DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

April 17, 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 letter regarding allegations made by a whistleblower at Federal Way Veterans Center, Federal Way, Washington (hereafter, the Vet Center). The whistleblower alleged 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 tracking.

The Secretary asked that the Interim Under Secretary for Health refer the whistleblower's allegations to the Office of the Medical Inspector who assembled and led a VA team to investigate these allegations. The team conducted a site visit to the Vet Center on November 4–5, 2014, and substantiated all three of the whistleblower's allegations. VA made three recommendations for the Vet Center, four for the Regional Office, and two for the Veterans Health Administration. Findings from the investigation are contained in the report, which I am submitting for your review.

VA submitted its original report on this matter on February 12, 2015. After further legal review, we have modified the report to incorporate additional information regarding applicable privacy laws. We therefore wish to rescind the previous version and substitute this amended one. There are no substantive differences between the recommendations for corrective action in the original report and the amended one.

Finally, we are reviewing the supplemental report that you requested on March 12, 2015. We hope to provide that report to you this month.

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

Thank you for the opportunity to respond.

Sincerely,

Jose D. Riojas
Chief of Staff

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Washington, DC

Report to the
Office of Special Counsel
OSC File Number DI-14-3337

Department of Veterans Affairs
Federal Way Vet Center
Federal Way, Washington

Report Date: April 17, 2015

TRIM 2014-D-1260

Executive Summary

At the request of the Secretary of Veterans Affairs, the Interim Under Secretary for Health (USH) 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 an anonymous whistleblower, a former employee 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.

III. Specific Allegations of the Whistleblower

1. (b) (6), the Vet Center team leader, repeatedly falsified clinical activity records.
2. (b) (6), a Veteran Outreach Specialist, failed to contact veterans who requested counseling services and closed cases without contacting individuals.
3. The Federal Way Vet Center maintains an unsecured paper Release of Information (ROI) log book instead of using the required electronic alternative.

VA either **substantiated** allegations when the facts and findings supported that the alleged events or actions took place, **did not substantiate** allegations when the facts showed the allegations were unfounded, and VA was **not able to substantiate allegations** when the available evidence was not sufficient to support conclusions about whether the alleged event or action took place with reasonable certainty.

After careful review of VA's findings, VA makes the following conclusions and recommendations:

Conclusions for Allegation #1

- VA **substantiated** that (b) (6), the Vet Center Team Leader (TL), repeatedly falsified clinical activity records by misrepresenting the amount of time she spent in face-to-face clinical activity.

- VA was **not able to substantiate** that the TL was inaccurately recording phone calls as substantive clinical interactions or that she recorded outreach phone calls made by work-study students as clinical activities that she had performed. There was insufficient evidence to support a definitive finding.

- Readjustment Counseling Service (RCS) does not have written policy specifying the number of hours TLs must spend on clinical activities. In addition, the RCS Guidelines and Instructions for Vet Center Client Records (hereafter, Guidelines for Records) require that a separate note be entered for follow-up activity regarding a client; they do not address whether or how to document pre-session preparation.

- Regional RCS leadership was aware of the allegation, following two consecutive Clinical Quality Reviews, that the TL had misrepresented her clinical activity, but there is no evidence that they have taken any corrective action.

- In falsifying RCSNet records, the TL violated the principles of ethical conduct.

Recommendations to Regional Office:

1. Review the TL's 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.

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.

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

Recommendations to VHA:

4. 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.

5. 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.

Conclusions for Allegation #2

- VA **substantiated** that the Outreach Specialist failed to contact those Veterans who had requested counseling services, unnecessarily collected Veterans' SSNs and home phone number, and closed cases without first contacting the Veteran. The collection of the full SSN through the use of Veteran Information Form (VIF) cards constitutes a violation of the Privacy Act's mandate, 5 U.S.C. §552a(e)(1), that an agency only maintain such information about an individual that is relevant and necessary to accomplish an agency purpose required by statute or executive order. The collection of SSNs and home address was not necessary for the contact with these Veterans. Because the VIF cards were only destroyed after the information had been copied to RCSNet, the VIF cards were not destroyed in violation of the Federal Records Act. This falsification and destruction of VIF cards did violate the principles of ethical conduct. The Outreach Specialist falsely created client records

and case files from the VIF cards collected at outreach events, in violation of RCS policy.

