are required to undergo at least 4 hours of monthly external clinical consultation. The sessions review the assessment and treatment planning for all active cases.
Crisis intervention	Vet Center staff	Vet Centers have plans that describe the appropriate method for addressing crisis situations such as suicide threats. The plans aim to reduce the (1) likelihood of a crisis at a Vet Center and (2) severity of a crisis when it occurs. Staff seek to identify clients at risk of dangerous behaviors to provide them with the means of handling their situations.
Mortality and morbidity (M&M) reviews	Regional office and Vet Center staff	M&M reviews are conducted on all suicide cases and serious suicide attempts to, among other things, determine (1) if care was appropriate and adequate, (2) if other steps and interventions might have altered the outcome, and (3) whether Vet Center practices are adequate.

Increased Emphasis Given to Vet Center Staff Credentials

Over time, RCS has enhanced the credentials of the Vet Center staff in order to meet the psychological counseling needs of veterans suffering with clinically diagnosed PTSD and sub-PTSD. Originally, Vet Centers were to serve as outreach, entry, and treatment points for Vietnam veterans, many of whom were unwilling to use mainstream VA programs. However, the Vet Centers soon became the preferred location for some Vietnam era veterans to obtain psychological treatment services.

To meet the clinical needs of clients suffering with psychological readjustment problems, RCS strengthened the educational backgrounds of

key staff. For example, as of January 1996, RCS reported that 87 percent (179 of 205) of its Vet Center team leaders had master's or doctorate degrees. In 17 of 18 Vet Centers with team leaders holding bachelor's degrees or less, other staff members had master's or doctorate degrees. In seven of eight Vet Centers without team leaders, other staff members also had master's or doctorate degrees. The other two Vet Centers were staffed with personnel who held less than a bachelor's degree. At these two Vet Centers, we were told that the clinical coordinator from another Vet Center and the PTSD clinical team at a nearby VA medical center provide clinical consultation. See table 4 for a summary of the educational levels of Vet Center team leaders.

Table 4: Summary of Vet Center Team Leader Educational Backgrounds

As of January 1996

Vet Center team leader educational backgrounds	Number	Percentage[a]
Doctorate degree	26	12.7
Master's degree	153	74.6
Bachelor's degree	13	6.3
Less than bachelor's degree	5	2.4
Vacant position	8	3.9

[a]Because of rounding, column does not equal 100 percent.

Source: RCS Staffing List for January 28, 1996.

Vet Center staff receive in-service training to further their professional development and, in 1995, RCS conducted its first national team leader training conference.

Documentation of Clients' Records Continues to Be a Problem

In 1987, we reported that about one-third of the client files we reviewed inadequately documented the reasons for the clients' visits and the assistance given them. Although RCS has increased its monitoring of Vet Centers, the documentation of clients' records continues to be a problem. As previously mentioned, 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 the results of treatment Vet Centers provided to veterans, we reviewed the fiscal year 1995 results from clinical site visits in the four regions we visited.[16]

[16]The four regions have a total of 119 Vet Centers under their jurisdiction, of which 117 had clinical site visits during fiscal year 1995. The 117 Vet Centers included in our analysis of four regions represent 57 percent of the program's centers.

Regional officials reported various Vet Center deficiencies in record keeping and other required activities. Record keeping problems included inadequate documentation of treatment plans, military histories, and progress notes. Forms that would have provided client information were sometimes missing from files, incomplete, or needed updating. For example, one region found 35 percent of its Vet Centers had deficiencies with the military history forms. In the four regions, RCS regional officials reported deficiencies in client treatment plans at 38 percent of the Vet Centers.

Other problems regional staff cited during Vet Center visits were associated with activities such as team leader record reviews and counselor follow-up of clients. For example, 26 percent of the team leaders in the four regions were not providing appropriate clinical reviews or supervision as RCS policy requires. Moreover, 19 percent of the Vet Centers were not documenting follow-up contacts with clients. See table 5 for a summary of the deficiencies reported by RCS regional officials in the four regions we visited during their fiscal year 1995 reviews.

Table 5: Summary of Vet Center Deficiencies Reported by Four Regions

Fiscal year 1995

Deficiency cited	Number of Vet Centers with deficiency	Percentage with deficiencies
Treatment plans	45	38
Military history	30	26
Team leader file reviews or supervision	30	26
Progress notes	27	23
Follow-up contact	22	19
Psychosocial assessment	19	16
Health history	17	15
Closing summaries	16	14

Source: RCS regional office clinical site visit reports.

Our own review of client records revealed findings similar to those of the regional staffs. In a sample of 90 client records, we found that in 26 (29 percent), forms such as problem lists and military histories were missing or incomplete.

While RCS has procedures in place for determining whether clients received appropriate care, records are often not well documented and

clinical record reviews are not always performed. Missing or incomplete clinical file information prevents an adequate assessment of the nature and quality of services rendered to veterans. The RCS director acknowledged that documentation within client records is a problem, and he has initiated actions to improve record keeping practices, such as standardizing client treatment files.

