

**Department of Veterans Affairs (VA)
Responses to Chairman Ron Johnson's Questions on
the Veterans Assistance Foundation (VAF)
January 2017**

Question 1: When and how did the Tomah VAMC leadership, including Tomah VAMC police, learn of the death of a Veteran in Building 407?

VA Response: Tomah VA Medical Center (VAMC) Police received notification at 9:12 a.m. on September 25, 2016. Tomah VAMC Police responded to a medical emergency on the second floor of Building 407, which is managed by VAF. Police were first on scene and began basic lifesaving efforts for a non-responsive VAF resident. At 9:47 a.m., Tomah VAMC Police notified Tomah VAMC Leadership.

Question 2: Did Tomah VAMC notify the VA OIG or VA headquarters about this death in Building 407?

Tomah VAMC Police notified the Office of Inspector General (OIG) Duty Agent (voicemail) at 10:48 a.m. This was followed up with a quickly returned phone call from an OIG Special Agent. Tomah VAMC Police notified VA Office of Security and Law Enforcement at 10:58 a.m. Tomah VAMC released an Issue Brief to the Veterans Integrated Service Network (VISN) 12 Office at 1:35 p.m. The Acting Network Director notified VA Central Office at 2:57 p.m.

Question 3: Why is local law enforcement leading the investigation?

VA Response: The VA OIG requested assistance from the City of Tomah Police Department on September 26, 2016, for the death investigation. At this time the incident is being investigated by the City of Tomah Police Department, with assistance from the Monroe County Joint Investigative Task Force (detectives from Tomah Police Department, Sparta Police Department, and the Monroe County Sheriff's Department) and the VA OIG.

Question 4: Has the Tomah VAMC conducted any internal audits or investigation of the VAF Program prior to the death? If so, please provide the results of those reports.

VA Response: Per VHA Handbook, "VA may inspect the facility and records of any applicant or recipient when necessary to determine compliance. The inspections are held to ensure the VAF's compliance with the original grant application proposal, which has been in place since 1998. VA conducts annual re-inspections. Guidelines for conducting inspections are standardized across all VA Grant and Per Diem (GPD) Programs and cover areas such as: clinical care; facilities management; fire, safety and security compliance; nutrition services; medication storage and van (transportation) services.

In addition, VAF staff is required to complete quarterly performance reports of their own oversight in reaching their program related goals. There are three specific goal related areas:

- Resident stability with six identified objectives;
- Increase skills and income with five identified objectives; and
- Improve Self-Determination with six identified objectives.

This year, the VAF has demonstrated their failure over three quarters to address and sustain improvement areas as outlined in those reports. This practice has significant clinical implications on Veteran recovery, risk to safety and security of Veterans and staff on medical center grounds, as well as meeting Veteran treatment goals.

Question 5: Does the Tomah VAMC provide security for the VAF program? Is there any written agreement pertaining to security for the VAF program?

VA Response: Tomah VAMC Police conduct daily rounds in the evening prior to midnight and again after midnight and before 6:00 a.m. to provide a check with VAF Security. Tomah VAMC Police would also be in the area for transit to the secure records room on the 3rd floor of Building 407. Tomah VAMC Police also respond to VAF areas for medical emergencies and any additional calls for Police assistance. The Agreement for Use of VA Health Care Resources states that, "VAF will provide 24 hour a day security within the building."

Question 6: How is the Tomah VAMC working to ensure that Veterans who participate in the program will not be harmed by the cancellation of the use agreement?

VA Response: Tomah VAMC has informed VAF, as well as Veterans residing at VAF, that through the many avenues, any Veteran requesting assistance will receive Tomah VAMC support. Also, to ensure that Veterans are not placed in harm's way, Tomah VAMC has taken the following actions:

- Increased rounds by Tomah VAMC Police on the VAF program floors of operation.
- VA Sharing Agreement requirement was amended to require VAF provide 24/7 security via a security company, effective October 25, 2016.
- Tomah VAMC provided an information session for VAF residents on October 25, 2016, to provide resources and assurance that Tomah VAMC is committed to the safe transition of Veterans from the program.
- Tomah VAMC provides clinical staff (Master's level Social Worker and a Registered Nurse) for oversight of program operations. They are embedded within the VAF Program to promote daily communication and oversight.

