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

Background

At the request of the Secretary of Veterans Affairs (VA), the Interim Under Secretary for Health directed the Office of the Medical Inspector (OMI) to assemble and lead a team to investigate allegations lodged with the Office of Special Counsel (OSC) by Jonathan Wicks (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.

Based on findings, VA made a total of nine recommendations: three to the Vet Center, four to the Regional Office, and two to the Veterans Health Administration (VHA). Two of the nine actions have been completed.

Vet Center

Recommendation 1: Review the Outreach Specialist's actions with respect to creating new case files, and if warranted, take appropriate administrative and disciplinary action.

Resolution: The Vet Center team, including the Outreach Specialist, has been provided education regarding the appropriate documentation procedures and has been directed to discontinue the practice of entering outreach contacts as counseling visits. The Outreach Specialist's activities remain under close supervision by the Vet Center Team Leader, the Associate Regional Manager for Counseling, and the Deputy Regional Manager.
This action is ongoing.

Recommendation 2: Identify those Veterans who had requested Vet Center services and contact them to determine whether they still require these services. If any have experienced problems due to the Vet Center's non-responsiveness, follow up immediately.

Resolution: The Vet Center identified 419 Veterans that required contact following an outreach event. Of the 419, no contact information (telephone number or address) was

available for 34, a voicemail was left or letter sent to 275, 101 were reached but declined service, and 9 were reached and requested service, which was arranged.
This action has been completed.

Recommendation 3: Provide documentation of the 100 cases that were abruptly closed within 1 week of their being opened, and, if this action was improper, take appropriate administrative and disciplinary action.

Resolution: These 100 cases were included among the 419 Veterans referenced above. The Outreach Specialist's activities remain under close supervision by the Vet Center Team Leader, the Associate Regional Manager for Counseling, and the Deputy Regional Manager. The Outreach Specialist occupies a term-limited appointment which will not be renewed upon expiration in the near future.
This action is ongoing.

Regional Office

Recommendation 1: Review the Team Leader's (TL) noncompliance with documentation of clinical activity and take disciplinary action. If the disciplinary action does not result in removal of the TL, provide the TL with education and training on appropriate documentation of clinical activity. Once completed, monitor the TL's subsequent documentation and verify that it is accurate.

Resolution: On December 30, 2014, the TL was instructed against, and has discontinued, the practice of holding orientation sessions for new clients. The orientation is now conducted during the initial session with their assigned clinician and appropriately entered into their records.

The Regional Manager for Clinical Oversight will conduct a monthly audit of 10 percent of the TL's documentation for 1 year to assess the accuracy of the documentation. The first audit was conducted on March 16, 2015, and three deficiencies were identified: 1) an intake assessment had not been completed; 2) a Veteran's military history was not included; and 3) a treatment plan was missing, and there was a problem with coding within the required timeframes. All three deficiencies were corrected on the day of the audit. In the future this audit will be conducted by the Associate Regional Manager for Clinical.

Vet Center management continues to consult with Regional Counsel to formulate appropriate corrective administrative action for the TL.

This action is ongoing.

Recommendation 2: Review notes entered by the TL between February and May 2014, and determine whether she recorded outreach phone calls by work-study students as clinical activities that she had performed.

Resolution: The Deputy Regional Manager reviewed all notes completed by the TL between February and May 2014 to determine whether she recorded outreach phone calls by work-study students as clinical activities that she had performed. All 100 notes were either an individual or group note and referenced contact between the TL and the Veteran, with no indication that a work-study student had been involved in any part of the interaction.
This action has been completed.

Recommendation 3: Take appropriate action to address the TL's violation of ethical codes of conduct.

Resolution: The Regional Office will continue to closely monitor her documentation and supervisory practices at the Vet Center, and address any noncompliance with appropriate, progressive disciplinary action.
This action is ongoing.

Recommendation 4: Provide more rigorous oversight of the Vet Center in complying with the recommendations of Clinical Quality Reviews, in particular, the actions of the TL after she had been informed that the ROI log book was unsecured. If warranted, take appropriate administrative and disciplinary action.

Resolution: The TL was instructed to discontinue the outdated process of keeping a paper log book for storing completed ROI forms, and to use the computerized ROI process. Compliance will be monitored and disciplinary action taken to address noncompliance. The Deputy Regional Manager will conduct weekly sessions with the TL to follow any open items related to administrative or clinical site visits. Any open items will be addressed and tracked until completed. The Regional Manager will also ensure that appropriate clinical care is being delivered.

The Associate Regional Manager for Clinical will conduct monthly audits of 10 percent of the TL's documentation to assess documentation accuracy and appropriateness of care provided. The first audit was conducted in March 2015, during which 2 of her 16 charts were reviewed. In one chart, three items were not completed within the required timeframe by the TL. No deficiencies were found in the other chart.
This action is ongoing.

VHA

Recommendation 1: Reinforce to Regional Office leadership that they must follow-up on findings and recommendations from annual Clinical Quality Reviews and monitor the Vet Center's corrective actions to completion.

Resolution: VHA leadership reinstructed Regional Office leadership on the importance of following up on findings and recommendations from annual quality reviews. The Regional Manager's Office completed a Clinical Quality Review at the Vet Center on November 21, 2014. Three deficiencies were identified: one related to external clinical

consultation, one related to a vacancy, and one related to chart reviews. All three deficiencies have been addressed, two of which have been completed, while one is an ongoing action item. VA is conducting an administrative investigation board (AIB) to investigate and address any oversight and accountability issues . The AIB has completed its investigative interviews and expects to issue its findings within the next 30-60 days.

This action is ongoing.

Recommendation 2: Provide more rigorous oversight of the Regional Office in its handling of alleged malfeasance by Vet Center staff members and, if warranted, hold all parties accountable.

Resolution: The Deputy Regional Manager will provide a monthly report to the Chief, Readjustment Counseling Office, Veterans Affairs Central Office (VACO) on all open deficiencies for a period of one year beginning in April 2015. The Associate Regional Manager for Counseling will be responsible for continuous review of Vet Center annual clinical site visit reports and ensure remediation of identified deficiencies within 60 days, whenever possible. The Associate Regional Manager for Counseling will provide a monthly report to the Chief, Readjustment Counseling Office on all open clinical site visit deficiencies for a period of 1 year beginning in April 2015. VACO Readjustment Counseling Service will monitor the progress of deficiency remediation, and take disciplinary action as appropriate.
This action is ongoing.