Systematic Approach Needed to Evaluate Psychological Services

RCS does not have a systematic approach to demonstrate whether the Vet Center program is effective, on a continuing basis, in meeting the psychological needs of its clients. Although PTSD may not be curable, improved record keeping would allow program officials to examine the progress made as a result of treatment services. In 1987, we concluded that RCS had little assurance that its centers were providing quality care because clinical record keeping practices and file review procedures were inadequate. Also, in May 1991, VA's Deputy Assistant Secretary for Program Coordination and Evaluation recommended, among other things, that RCS and the Mental Health and Behavioral Sciences Service establish a joint program evaluation and research component to include mechanisms for developing ongoing outcome data to measure the effectiveness of all PTSD programs.[17]

RCS officials acknowledge that outcome measures have not been developed for the Vet Center program but said they have relied on other ways of determining how well centers are serving their clients. For example, clinicians review records to determine whether clients are receiving appropriate care and making progress toward their treatment goals. Other methods, such as surveys of client satisfaction with Vet Center services, stability in clients' work lives, and improved family relationships are used by RCS officials as outcome measures in evaluating the effectiveness of the program.

RCS has been associated with two efforts that addressed the effectiveness of Vet Centers. In 1991, it undertook a study with the National Center for PTSD of 1,006 Persian Gulf war zone veterans to evaluate the prevalence of PTSD over time. They found that veterans who obtained psychological treatment at Vet Centers upon their return from the Persian Gulf showed lower levels of PTSD after approximately 6 months than those who were

[17]Department of Veterans Affairs, A Program Evaluation of the Department of Veterans Affairs Post Traumatic Stress Disorder (PTSD) Programs, report no. 1990-04 (Washington, D.C.: Office of the Deputy Assistant Secretary for Program Coordination and Evaluation, May 1991).

not immediately treated.[18] PTSD prevalence among veterans who sought psychological treatment from Vet Centers decreased from 26.9 to 19.4 percent. On the other hand, the prevalence of PTSD symptoms among veterans who used Vet Centers but did not seek psychological counseling increased from 7.8 to 9.8 percent. RCS officials concluded, among other things, that the Vet Center treatment model of providing outreach, social and economic services, and psychological counseling for PTSD is appropriate for the needs of returning war veterans.

In May 1995, RCS reported the results of a nationwide customer satisfaction survey it conducted of a random sample of 1,112 veterans who used the Vet Centers during fiscal years 1988 and 1991. On the basis of a 30-percent response rate, RCS found that 90 percent of these clients indicated they would recommend the Vet Center program to other veterans. RCS officials also reported that clients who visited Vet Centers more often were more likely to benefit from the services provided. For example, of those surveyed, the clients who made between 25 to 49 visits reported that they derived the most benefit from Vet Center services.

RCS' actions and evaluation efforts do not, however, clearly demonstrate the overall effectiveness of Vet Centers in meeting the psychological needs of their clients. While assessments of the quality of the care clients receive are made during internal and external clinical reviews, these reviews are limited to a sample of current clients and do not measure progress on a program basis. A systematic approach is needed for measuring outcomes and evaluating the extent to which Vet Centers are effective, on a continuing basis, in treating their clients, but RCS has not developed one. Without a systematic evaluation approach, RCS lacks the information necessary to demonstrate that its psychological services are effective.

Current RCS Organizational Independence Within VHA Does Not Conflict With Assigned Responsibilities

In meeting their readjustment counseling responsibilities as defined by authorizing legislation, Vet Centers provide both social and psychological services to veterans. Although the psychiatric treatment in Vet Centers is similar to the outpatient PTSD care provided by some medical centers, the two types of facilities generally focus on different clients and missions.

The health care management structure VA is currently implementing maintains RCS' organizational independence within VHA. Our work suggests that RCS independence, at this time, is consistent with its mission of providing both social and psychological readjustment counseling services

[18]These results relate to the PTSD levels in the 226 veterans who were tracked over a 6-month period.

to veterans and the developing nature of VHA's VISN structure. Once the VISN structure has been fully implemented, reconsideration of RCS' organizational structure may be warranted.

Attitudes Have Changed Since Vet Center Program Was Established

The alienation and hostility Vietnam era veterans felt toward the VA system at the end of the war have diminished for many to the point that they are now more likely to seek clinical care at VA medical centers. While many veterans would rather obtain the therapeutic services they need from Vet Center staff, reluctance to use the VA system is often related to the bureaucracy veterans encounter or expect to encounter when visiting a VA medical center.

Some Vet Center counselors with whom we met estimated that the segment of all Vietnam era veterans who are still unwilling to seek help from medical centers ranges from 10 to 35 percent. More favorable veteran attitudes toward VA medical center care relate to, in part, the time that has passed since the war ended and improvements in medical center staff understanding and treatment of PTSD.

During our discussions with veterans at three of the five Vet Centers we visited, many told us that they prefer to receive their care in the Vet Center rather than the medical center. However, a number of them indicated that they were using or had used medical center services as well. These veterans, many of whom were long-term clients of the Vet Centers, were not averse to using medical center services when needed.

RCS staff told us that over the past several years, referrals of veterans to medical centers for PTSD care have increased. Some staff stated that they have been instrumental in easing veterans' resistance to seeking medical center care. In some cases, clients are referred for inpatient care or for medication that the Vet Center staff do not prescribe. We were told that Vet Center staff not only refer veterans to medical centers but may, if necessary, take the veterans there.

Vet Centers and Medical Centers Generally Serve Different Clients and Missions

Many medical centers support their own inpatient and outpatient programs to specifically address PTSD-related problems. In some cases, veterans need inpatient care to address debilitating symptoms, while others may need medications to treat symptoms but only on an outpatient basis. Today, there are 61 inpatient and 93 outpatient specialized medical center programs designed to meet the needs of veterans diagnosed as

having PTSD. In contrast, Vet Centers do not provide inpatient care or medical prescriptions but do provide services that medical centers cannot or do not provide.