- Tomah VAMC and VAF Leadership conduct quarterly meetings to increase communication and collaboration. Within this forum the Acting Medical Center Director attempted to address the increased concerns for Veteran safety and program compliance.
- Weekly meetings between Tomah VAMC and VAF staff occur to discuss difficult cases, staffing or Veteran related issues and progress of Veterans toward discharge. This past year, Tomah VAMC staff requested a second weekly meeting be held with the intent to readily address the increased concerns identified by Tomah VAMC staff. However, that meeting request was denied by the VAF Executive Director.
- Tomah VA Health Care for Homeless Veterans interdisciplinary team is in the process of providing resources for VAF Veterans to find safe and affordable housing and to rapidly transition to permanent housing.
- To monitor the status of VAF Veterans, Tomah VAMC GPD staff is providing a daily update to Tomah VAMC Leadership to identify Veteran needs, barriers to discharge, and status updates for the successful transition of Veterans from the VAF.

Question 7: Have there been previous complaints about the VAF program? If so, please provide a summary of the complaints and what actions, if any, the VA took to mitigate any problems.

VA Response: Complaints or concerns for the operations of the GPD Program are received through several forums to include direct Veteran contact with VA Leadership, Patient Advocates, VA Mental Health and Primary Care staff. Tomah VAMC Police are intimately involved with security concerns. While concerns were brought to the attention of VAF Leadership, the emphasis in which to address has been met with resistance.

The following categories highlight complaints and VA actions to mitigate concerns:

- **Lack of security:** VAF does not provide a level of security required (24/7) per the Sharing Agreement. A paid security company is on station 5:00 p.m. - 8:00 a.m. (Monday - Friday) and 24 hours a day on weekends and holidays. However, VAF staff is unavailable during the work day to provide the level of security needed for the complexities of the Veteran cases, amount of access points, and opportunities for Veterans to bring in contraband into the facility.

VA ACTION: The Acting Medical Center Director has enforced the requirement for 24/7 security pursuant to the Sharing Agreement. The Great Lakes Acquisition Center spoke directly with the company and was able to get this service in place within 24 hours of the contact.

- Lack of rule enforcement: VAF staff does not enforce the rules of the program or VAF Resident Handbook on a fair or consistent level.

VA ACTION: Tomah VAMC staff will provide input during weekly meetings to offer VAF staff options for interventions. Annual re-inspection deficiencies will be identified and a corrective action plan will be required.

- Recovery risk factors: Veteran complaints of access to drugs and alcohol within the program place the Veterans recovery or well-being at risk. The VAF is not in compliance with their VAF Handbook regarding random room inspections and appropriate urine drug screens. This has only increased risk to Veterans and Veterans have complained that they cannot sustain their recovery in that environment.

VA ACTION: Tomah VAMC GPD staff will assist with room inspections alongside the VAF staff to ensure they are completed and to offer support with enforcement, which is beyond the scope of the GPD requirements. Tomah VAMC has developed a Standard Operating Procedure for urine drug screens to ensure these were completed in a manner in which would be acceptable to VA standards.

- Lack of assessment, goal planning: Tomah VAMC GPD staff identify Veterans within the programs who are not actively participating in treatment goals, making efforts to transition into the community or have a general lack of willingness to follow program requirements. VAF staff does not enforce program rules consistently, Veterans who are otherwise able to support their own living arrangements are not held to the same standards.

VA ACTION: Tomah VAMC staff has asked for expedited discharge plans, updated treatment or program goals and on many occasions VAF staff are unable to provide this information. This is seen as a conflict of interest as VAF continues to receive per diem payment.