- The Vet Center's failure to provide Veterans with requested services poses a risk to public health and safety.

Recommendations to the Vet Center

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

7. 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.

8. 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.

Conclusions for Allegation #3

- VA **substantiated** that the Vet Center had maintained an unsecured paper ROI log book instead of using the required RCSNet. This practice was not in compliance with the Guidelines for Administration. At the time of our site visit, the paper log book still contained ROI requests, but it is now secured, and the Vet Center is in the process of loading these requests into RCSNet.

- The August 2013 Clinical Quality Review identified the problem with the unsecured log book, but the Vet Center took no action to secure it.

- By maintaining a paper ROI log book, the Vet Center violated RCS policy governing Guidelines for Records.

Recommendation to Regional Office

9. 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.

Summary Statement

The VA team has developed this report in consultation with other VA and VHA offices to address OSC's concerns that the Vet Center may have violated law, rule or regulation, engaged in gross mismanagement, an abuse of authority, or risked public health or safety. In particular, the Office of General Counsel (OGC) has provided a legal review and the Office of Accountability Review has examined the issues from a Human Resources perspective, establishing individual accountability, when appropriate, for improper personnel practices. VA found violations of the principles of ethical conduct found in 5 CFR § 2635.101 and actions that constituted a substantial and specific danger to public health and safety. There were also violations of VA and Vet Center policy.

Table of Contents

I. Introduction

At the request of the Secretary of Veterans Affairs, the USH directed the OMI to assemble and lead a team to investigate allegations lodged with OSC by an anonymous whistleblower, a former employee at 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.

II. Vet Center Profile

The Vet Center was established in 2008 and currently provides services to residents in six counties in the Pacific Northwest. The Vet Center is overseen by leadership in the Readjustment Counseling Service (RCS) Region 4A located in Denver, Colorado. At the time of the site visit, the Vet Center had 116 active clients. During fiscal years (FY) 2013 and 2014, the Vet Center recorded the following number of visits:

	Veteran Visits	**Family Visits**	**Phone Visits**	**Total Visits**
FY 2013	3122	305	817	**4244**
FY 2014	4331	325	909	**5565**

III. Specific Allegations of the Whistleblower

1. (b) (6), the Vet Center team leader, repeatedly falsified clinical activity records.
2. (b) (6), a Veteran Outreach Specialist, failed to contact veterans who requested counseling services and closed cases without contacting individuals.
3. The Federal Way Vet Center maintains an unsecured paper ROI log book instead of using the required electronic alternative.

IV. Conduct of the Investigation

The VA team consisted of (b) (6), Medical Investigator; (b) (6), (b) (6), Clinical Program Manager (b) (6), Health Systems Specialist; (b) (6) (b) (6) LCSW-C, Associate Director, Readjustment Counseling Service (RCS); (b) (6) (b) (6) Regional Manager of the Western Pacific Region of RCS; (b) (6), (b) (6), Associate Regional Manager for Counseling for the Central Region of RCS; and (b) (6), Human Resources Consultant, VA Office of Accountability Review (OAR).

VA reviewed relevant policies, procedures, reports, memorandums, and additional documents as listed in Attachment A. We interviewed the whistleblower by telephone prior to the site visit, and conducted face-to-face interviews with the following individuals at the Vet Center:

- (b) (6), Clinical Psychologist (former employee)
- (b) (6), Outreach Specialist
- (b) (6), Military Sexual Trauma Counselor
- (b) (6) LMHC Readjustment Counselor
- (b) (6), Office Manager
- (b) (6), Associate Regional Manager
- (b) (6), Work-Study Student
- (b) (6), Work-Study Student
- (b) (6), Clinical Psychologist
- (b) (6), MA, Regional Manager

During this site visit, VA held entrance and exit briefings with the Regional Manager via telephone, and toured the facility.