When compared with medical centers, Vet Centers serve different roles, purposes, and benefits by

- being located in small, community-based storefront facilities;
- providing care to all veterans who served during the authorized eras of conflict without regard to their income (generally, to receive free medical center services for non-service-connected illness, veterans must have incomes below a specified amount);
- providing counseling to veterans' family members and significant others to assist with the veterans' readjustment (medical centers seldom include others in veterans' treatment);
- providing counseling for social and economic needs such as employment and VA benefits, which is generally not provided by medical centers;
- performing outreach activities to identify veterans who could benefit from Vet Center or other VA services (medical centers perform little or no outreach);
- establishing close ties with local service providers and linking veterans with the services they need;
- hiring a staff of team leaders and counselors of whom about 60 percent are veterans of Vietnam and later conflicts; and
- if needed, working with veterans for longer periods than medical centers generally do.

Some medical centers do provide services that Vet Centers cannot by

- providing psychological services for veterans from World War II and the Korean War, which Vet Centers are not authorized to serve on an extended basis;
- dealing with veterans severely affected by psychological problems who are more appropriately cared for in medical centers; and
- developing specialized outpatient programs that provide medication for veterans with PTSD, if needed.

Vet Center and medical center services also differ in their treatment settings, staff expertise, and emphasis. Medical centers focus primarily on psychological issues while Vet Centers address social as well as psychological issues. As a result, some veterans are more likely to contact

and be successfully treated in Vet Centers, while others are more likely to contact and be treated in medical centers.

How Does RCS Fit Into VA's Vision for Restructuring Its Health Care System?

VHA is implementing a new plan for managing its health care resources. Recognizing that major changes are occurring in the health care environment, VHA intends to increase ambulatory care access points, emphasize primary care, decentralize decision-making, and integrate VA's delivery assets to provide an interdependent, interlocking system of care. Vet Centers will be an indirect part of that interlocking system.

In 1995, VA operated 159 medical centers, 375 ambulatory clinics, 133 nursing homes, 39 domiciliaries, and 205 Vet Centers. VHA's plan calls for these providers to be reorganized into a community-based system founded on the concept of coordinating and integrating all health delivery assets into 22 Veterans Integrated Service Networks (VISN). Under VHA's plan, the geographic area each VISN serves is defined by patient referral patterns; the number of beneficiaries in each area; facilities needed to support and provide primary, secondary, and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. While hospitals will remain an important, albeit less central, component of each network, the integration of ambulatory, acute, and extended care services will be emphasized to provide a coordinated continuum of care.

Under VHA's VISN plan, RCS will remain independent within VHA, and RCS Vet Center coordinators will act as the link with, but will not report to, VISN directors. VHA's Deputy Under Secretary for Health told us that RCS will retain its independence under the plan primarily for three reasons. First, VHA's top officials believed RCS had done a good job of serving its clients in the past, and they did not want to draw it into the difficulties of implementing a major medical program reorganization. Second, Vet Centers offer a unique approach to client care in that they are community-based, they act as access points for many veterans seeking VA services, and they perform outreach to the veteran population. Finally, these officials believed that in a number of locations, good interaction and coordination occurs between Vet Center and medical center staff and they did not want to interrupt it. The Deputy Under Secretary stated that as the VISN structure is implemented and as network services become more integrated, VHA may need to reassess RCS' organizational relationship within that structure.

Once the VISN structure is in place, VA can reassess the role and relationship Vet Centers have with other VA health care providers and how Vet Centers can best be integrated into VA's continuum of care to serve the greatest number of veterans with the health care resources currently available. For example, in some communities, the Vet Center represents the only nearby access point veterans have to VA personnel and the care and services available through the VA system. Forty-one Vet Centers are more than 30 miles from a VA medical center or VA outpatient clinic and 27 of these are more than 50 miles from such facilities. For veterans in those communities, the Vet Centers not only provide psychosocial services but also act as access and referral points for needed medical center services. In other communities, Vet Centers are close to VA medical centers; 133 are within 10 miles of a VA medical center or an outpatient clinic. Future consideration of Vet Center locations and their relationship with other VA providers might best take place within the context of each VISN's geographic area.

RCS' continued independence is consistent with recommendations made by past studies. In its January 1986 report, the Vet Center Planning Committee concluded that of the five options considered for RCS' future organizational structure, the one that would maintain RCS' organizational independence was the most appropriate. Two more recent studies—the May 1991 VA program evaluation of PTSD programs and the April 1995 biannual report of the Advisory Committee on the Readjustment of Vietnam and Other War Veterans—also concluded that RCS' current independent organizational structure should be maintained.[19]

Conclusions

Vet Centers continue to provide a range of services to a large number of veterans and their significant others. We found three program areas, however, that need improvement. First, the workload reporting system, SARS, focuses only on quantitative, not qualitative, aspects of the Vet Center program. Hence, although SARS reports productivity data, it provides insufficient information about actual Vet Center activities and the resources used to perform them. Second, the documentation in client case files is not always sufficient to ensure that veterans are receiving the care they need and that an adequate assessment of the appropriateness and quality of services rendered can be made. And third, RCS lacks a method of demonstrating that its treatment services are effective in meeting the psychological needs of Vet Center clients.

[19]For complete citations, please see the bibliography.