- Clinical needs: Veterans are referred by VAF staff for services that exceed the clinical scope of the program. These practices continue despite recommendations by Tomah VAMC to cease. VAF Leadership support has not been in place to enforce the GPD regulations where financial per diem payment would be held if the Veteran was admitted.

VA ACTION: There is now support for local GPD to make clinical determinations to withhold per diem payment if indicated.

- Lack of services/programming: Veterans coming to the VAF Program are not provided with program and supportive services to address unmet needs for permanent housing.

VA ACTION: Tomah VAMC GPD staff will provide assessment and referral services for Veterans within 30 days of admission and meet with Veteran on an on-going basis. Annual re-inspection deficiencies will be identified and a corrective action plan will be required.

- VAF staff lack of clinical knowledge/expertise: VAF does not employ staff with clinical background or education levels that are required by the original grant application. As the trend of the Veteran clinical needs rise, the level of staff education and experience, is not congruent with addressing those appropriately.

VA ACTION: Tomah VAMC GPD staff will continue to offer additional support for VAF staff in the form of case study reviews, and provide clinical education.

- Unprofessional conduct: Veteran complaints received regarding the unprofessional nature of the VAF staff interactions with the Veterans, to include being addressed in a demeaning and disrespectful manner.

VA ACTION: Tomah VAMC staff will provide support and strategies for Veterans to address those concerns directly with the VAF staff member. Additionally, Veterans are offered the opportunity for joint meetings with the VAF staff as an attempt to mitigate the situation.

- Professional boundaries/misconduct: There have been several occasions in which Tomah VAMC staff have been spoken to by VAF Veterans inappropriately or threatened with serious physical harm. There has been a Tomah VAMC staff member who has been injured by a VAF resident and there was a sexual assault of a previous VAF male resident on a current VAF female resident.

VA ACTION: This was reported to VAF Leadership. Tomah VAMC Police interventions were completed and boundary education was given by Tomah VAMC Police to VAF residents.

- Professional boundaries/misconduct: A VAF staff member owns a financial payee company and has her family members as employees of the payee organization. Veterans within the VAF have been offered payee services for her organization and staff has received numerous complaints of inappropriate

management of those funds, inability to access those funds, and a delay in receiving their personal funds back when the Veteran initiates the termination of the payee service.

VA ACTION: Tomah VAMC staff has brought this issue to the attention of VAF Leadership who does not see this as a conflict of interest or vulnerability for a Veteran who may feel obligated to sign on for the payee service as a contingency for entry or remaining in the program. Tomah VAMC staff sees this as a clear conflict of interest for VAF staff to be financially benefiting from a payee service where fees are obtained from VAF residents. It is also noted that this payee service prioritizes payments to the VAF prior to Veterans paying other debts owed.

- Professional boundaries/misconduct: Inappropriate use of conference rooms. A VAF Veteran sent a letter complaining that the Veteran Bible Study Class was cancelled so that a youth hockey association could meet. According to the Sharing Agreement, the facilities are only to use conference rooms for Veteran activities.

VA ACTION: The Acting Medical Center Director spoke with VAF Executive Director and clarified the requirements of the Sharing Agreement.

The Tomah VAMC has no authority to instruct or manage the VAF Program, however, the Acting Medical Center Director has an obligation, both professionally and ethically, to protect and care for our Veterans. The Acting Medical Center Director has put forward her best efforts to intervene and take appropriate steps to meet this obligation by terminating the agreement with VAF. Terminating the agreement was not a cavalier decision, and efforts have been made to rectify the barriers to care. The Acting Medical Center Director has assured that guidance and support is in place during this time to ensure all Veteran needs are being addressed. The Acting Medical Center Director has developed a plan of action, which makes sure that every Veteran's needs are met.

VA can assure that through the many mechanisms in place, any Veteran requesting assistance will receive all available resources and support. If you have any further questions or concerns, please do not hesitate to contact Mr. Saki Ververis at (202) 461-7126.