DEPARTMENT OF VETERANS AFFAIRS
Under Secretary for Health
Washington DC 20420

August 18, 2015

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-14-3337

Dear Ms. Lerner:

I am responding to your request for a supplemental report on the Vet Center in Federal Way, Washington, related to the Department of Veterans Affairs' (VA) report to the Office of Special Counsel dated February 12, 2015. Your office posed nine follow-up questions to the report and our responses can be found in the enclosed document.

The Secretary has delegated to me the authority to sign the enclosed supplemental report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

If you have any other questions, I would be pleased to address them.

Sincerely,

David J. Shulkin, M.D.

Enclosure

Department of Veterans Affairs
Supplemental Report
to the
Office of Special Counsel
Federal Way Vet Center
Federal Way, Washington
OSC File No. DI-14-3337

August 21, 2015

At the request of the Secretary of the Department of Veterans Affairs (VA), the Interim Under Secretary for Health directed the Office of the Medical Inspector (OMI) to assemble and lead a VA team to investigate allegations lodged with the Office of Special Counsel (OSC) by Whistleblower (hereafter, the whistleblower), a former social worker at the Federal Way Vet Center (hereafter, the Vet Center). The whistleblower claimed that the Vet Center engaged in conduct that may constitute a violation of law, rule or regulation, gross mismanagement, and an abuse of authority. He described issues regarding documentation of clinical activity, contact of Veterans following outreach activities, and unsecured Release of Information (ROI) tracking. The VA team conducted a site visit on November 4–5, 2014.

On May 06, 2015, in an email request to the Office of General Counsel, OSC asked VA to answer nine questions related to the original investigation. The questions and our responses are as follows:

1. The OMI investigation also recommended that the Regional Office take appropriate action "to address the TL's violation of ethical codes of conduct." (Regional Office Recommendation 3). In response, the Regional Office stated that it will closely monitor the TL's documentation, but did not indicate whether disciplinary action would be taken for the violation.

a. In response to OMI's recommendation, why was the Team Leader (TL) instructed not to hold orientation sessions, rather than disciplined or provided education and training on appropriate documentation?

The TL is being disciplined for failure to provide effective oversight and failure to accurately document clinical time. Specifically, she is being disciplined for the time between June 2014 and November 2014, conflating the time she spent in group orientation sessions and the time she spent with the Veterans individually into one meeting, instead of creating a separate appointment for each.

The TL was not provided education or training on appropriate documentation because when her documentation deficiencies were pointed out to her she understood what was expected of her. She did not require training.

On December 30, 2014, the TL was instructed to discontinue the practice of holding orientation sessions for new clients. The orientation is now conducted during the initial session with the Veteran's assigned clinician and appropriately entered into his or her records.

b. Did the falsifications identified in OMI's investigation provide a sufficient basis for disciplinary action against the Team Leader, or only for ongoing review of her documentation?

Yes, the falsifications identified in VA's investigation provided a basis to discipline the TL.

c. Did the ongoing deficiencies in documentation identified in the audit provide a sufficient basis for disciplinary action against the Team Leader?

Yes.

d. Did the ethical violation identified in OMI's investigation provide a sufficient basis for disciplinary action against the Team Leader?

Yes, and the disciplinary charges address the TLs ethical violation.

e. If the Region anticipates taking disciplinary or corrective action against the Team Leader, when will that action be taken?

Disciplinary action will be taken by approximately mid-August 2015.

2. OMI's investigation noted that the Regional Office was aware, prior to the investigation, of allegations that the Team Leader misrepresented the amount of face-to-face time spent in clinical sessions. The allegations were not limited to orientation sessions, but seemed to extend to other counseling sessions held by the Team Leader. OMI's investigation further states that it could find no evidence that the Regional Leadership took action to address the allegations, which were later confirmed by OMI.

The Deputy Regional Manager testified during the Administrative Investigation Board (AIB) conducted by the Office of Accountability Review[1], that two employees contacted him in June 2014 regarding, among other things, the possibility that the TL was fabricating her number of clinical hours. He convened a fact-finding team[2], which was led by a Team Leader from a different Vet Center. That team recommended a more formal investigation be conducted into the Team Leader's time-tracking activities and that corrective action be taken if needed.

[1] Report of Investigation dated May 18, 2015.
[2] Fact Finding conducted on June 17-19, 2014

Readjustment Counseling Service leadership began preparing to conduct a more formal AIB to investigate the accuracy of the Team Leader's reporting of clinical hours, but halted this effort when notified that OMI, at the direction of the Secretary of VA, was going to conduct a similar investigation in response to the OSC referral.

a. Does the VA believe that the TL had the resources needed to properly care for veterans at the Vet Center?

There was no indication that the issues identified were due to a lack of resources. The Federal Way Vet Center is authorized 7 full-time employee equivalents (FTEE). The Vet Center operated at full strength (7 FTEE) during fiscal year (FY) 2013 and FY 2014. The core clinical staff operated at 70 percent Total Activity, and at 50 percent Direct Service, so there was ample time to meet the clinical needs of all clients. The TL was scheduled to attend the Readjustment Counseling Services, Team Leader Academy during March of 2012, but training was cancelled that FY per VHA direction regarding travel. The Team Leader Academy is a 1 week training to assist new TLs with developing the skill set to manage the administrative and clinical operations of the Vet Center. Travel restrictions for training remained in effect until Spring of 2014; the Federal Way TL attended the Academy in July 2014. During the lapse in time between when the TL was hired (October 7, 2012) and her attendance at the Team Leader Academy (July 2014), training and guidance was provided by the Regional Office via telephone, and face-to-face meetings that occurred during annual clinical and administrative site visits. Additionally two senior TLs, one from the Tacoma Vet Center and one from the Seattle Vet Center provided guidance, consultation, and mentorship via telephone and face-to-face meetings, given both of their Vet Centers are within 30 miles of the Federal Way Vet Center.

b. In light of the Regional Leadership's failure to act on the prior information, will the VA pursue disciplinary or corrective action against the Regional Leadership for its failure to monitor and appropriately address the Team leader's conduct?

Regional Leadership acted promptly when they were first notified in June 2014, of possible unethical conduct at the Vet Center by initiating a fact-finding investigation by an outside employee. They were in the process of addressing the TLs conduct regarding accounting her time during group orientations, but stopped when they were notified of a VA investigation into the same allegations. However, Regional Leadership failed to monitor the TLs compliance regarding the Vet Center's use of a paper log book rather than the electronic tracking system. Appropriate action will be issued against the Regional Manager and Deputy Regional Manager; each will be charged with lack of oversight regarding the usage of the paper logs.

c. Has the VA Office of Accountability Review had the opportunity to assess whether disciplinary action against Regional Leadership is appropriate, given OMI's findings?

Yes, the Office of Accountability Review has reviewed the matter and concurs with the disciplinary action to be taken against the Regional Manager and Deputy Regional Manager.