VA's current restructuring of medical services under the VISN concept maintains RCS' independence within VHA. We believe that continuing RCS' organizational independence is consistent with its mission of providing both social and psychological services to veterans and the developing nature of VHA's VISN structure. Once the VISN structure has been implemented, however, reconsideration of RCS' organizational position may be warranted.

Recommendations

We recommend that the Secretary of the Department of Veterans Affairs direct RCS to

- make changes to the Service Activity Reporting System so that it will more accurately reflect Vet Center activity and staff resources used;
- require Vet Center counselors to properly document the care provided to veterans and that when documentation problems are identified, take corrective action; and
- develop a method for demonstrating, on a continuing basis, the effectiveness of the Vet Center program.

Agency Comments and Our Evaluation

In a letter dated May 28, 1996, VA's Under Secretary for Health expressed satisfaction with our generally positive conclusions about RCS' operations and concurred with our three recommendations, with qualifications. VHA agreed that limitations of the existing workload reporting system, SARS, are responsible for significant underreporting of actual RCS activities but did not agree that overreporting of activities is an issue since it assumed that our conclusions were based on evidence from only one Vet Center. It indicated that reporting group contacts made under the Transition Assistance Program as though they were individual visits is not a serious problem and stated that the generalization of our findings in this area to other centers was misleading.

Our discussion of Vet Centers' overreporting as a result of the way TAP contacts are recorded was based on data obtained from a number of Vet Centers. We added information to the report to clarify the basis for our conclusions. We are encouraged by RCS' stated efforts to upgrade the SARS information collection capability to more fairly and accurately report Vet Center staff activity and believe that this may address the overreporting problem that we identified during our review.

VHA stated that established processes are already in place to meet the intent of our recommendation that counselors be required to properly document the care provided to veterans and that when problems are identified, corrective action be taken. VHA cited the standards established by RCS for clinical record keeping and the processes in place for quality and chart reviews. Our report does not take issue with the standards and processes in place. Our concern rests with the high level of noncompliance identified during RCS regional office clinical site visits, the level of noncompliance identified in the sample of cases we reviewed, and similar file documentation problems we noted in our 1987 report on RCS.

We believe that continued documentation problems of the magnitude we identified point to the need for stronger action than proposed in VHA's comments. VHA's statements that "monitoring of compliance with these policies and processes will continue to be an ongoing activity" and "The RCS program office will . . . continue to stress the importance of complete documentation" do not indicate a recognition of the need for compliance that we believe is called for in this area. We believe that RCS must initiate a concerted effort to educate counselors on the importance of full case documentation and to ensure that when documentation problems are identified, effective action is taken to correct deficiencies. Not doing so leaves in question the quality of care Vet Center clients are receiving.

VHA also offered several technical comments on our draft report that we incorporated into the final report, as appropriate. The text of VHA's comments is in appendix IV.

Copies of this report are being sent to the Secretary of Veterans Affairs, other congressional committees, and interested parties. Copies will be made available to others upon request.

Please call me at (202) 512-7101 if you have any questions or need additional assistance. Other GAO contacts and contributors to this report are listed in appendix V.

Sincerely yours,

David P. Baine
Director, Federal Health Care
Delivery and Quality Issues

Contents

Letter 1

Appendix I Scope and Methodology 26

Appendix II RCS' 205 Vet Centers by Location 30

Appendix III Readjustment Counseling Service Fiscal Year 1995 SARS Data 31

Appendix IV Comments From the Department of Veterans' Affairs 33

Appendix V GAO Contacts and Staff Acknowledgments 40

Bibliography 41

Tables

Table 1: FY 1995 Visits by New Veterans and Family and Significant Others, by Problem Addressed 8

Table 2: FY 1993-95 Visits by New Veterans and Family and Significant Others, by Problem Addressed 8

Table 3: Summary of Activities to Ensure the Appropriateness of Vet Center Services 12

Table 4: Summary of Vet Center Team Leader Educational Backgrounds 13
Table 5: Summary of Vet Center Deficiencies Reported by Four Regions 14
Table I.1: Sampling Errors for Average FY 1995 Visits by New Veterans and Family and Significant Others, by Problem Addressed 28
Table I.2: Sampling Errors for Average FY 1993-95 Visits by New Veterans and Family and Significant Others, by Problem Addressed 28

Figure

Figure II.1: Vet Center Locations 30

Abbreviations

M&M	mortality and morbidity
PTSD	post-traumatic stress disorder
RCS	Readjustment Counseling Service
SARS	Service Activity Reporting System
TAP	Transition Assistance Program
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Scope and Methodology

In performing our review of the Readjustment Counseling Service's (RCS) Vet Center program, we (1) interviewed officials from VHA's and RCS' central office in Washington, D.C., and RCS' regional offices in Bay Pines, Florida; Hines, Illinois; Denver, Colorado; and Providence, Rhode Island; (2) reviewed studies, reports, and program information from RCS' central office and the RCS regional offices we visited as well as documents from several advisory councils and committees; (3) visited Vet Centers in Cheyenne, Wyoming; Chicago, Illinois; Norwich, Connecticut; Tampa, Florida; and White River Junction, Vermont; (4) analyzed workload reporting system data for a sample of 39 Vet Centers for fiscal years 1993 through 1995; and (5) talked with officials of VA's National Center for Post-Traumatic Stress Disorder (PTSD) in White River Junction, Vermont, and four veteran service organizations.