V. Findings, Conclusions, and Recommendations

Allegation #1
(b) (6), the Vet Center team leader, repeatedly falsified clinical activity records.

Findings

In 1979, Congress passed Public Law 96-22, the Veterans Health Care Amendments of 1979, establishing the RCS and Vet Centers.[1] VA's statutory authority to provide eligible individuals with readjustment counseling (as that term is defined in regulation) is codified at section 1712A of title 38, United States Code (USC). It authorizes VA to furnish professional readjustment counseling to, among others, eligible Veterans through the Department's Vet Centers. Eligible Veterans include those who have served in a theater of combat operations, or in an area at a time during which hostilitites occurred in that area, including the Global War on Terrorism.[2] The goal of the Vet Center program is to provide outreach, direct readjustment counseling services, and referral services to address the psychological and social sequelae of combat and armed conflict related problems. Section 17.2000(d) of title 38, Code of Federal Regulations, defines readjustment counseling to include (but not be limited to):

- Psychosocial assessments.
- Individual and group counseling for Veterans and their families.
- Family counseling for military-related readjustment issues.

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[1] Public Law 96-22-June 13, 1979, 96th Congress. http://www.gpo.gov/fdsys/pkg/STATUTE-93/pdf/STATUTE-93-Pg47.pdf .

[2] VHA Directive 1500, *Readjustment Counseling Service (RCS) Vet Center Program.* September 8, 2010.

- Bereavement counseling for families of military personnel who died while on active duty.
- Counseling and referral for conditions related to military sexual trauma.
- Outreach and education including Post-Deployment Health Reassessment events, and other community events.
- Substance abuse assessment.
- Employment assessment and referral.
- Referral to Veterans Benefits Administration (VBA) for additional VA benefits. The definition of this term in VHA Handbook 1500.01 includes the following additional element: "screening and referral for medical and mental health issues."[3]

As specified in Veterans Health Administration (VHA) Handbook 1500.01, *Readjustment Counseling Service,* every Vet Center is aligned with a VA Medical Center for support with fiscal, human resources, contracting acquisition, and engineering service functions. The Vet Centers are not supervised by local VA Medical Center Leadership, but report to VHA leadership via its supervisory Regional Office.

The Vet Center is allotted seven staff positions: one team leader, four counselors (two positions are currently vacant), one outreach specialist, and one office manager. The Vet Center also employs work-study students to provide some administrative support.

According to RCS *Guidelines and Instructions for Vet Center Administration* (hereafter, Guidelines for Administration), "every Vet Center shall have an annual administrative and clinical quality review site visit."[4] The quality review assesses Vet Center staffing levels, community collaborations, the physical environment, outreach plan, appointment availability, delivery of readjustment counseling services, and documentation of services provided. Counselors are required to document all assessments, treatments, and other client encounters, as well as time spent for each encounter, in the electronic RCS record (RCSNet).

These guidelines specify that time spent preparing for a client interaction and in follow-up activities must be documented separately, and not counted as time in face-to-face interaction. The RCS Guidelines for Records require that a separate note be entered for follow-up activity regarding a client, but do not address whether or how to document pre-session preparation. Vet Center counselors are also required to document telephone contacts with clients. Brief calls reminding clients of upcoming appointments or informing them of upcoming events are considered non-clinical and non-substantive, since no clinical care is provided. Telephone contact during which RCS services are

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[3] See also VHA Directive 1500, *Readjustment Counseling Service (RCS) Vet Center Program.* September 8, 2010.

[4] *Readjustment Counseling Service Guidelines and Instructions for Vet Center Administration*, November 23, 2010.

provided is considered substantive and usually requires more time interacting with the client.