At the four RCS regional offices, we discussed the Vet Center program and reviewed documentation on regional efforts to evaluate the care provided by the centers. In Providence, we also met with RCS' National Data Coordinator to discuss the Service Activity Reporting System (SARS) and to collect program data from it. In Bay Pines and Denver we met with RCS' clinical field managers to discuss their role in monitoring and improving the quality of clinical services Vet Centers provide in their areas of responsibility.

The five Vet Centers we visited were selected because they are geographically and operationally diverse. For example, the White River Junction Vet Center is in a rural area close to a medical center. The Vet Center in Norwich is about 50 miles from the closest VA medical center and has a military base in its catchment area. The Tampa and Chicago Vet Centers are in large urban areas and both are close to VA medical centers. Chicago is unique within the five in that it is a Veterans Resource Center—a Vet Center with expanded employment and alcohol/drug abuse services and staffing. The Cheyenne Vet Center is close to a VA medical center and did not, at the time of our visit, have a full-time team leader. While the White River Junction and Norwich Vet Centers are geographically similar, the others serve distinctly different geographic areas. At each Vet Center we met with the team leader and counselors to get their views about the program. We reviewed activities, observed Vet Center operations, and in three Vet Centers we met with veterans and significant others to obtain their views. We also obtained workload data from each center and, in four centers, reviewed a sample of case files to evaluate case documentation and the accuracy of SARS data compared with data in case files.

We met with officials of VA's National Center for Post-Traumatic Stress Disorder in White River Junction to discuss the treatment of PTSD in VA medical centers and Vet Centers and the current methods of evaluating treatment outcomes. We also met with officials of four veteran service organizations—The American Legion, Vietnam Veterans of America, Inc., Veterans of Foreign Wars, and Disabled American Veterans—to obtain their views on the program.

We reviewed a number of studies and reports on readjustment counseling services and the diagnosis and treatment of PTSD in VA programs, prepared by several organizations, advisory councils, and committees, including our 1987 report on the readjustment counseling program.[20]

As part of our review of RCS' workload reporting system—SARS—we requested activity data for 40 randomly selected Vet Centers for fiscal years 1993 through 1995. The 40 were selected from the universe of 205 Vet Centers, minus three[21] that were new in 1995 and did not have many cases in their data system and five[22] that are not located in the continental United States and, according to an RCS official, are not typical of other Vet Centers. This resulted in a sample universe of 197 Vet Centers. We obtained data from 39 of the 40 Vet Centers. One center was unable to provide information as a result of a computer problem. The data include information on all clients who visited the 39 Vet Centers during fiscal years 1993, 1994, and 1995. We analyzed the data from the 39 Vet Centers to describe the clients served, the number of visits clients made, and the type of problems addressed.

The statistics we cite are estimates relating to all 197 Vet Centers contained in our sampling universe. Our sampling errors for the estimates were calculated at the 95-percent confidence level. This means that in 95 out of 100 instances, the sampling procedure we used would produce a confidence interval[23] containing the population value we are estimating.

[20]Vietnam Veterans: A Profile of VA's Readjustment Counseling Program (GAO/HRD-87-63, Aug. 26, 1987).

[21]The three new Vet Centers that opened in 1995 were Raleigh, North Carolina; Bellingham, Washington; and Yakima Valley, Washington.

[22]These five Vet Centers are in Agana, Guam; Arecibo, Puerto Rico; Ponce, Puerto Rico; St. Croix, Virgin Islands; and St. Thomas, Virgin Islands.

[23]"Confidence interval" is another term for the range defined by our estimate, plus or minus the sampling error.

The sampling errors for estimates of the average number of visits used in this report are given in tables I.1 and I.2 and in subsequent paragraphs.

Table I.1: Sampling Errors for Average FY 1995 Visits by New Veterans and Family and Significant Others, by Problem Addressed

	New veterans		Family and significant others	
Problem addressed	Average visits	95% sampling error (±)	Average visits	95% sampling error (±)
Sexual trauma	6.7	1.7	2.8	0.6
PTSD	5.0	0.7	2.7	0.6
Sub-PTSD	4.3	0.8	2.7	1.0
Marital/family	3.1	0.4	2.8	0.6
Psych/other	3.0	0.5	1.9	0.3
Legal	2.4	1.0	1.3	0.4
Drug/alcohol	2.4	0.4	1.3	0.1
Homeless	1.8	0.5	1.0	0.0
Employment	1.6	0.2	1.1	0.1
Basic needs	1.6	0.3	1.1	0.2
Other	1.5	0.3	1.1	0.1
Medical	1.4	0.1	1.2	0.2
Benefits	1.3	0.1	1.2	0.1

Table I.2: Sampling Errors for Average FY 1993-95 Visits by New Veterans and Family and Significant Others, by Problem Addressed

	New veterans		Family and significant others	
Problem addressed	Average visits	95% sampling error (±)	Average visits	95% sampling error (±)
Sexual trauma	11.2	2.1	4.8	1.2
PTSD	9.4	1.3	4.1	0.8
Sub-PTSD	6.4	1.1	3.6	1.0
Marital/family	4.5	0.5	4.8	0.8
Psych/other	3.8	0.6	2.8	0.6
Drug/alcohol	3.0	0.4	1.5	0.1
Homeless	2.5	1.2	1.1	0.1
Legal	2.2	0.4	1.4	0.3
Other	2.1	0.5	1.2	0.1
Employment	1.9	0.3	1.2	0.2
Basic needs	1.7	0.2	1.2	0.2
Medical	1.6	0.2	1.4	0.2
Benefits	1.5	0.1	1.3	0.1

Our estimates and corresponding sampling errors for the number of visits made by new veterans during fiscal years 1993 through 1995 are as

follows: 59 percent had only one visit with Vet Center staff ± 4 percent, 80 percent had three or fewer visits ± 2 percent, and 90 percent had seven or fewer visits during the 3-year period ± 1 percent. The remaining 10 percent of Vet Center clients visited eight or more times ± 1 percent.

For the core group of veterans who are long-term users of the Vet Center program, our sampling errors were as follows: 20 percent ± 3 percent of the veterans who first visited a Vet Center prior to fiscal year 1993 had 13 or more visits and of these 10 percent ± 2 percent had 32 or more visits through fiscal year 1995.

RCS' 205 Vet Centers by Location

Figure II.1: Vet Center Locations

Alabama
- Birmingham
- Mobile

Alaska
- Anchorage
- Fairbanks
- Kenai
- Wasilla

Arizona
- Phoenix
- Prescott
- Tucson

Arkansas
- Little Rock

California
- Anaheim
- Burlingame
- Chico
- Concord
- East Los Angeles
- Eureka
- Fresno
- Los Angeles (2)
- Marina
- North Bay
- Oakland
- Riverside
- Sacramento
- San Diego
- San Francisco
- San Jose
- Santa Barbara
- Sepulveda
- Upland
- Vista

Colorado
- Boulder
- Colorado Springs
- Denver

Connecticut
- Hartford
- New Haven
- Norwich

Delaware
- Wilmington

District of Columbia
- Washington

Florida
- Fort Lauderdale
- Jacksonville
- Miami
- Orlando
- Palm Beach
- Pensacola
- Sarasota
- St. Petersburg
- Tallahassee
- Tampa

Georgia
- Atlanta
- Savannah

Guam
- Agana

Hawaii
- Hilo
- Honolulu
- Kauai
- Kailua-Kona
- Maui

Idaho
- Boise
- Pocatello

Illinois
- Chicago
- Chicago Heights
- East St. Louis
- Evanston
- Moline
- Oak Park
- Peoria
- Springfield

Indiana
- Evansville
- Fort Wayne
- Gary
- Indianapolis

Iowa
- Cedar Rapids
- Des Moines
- Sioux City

Kansas
- Wichita

Kentucky
- Lexington
- Louisville

Louisiana
- New Orleans
- Shreveport

Maine
- Bangor
- Caribou
- Lewiston
- Portland
- Sanford

Maryland
- Baltimore
- Elkton
- Silver Spring

Massachusetts
- Boston
- Brockton
- Lowell
- New Bedford
- Springfield
- Worcester

Michigan
- Grand Rapids
- Lincoln Park
- Oak Park

Minnesota
- Duluth
- St. Paul

Mississippi
- Biloxi
- Jackson

Missouri
- Kansas City
- St. Louis

Montana
- Billings
- Missoula

Nebraska
- Lincoln
- Omaha

Nevada
- Las Vegas
- Reno

New Hampshire
- Manchester

New Jersey
- Jersey City
- Newark
- Trenton
- Ventnor

New Mexico
- Albuquerque
- Farmington
- Santa Fe

New York
- Albany
- Buffalo
- Harlem
- Long Island
- New York (Bronx)
- New York (Brooklyn)
- New York (Queens)
- New York (Manhattan)
- New York (Staten Island)
- Rochester
- Syracuse
- White Plains

North Carolina
- Charlotte
- Fayetteville
- Greensboro
- Greenville
- Raleigh

North Dakota
- Fargo
- Minot

Ohio
- Cincinnati
- Cleveland
- Cleveland Heights
- Columbus
- Dayton

Oklahoma
- Oklahoma City
- Tulsa

Oregon
- Eugene
- Grants Pass
- Portland
- Salem

Pennsylvania
- Erie
- Harrisburg
- McKeesport
- Philadelphia (2)
- Pittsburgh
- Scranton

Puerto Rico
- Arecibo
- Ponce
- San Juan

Rhode Island
- Cranston

South Carolina
- Columbia
- Charleston
- Greenville

South Dakota
- Rapid City
- Sioux Falls

Tennessee
- Chattanooga
- Johnson City
- Knoxville
- Memphis

Texas
- Amarillo
- Austin
- Corpus Christi
- Dallas
- El Paso
- Fort Worth
- Houston (2)
- Laredo
- Lubbock
- McAllen
- Midland
- San Antonio

Utah
- Provo
- Salt Lake City

Vermont
- South Burlington
- White River Junction

Virgin Islands
- St. Croix
- St. Thomas

Virginia
- Norfolk
- Richmond
- Roanoke
- Springfield

Washington
- Bellingham
- Seattle
- Spokane
- Tacoma
- Yakima Valley

West Virginia
- Beckley
- Charleston
- Huntington
- Martinsburg
- Morgantown
- Princeton
- Wheeling

Wisconsin
- Madison
- Milwaukee

Wyoming
- Casper
- Cheyenne

Readjustment Counseling Service Fiscal Year 1995 SARS Data

Veterans seen first time this fiscal year	138,393
New veteran clients	
Vietnam theater	28,363
Vietnam non-theater	21,809
Persian Gulf	10,692
Lebanon	534
Grenada	309
Panama	418
Somalia	1,047
Korean theater	1,634
World War II theater	1,469
Other	17,978
Total	84,253
Non-time defined visits	
Veteran	587,116
Significant others	53,729
Total	640,845
Visits by location	
In center	488,293
Out of center	123,728
Phone	37,351
Client sessions by type	
Individual	383,674
Group	209,842
Family	22,001
Hours of outreach/education	114,432
Hours of consultation/supervision	128,511
Problem areas treated	
PTSD	279,323
Sub-PTSD	63,955
Drug/alcohol	84,020
Marital/family	85,633
Psychological, other	111,404
Employment	66,500
Benefits	81,769
Basic needs	20,564
Medical	19,150
Legal	7,908

(continued)

Homeless	14,425
Other	25,163
Women veteran-sexual trauma	29,004
Total	888,818

Source: Service Activity Report for Period Ending September 30, 1995, Readjustment Counseling Service, VA.