The TL is the person responsible for overall Vet Center operations – ensuring that the facility runs effectively and meets the needs of its clients. The TL's responsibilities include overseeing clinical programs, staff supervision, administrative and fiscal operations, outreach events, and community relations. Charged with a range of oversight responsibilities, the TL is expected to see fewer clients than other clinical providers at the Vet Center. RCS leadership estimates that TLs should be spending about 25 percent of their time providing direct clinical care. However, the expectation that TLs spend 25 percent of their time in such activities is not a requirement in any RCS policy. RCS leadership regards this as an accepted rule of thumb.

The current TL has been in her position since October 2012. The Regional Office conducted a Clinical Quality Review of the Vet Center in August 2013, identifying the following deficiencies: TL needs to increase her client contact hours; no evidence that the electronic ROI in RCSNet is being used; and need improved external supervision and consultation. With regard to the first deficiency, over a 3-month period, the TL was expected to see 150 clients, but saw only 13. The Deputy Regional Manager was aware of this problem and proposed corrective actions for the TL. During our investigation, we found that the TL, in an effort to increase her client contact hours, began falsely documenting more clinical hours. She admitted to spending 60-90 minutes in face-to-face client orientation sessions, while documenting that she had spent 120 minutes in each session. She acknowledged documenting as face-to-face clinical time the time she had spent reviewing client records prior to orientation sessions and the time she had spent making client appointments following a session. Our review of information in RCSNet confirmed that the TL consistently documented orientation sessions of 120 minutes duration. In falsifying RCSNet records, the TL violated the principles of ethical conduct in 5 CFR § 2635.101, which include statements that employees shall put forth honest effort in the performance of their duties and shall endeavor to avoid any actions creating the appearance that they are violating the law or the ethical standards set forth in the Standards of Ethical Conduct.

On June 17–19, 2014, a TL from another Vet Center conducted a fact-finding review at the request of the Regional Office, addressing allegations from staff who had observed that the TL's face-to-face clinical sessions lasted only 60 minutes, despite the fact that she was documenting them as lasting 120 minutes. The reviewer recommended in a report to the Deputy Regional Manager, (b) (6) , that the Regional Office investigate these allegations and take corrective action as warranted. VA could find no evidence that the RCS Regional leadership investigated these allegations or took the recommended corrective actions. Despite these irregularities, the TL received performance ratings from RCS Regional leadership of fully successful in both FY 2013 and 2014.

The whistleblower alleged that after the Clinical Quality Review in August 2013, the TL began recording a greater number of non-clinical phone calls as substantive clinical

interactions.[5] The whistleblower stated that the TL would make calls to remind clients of an upcoming appointment, or to inform them of an upcoming event, and then record the encounter as a substantive clinical interaction. Although the whistleblower did not provide client-specific examples, another former employee did. VA's review of these notes revealed that the TL documented counseling provided during the call to justify the call as a substantive clinical interaction.

Section 3485 of title 38, United States Code (USC), "work-study allowance," establishes the criteria for authorizing an additional educational assistance allowance (hereafter referred to as work-study allowance) to eligible Veteran-students who are pursuing certain programs of education or training under Title 38 USC at a rate at least ¾ of a full-time student.[6] These provisions specify that Veteran-students must enter into an agreement to perform services (at VA facilities or educational institutions), not to exceed the maximum hourly limitation of 25 times the number of weeks in the enrollment period.[7] VA's work-study program gives Veteran-students the opportunity for hands-on work experience and a monthly part-time income while they are pursuing education and training, as part of the Post-9/11 GI Bill or other VA education benefit programs.[8] At the Vet Center, work-study students perform administrative tasks, such as answering phones, taking messages, setting up client appointments, calling clients to remind them of upcoming appointments or events, and greeting clients as they arrive.