Comments From the Department of Veterans' Affairs

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

MAY 2 8 1996

In Reply Refer To: 105E

Mr. David P. Baine
Director, Health Care Delivery
and Quality Issues
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Baine:

The GAO Draft Report, *Readjustment Counseling Service: Vet Centers Address Multiple Client Readjustment Problems But Further Program Improvements Are Needed* (GAO/HEHS-96-113), has been reviewed by appropriate Veterans Health Administration (VHA) program officials. Although we concur in the three recommendations, we do so with qualifications. The enclosed action plan details our qualifying statements. Also enclosed are some general comments in response to several report findings.

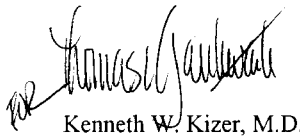
We are pleased that your conclusions about Readjustment Counseling Service (RCS) operations are generally very positive. It should be noted that the Vet Centers are accessible not only to Vietnam-era veterans, but also to veterans of post-Vietnam conflicts and to women veterans from any era of service who experienced sexual trauma while in the military. In regard to your conclusions about workload reporting, we agree that limitations in the existing SARS data system lead to significant under-reporting of actual RCS workload activity. Also, specific steps are currently being taken by the RCS to upgrade information collection capability and needed enhancements to the system are anticipated to be in place by December 31, 1996. We do not agree with the implications of the report that over-reporting of workload is an issue. As discussed in the action plan, your reference to questionable reporting of Transition Assistance Program (TAP) participants by RCS actually reflected potential reporting discrepancies at only one Vet Center visited by GAO. A generalization that similar reporting practices are probable in other Centers is misleading. Specific RCS policies and operational guidelines preclude reporting of any visits that do not involve substantive interaction between counselor and client.

Clinical record documentation, another area cited in the report as needing improvement in the Vet Centers, is a universal concern in almost all health care operations, particularly in mental health-related fields. We believe that RCS already has unusually rigorous record review requirements that provide appropriate direction for Vet Center staff to fulfill necessary requirements. Nevertheless, monitoring of compliance with these policies and processes will continue to be an ongoing activity. The RCS program office will share the findings of your report with all Vet Center staff and continue to stress the importance of complete documentation.

VHA fully supports the need for all program units to have the capability of validly measuring performance effectiveness on an ongoing basis. Performance measurement is a key component of VHA's major restructuring effort. As a participant in this effort, RCS is actively defining and implementing reliable measurements, and will work closely with VHA's Mental Health and Behavioral Sciences Service in the development of clinical guidelines. Other RCS activities are further identified in the action plan. It is important to stress, however, that such program evaluation concepts are still in the emergent stage throughout the national health care scene. In the mental health field, such evaluation has been virtually non-existent. The National Committee for Quality Assurance, which is the accrediting body for managed care organizations, has only very recently circulated outcome measures for mental health services.

Your report will be helpful in assisting us to continually improve our services to Vet Center clients, and your findings and recommendations will be shared with all involved staff members. If additional information is required, please contact Paul C. Gibert, Jr., Director, Management Review Service (105E), Office of Policy, Planning and Performance, at 273.8355.

Sincerely,



Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

Enclosures: 2

Action Plan in Response to OIG/GAO/MI Audits/Program Evaluations/Reviews

Name of Report: GAO Draft Report: ***Readjustment Counseling Service: Vet Centers Address Multiple Client Readjustment Problems But Further Program Improvements are Needed***
Report Number: GAO/HEHS -96-113
Date of Report: undated

Recommendations/ Actions	Status	Completion Date

We recommend that the Secretary of the Department of Veterans Affairs direct the RCS to:

--Make changes to the SARS data system so that it will more accurately reflect Vet Center activity and staff resources used;

Concur with Qualifications

VHA agrees that limitations in the existing SARS data system are responsible for significant under-reporting of actual RCS workload activity and believes that under-reporting is of much greater magnitude than over-reporting. Community outreach activity, case finding, and management and brokering of a wide assortment of services for veterans and family members routinely require time consuming assessment, referral and follow-up which vary in relation to the levels of emotional, social and physical stability of the involved veterans. This time is not adequately captured in existing data systems.

The report implies that over-reporting of workload is of equal concern. To support this premise, you cite RCS staff participation in the Transition Assistance Program (TAP) for soon-to-be-released military personnel. As stated on page 15 of the report, "These meetings (i.e. TAP) may consist of a group ranging from 10 to 100 people, each of whom are counted as representing an individual client visit." In fact, RCS operational guidelines specifically exclude recording of veteran visits without evidence of substantive interaction between counselor and client. The SARS policy memorandum also clearly indicates that counting the members of an audience of potential consumers is prohibited. In responding to this statement, RCS program staff carefully reviewed the operational records of the five Vet Centers you visited. In only one Center was there evidence of potential questionable counting of TAP clients. Two other Centers reported less than 15% and 10% of TAP participants respectively.