The whistleblower alleged that the TL recorded outreach phone calls made by work-study students as clinical activities that she performed. VA interviewed two work-study students currently employed by VA at the Vet Center. The students said that between February and May 2014 they were instructed to call potential clients to ask if they were still interested in Vet Center services, and what types of services they needed. After they completed the call, they documented the outcome – unable to reach the Veteran, appointment scheduled, or referral needed – on the back of the outreach card (Attachment B). They returned the cards to the Outreach Specialist who reviewed the information and then destroyed the cards.

None of the staff interviewed stated that the TL recorded the work-study student calls as clinical activities she had performed. Since the individual outreach cards were destroyed after contact was made or attempted, the names of the potential clients who were contacted by the students are not available. The RCSNet captured the number of follow-up contacts requested during each outreach event, but not the names of individual clients. All notes entered by the TL between February and May 2014 will need to be reviewed by the Regional Office leadership against this allegation.

Conclusions for Allegation #1

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[5] Clinical Quality Reviews are completed annually at all Vet Centers by different clinical psychologists from other RCS Regions.

[6] 38 U.S.C. § 3485

[7] Id.

[8] VA's Work-Study Program: http://www.blogs.va.gov/VAntage/9779/earn-while-you-learn-vas-work-study-program/

- VA **substantiated** that (b) (6), the Vet Center TL, repeatedly falsified clinical activity records by misrepresenting the amount of time she spent in face-to-face clinical activity. This falsification of government documents violates the principles of ethical conduct.

- VA **was not able to substantiate** that the TL was inaccurately recording phone calls as substantive clinical interactions or that she recorded outreach phone calls made by work-study students as clinical activities that she had performed. There was insufficient evidence to support a definitive finding.

- RCS does not have a written policy specifying the number of hours TLs must spend on clinical activities. In addition, the RCS Guidelines for Records require that a separate note be entered for follow-up activity regarding a client; they do not address whether or how to document pre-session preparation.

- Regional RCS leadership was aware of the allegation, following two consecutive Clinical Quality Reviews, that the TL had misrepresented her clinical activity, but there is no evidence that they have taken any corrective action.

Recommendations to Regional Office:

1. Review the TL's 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.

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.

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

Recommendations to VHA:

4. 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.

5. 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.

Allegation 2

(b) (6), a Veteran outreach specialist, failed to contact veterans who requested counseling services and closed cases without contacting individuals.

Findings

The Outreach Specialist is supposed to brief new Veterans and organizes outreach events. During these activities, he provides Veterans with an overview of the services available at the Vet Center. At the completion of these activities, the Outreach Specialist in question would furnish each Veteran with an enhanced outreach card, also referred to as VIF card (Attachment C). Unlike the approved outreach card, the VIF card includes a place for the Veteran's complete social security number, home address, a checklist for requested RCS services, and additional information necessary for Vet Center staff to open a new counseling case. However, according to the Guidelines for Records, a VIF is only to be used when opening a clinical case or updating contact information for active clients.

The outreach specialist used the information on the VIF cards to open new counseling cases. When asked why VIF cards were used in place of outreach cards, he explained that gathering the complete social security number allowed him to create new counseling cases; the information contained on the outreach cards was insufficient to complete this task. According to the Guidelines for Administration, an outreach event should have been documented in RCSNet as such, and should not have been the basis for opening new client cases.

To comply with the RCS Handbook that calls for providing services within 30 days of opening a case, the Outreach Specialist was obligated to manage these improperly opened counseling cases. In an effort to do this, he asked several Vet Center counselors to contact the Veterans who had completed the VIF cards and to initiate the provision of services. The counselors we spoke to told us that they had tried unsuccessfully to contact many of these Veterans. The whistleblower alleged that during the spring of 2014, approximately 100 clinical cases that had been created using the VIF cards were abruptly closed within 1 week, and the VIF cards destroyed. He claimed that RCSNet entries for these Veterans included a statement in a non-clinical note indicating that, "the Veteran has been contacted several times and this case has been closed." Neither the Outreach Specialist nor the TL was able to identify any of the Veterans impacted by these improper actions.

VA instructed the Vet Center to immediately discontinue the use of VIF cards at outreach events and the practice of opening new client cases before services have been rendered by the office.

Conclusions for Allegation #2

- VA **substantiated** that the Outreach Specialist failed to contact those Veterans who had requested counseling services, unnecessarily collected Veterans' SSNs and home phone number, and closed cases without first contacting the Veteran. The collection of the full SSN through the use of VIF cards constitutes a violation of the Privacy Act's mandate, 5 U.S.C. §552a(e)(1), that an agency only maintain such information about an individual that is relevant and necessary to accomplish an agency purpose required by statute or executive order. The collection of SSNs and home address was not necessary for the contact with these Veterans. Because the VIF cards were only destroyed after the information had been copied to RCSNet, the VIF cards were not destroyed in violation of the Federal Records Act. This falsification and destruction of VIF cards did violate the principles of ethical conduct. The Outreach Specialist falsely created client records and case files from the VIF cards collected at outreach events, in violation of RCS policy.

- The Outreach Specialist falsely created client records and case files from the VIF cards collected at outreach events, in violation of RCS policy.

- The Vet Center's failure to provide Veterans with requested services poses a risk to public health and safety.

Recommendations to the Vet Center

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

7. 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.

8. 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.

Allegation 3

The Federal Way Vet Center maintains an unsecured paper Release of Information (ROI) log book instead of using the required electronic alternative.

Findings

RCSNet is a confidential system of records that is separate from VHA's computerized patient record system (CPRS) for patient care documentation. Information in RCSNet

includes personally identifiable information (PII) about each client as well as assessment and treatment information. Information from the client's record can be released to entities outside of VHA — including community care providers, the Veterans Benefits Administration, and the legal system — for many purposes, provided that the client has signed VA form 10-5345, *Release of Information (ROI) form*, authorizing the Vet Center to release information to the identified entity. Once the client has signed the ROI form, it must be entered into the client's RCSNet record.

The Vet Center's Clinical Quality Review of August 2013 noted the ROI electronic tracker as a new requirement. However, the reviewer documented that, "Use of the ROI Log in RCSNet: There is no evidence that the ROI log is being used. The office manager is keeping a paper log. I have asked him to begin using the ROI log on RCSNet." The Vet Center developed objectives in response to the findings from the review and the Deputy Regional Manager approved these objectives, which included the TL increasing her client contact; better management of the ROI log; and improved external supervision and consultation.

In January 2014, a former staff member, covering as TL, found the ROI log book unsecured and open in an unattended office. Since the book contained PII pertaining to clients, he determined that the Vet Center was not in compliance with Guidelines for Administration, which require that "the Vet Center shall also have a secure double-locked room for the storage of confidential client records." When the TL returned to duty, the former staff member notified her of the security violation involving the ROI log book. According to the TL, a month later, locks were installed on both the cabinet where the book was kept and on the front office door where the cabinet was located. During the site visit, we observed that the front office door was open when the office manager was in the office, and locked when the office manager was out of the office.

On June 16, 2014, the former employee sent an email to the Regional Manager notifying him about the unsecured ROI log book and the TL's delayed response. In an email reply the following day, the Regional Manager, (b) (6), stated that "we will be pursuing" these concerns.

In the Vet Center's 2014 Clinical Quality Review, reviewers noted that the "ROI function in RCSNet has never been used." The paper log book still existed, but according to the current office manager and the TL, it is secured in a locked cabinet in a locked office.

The new office manager, who began working at the Vet Center in September 2014, is in the process of scanning all ROI requests from the paper log book into RCSNet, and then shredding the documents. She told us that she scans all new ROI requests into the RCSNet and no longer uses the paper log book. This practice is in compliance with Guidelines for Administration.

Conclusions for Allegation #3

- VA **substantiated** that the Vet Center had maintained an unsecured paper ROI log book instead of using the required RCSNet. This practice was not in compliance with the Guidelines for Administration. At the time of our site visit, he paper log book still contained ROI requests, but it is now secured, and the Vet Center is in the process of loading these requests into RCSNet.