The remaining two Centers did not conduct TAP briefings. It is, therefore, inappropriate to generalize the findings from one Vet Center to the other 204 facilities.

On page 16 of the report, you also identifiy three perceived consequences of lack of data capture of "time spent with clients." The report states that without this information, supervisors cannot identify the core group of clients who use the largest portion of staff resources or adequately measure the appropriateness of staff time allocation. Although VHA agrees that such data should be collected, we also stress that RCS managers do not rely solely on SARS national data reports for administrative support. For example, RCS has other locally-generated computer programs that track counselor interaction with clients. These printouts depict not only sessions with clients, but also problem codes and other important demographic data. RCS also tracks data relating to ethnicity, gender, service era, service-connection and other domains to ensure that target populations are being served.

With these clarifications in mind, however, VHA is addressing recognized reporting deficiencies in the SARS system which also impact on the operations of other program areas throughout the system. The Readjustment Counseling Service has initiated steps to upgrade information collection capability by establishing an internal work group of RCS staff to identify specific needs. The Service has also requested an external assessment by the VA Advisory Committee on the Readjustment of Vietnam and Other War Veterans. RCS will work closely with Chief Information Officer staff to coordinate any needed technical system enhancements. The Advisory Committee has already provided some preliminary recommendations and will continue its review on an ongoing basis to assist in the evaluation of new workload measuring procedures. As a preliminary projection, RCS has targeted the following areas for consideration in upgrading workload data collection: time spent in direct service activities; systematic tracking of referrals; crises intervention work; and community work in support of a broad range of veteran-related functions.

Ongoing December 31, 1996

Enclosure 1

--Require Vet Center counselors to properly document the care provided to veterans and that when documentation problems are identified, take corrective action;

Concur in Principle

We believe that established processes are already in place to meet the intent of this recommendation. The need for ongoing improvement in clinical record documentation is a universally-cited deficiency in almost all arenas of the health care system. The need is even more pronounced in mental health-related programs, where unanticipated psychiatric crises and unscheduled clients frequently require immediate action that may delay chart documentation.

In comparison with other VA and non-VA mental health programs, RCS has unusually rigorous quality/chart review requirements. RCS standards for clinical documentation are contained in numbered policy memoranda and are reiterated in the VHA manual for the Vet Centers. The standard for "clinical record keeping," which is included in the RCS clinical site visit protocol, consists of a checklist of 15 elements, a deficiency in any one of which could result in a recorded deficiency for clinical documentation on the site visit report. Table 5 (p.21) is supposedly a summary of the four regional RCS site visit deficiencies identified during FY 1995. Data included in Table 5 is used to support this recommendation. However, information included in the Table is confusing (See enclosed "General Comments"). In addition, identified documentation deficiencies, though they may be high in number, frequently reflect minor omissions that can be easily corrected and that have minimal impact on the effectiveness of patient care delivery. The RCS program office recognizes this fact and will consider the feasibility of revising their monitoring processes to reflect a prioritization of documentation deficiency levels ranging from minor omissions to potential clinical negligence. Such a move will provide a much more valid determination of the actual significance of documentation lapse.

As currently designed, RCS's established policies and processes for clinical documentation of client records provide appropriate direction for Vet Center staff to fulfill necessary requirements. Monitoring of compliance with these policies and processes is, of course, an ongoing activity. RCS program officials will share the

Enclosure 1

findings of this report with all Vet Centers and continue to provide consistent guidance about the importance of accurate and complete documentation.

In Process Ongoing

-Develop a method for demonstrating, on a continuing basis, the effectiveness of the Vet Center program

Concur with Qualifications

VHA agrees with the underlying premise of this recommendation not only for the Vet Center program, but also for every other program area. Until very recently, only a few experimental or demonstration projects had program evaluation built into their design and implementation. In the mental health field, such evaluation was virtually non-existent. For example, the national accrediting body for managed care organizations (National Committee for Quality Assurance/NCQA) is only now circulating outcome measures for mental health services. Therefore, very few, if any, managed care organizations can currently meet the standard in behavioral mental health that you recommend for the Vet Center program. In fact, there was no provision in the enabling legislation that supported RCS program initiatives requiring the performance of outcome research and evaluation. There were also no resources allocated towards that goal. Within existing resources, RCS staff nevertheless initiated useful processes to measure program effectiveness, some of which are described in this report.

Within this context, VHA in general, and RCS in particular, are making positive strides in developing valid, ongoing measurements of program effectiveness. Performance measurement is a key component of VHA's major restructuring initiative, and every program area, including RCS, is actively involved in defining and implementing reliable measurements. In addition, RCS is participating with the Mental Health and Behavioral Sciences Service in developing practice guidelines in the diagnosis and treatment of depression as associated co-morbidly with substance abuse and post traumatic stress disorder. In addition to developing guidelines, this joint effort will also result in the identification of outcome variables that will measure effectiveness. The RCS is additionally in the process of field testing clinical charts that will be standardized nationally. The charts contain assessment and treatment scales that will

Enclosure 1

provide program feedback about the effectiveness of clinical interventions. RCS, as well as other mental health components within VHA, will also monitor the development of national standards for behavioral health organizations in the private sector for potential application within the VA system.

In Process Ongoing

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