- The August 2013 Clinical Quality Review identified the problem with the unsecured log book, but the Vet Center took no action to secure it.

- By maintaining a paper ROI log book, the Vet Center violated RCS policy governing Guidelines for Records.

Recommendation to Regional Office

9. 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.

VI. Summary Statement

The VA team has developed this report in consultation with other VA and VHA offices to address OSC's concerns that the Vet Center may have violated law, rule or regulation, engaged in gross mismanagement, an abuse of authority, or risked public health or safety. In particular, the Office of General Counsel (OGC) has provided a legal review and the Office of Accountability Review has examined the issues from a Human Resources perspective, establishing individual accountability, when appropriate, for improper personnel practices. VA found violations of the principles of ethical conduct found in 5 CFR § 2635.101 and actions that constituted a substantial and specific danger to public health and safety. There were also violations of VA and Vet Center policy.

Attachment A

Documents Reviewed by OMI

1. *Guidelines and Instructions for Vet Center Administration*
2. *Guidelines and Instructions for Vet Center Client Records*
3. Performance Appraisals for (b) (6)
4. Client Record Reviews in RCSNet.
5. VHA Handbook 1500.01, September 8, 2010, *Readjustment Counseling Service (RCS) Vet Center Program.*
6. Readjustment Counseling Service Vet Center Clinical Quality Review conducted August 8-9, 2013.
7. Fact Finding conducted on June 17-19, 2014.
8. Readjustment Counseling Service Vet Center Clinical Quality Review conducted on August 14, 2014.
9. Veterans Health Administration, VHA Directive 1605, April 11, 2012, *VHA Privacy Program.*
10. Veterans Health Administration, VHA Handbook 1907.06, January 13, 2013. *Management of Release of Information.*

Attachment B

Outreach Card

FRONT

Vet Center
Federal Way, Washington

Thank You For Your Service

Veteran's Name:_____

Today's Date: ____/____/____ Sex: M or F Birth Date: ____/____/____

SSN Last 4 _____ Branch of Service:_____

Theater of Operations (if deployed): _____

Phone #: (_____) _____ Would you like us to contact you? Yes No

Which Services Interest You?

___ Individual Counseling ___ Couple's Counseling

___ Family Counseling ___ Group Counseling

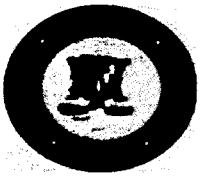
___ Job Assistance ___ Housing Assistance

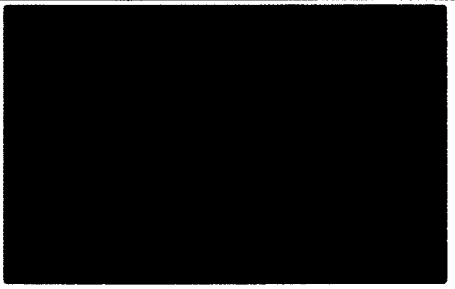
___ Other:

We are asking for this information in accordance with US Code 38. The Privacy Act of 1974 Applies.

BACK

Thank You for your Service!





Attachment C

Veteran Information Form (VIF) Card

FRONT

Vet Center
Federal Way, Washington

Thank You For Your Service

Veteran's Name: _____

Sex: M or F Birth Date: _____ SSN: _____ - _____ - _____

Marital Status: _____ Branch of Service: _____

Date Entered: _____ Date Separated: _____

Theater of Operations (if deployed): _____

Home Address: _____

City, State, Zip: _____

Phone #: (_____) _____ Would you like us to contact you? Yes No

We are asking for this information in accordance with US Code 38. The Privacy Act of 1974 Applies.

BACK

Which Services Interest You?

____ Individual Counseling	____ Couple's Counseling
____ Family Counseling	____ Group Counseling
____ Job Assistance	____ Housing Assistance
____ Education Assistance	____ Financial Assistance

____ Other: _____

Comments: