



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

October 28, 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-15-1544

Dear Ms. Lerner:

I am responding to your letter regarding allegations made by a whistleblower at the Jacksonville Department of Veterans Affairs (VA) Outpatient Clinic, in Jacksonville, Florida, operated by the North Florida/South Georgia Veterans Health System, Gainesville, Florida (the Medical Center). The whistleblower alleged that a social worker (SW) there improperly dispensed medications, improperly documented patients, and received gifts from a non-VA care center, and that these practices constitute a violation of law, VA directives, and a substantial and specific danger to public health. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary under 5 United States Code § 1213(d)(5).

The Interim Under Secretary for Health directed the Office of the Medical Inspector to assemble and lead a VA team to conduct an investigation. The report does not substantiate the first allegation, substantiated that the SW improperly documented one patient's care, but did not substantiate that this lapse endangered VA employees, was unable to substantiate the SW's receipt of a gift card, but did substantiate that her employment at a non-VA facility was in conflict with her official Government duties and responsibilities. The report makes 14 recommendations to the Medical Center and 2 recommendations to the Veterans Health Administration. We will send your office follow-up information describing actions that have been taken by the Medical Center and other entities to implement these recommendations.

Thank you for the opportunity to respond.

Sincerely,

A handwritten signature in black ink, appearing to read "R. Nabors II", written over a circular stamp or mark.

Robert L. Nabors II
Chief of Staff

Enclosure

**DEPARTMENT OF VETERANS AFFAIRS
Washington, DC**

**Report to the
Office of Special Counsel
OSC File Number DI-15-1544**

**Department of Veterans Affairs
North Florida/South Georgia Veterans Health System
Gainesville, Florida
Jacksonville Outpatient Clinic
Jacksonville, Florida**



Report Date: October 16, 2015

TRIM 2015-D-2157

Executive Summary

The Interim Under Secretary for Health (I/USH) requested that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the Jacksonville VA Outpatient Clinic (hereafter, the Clinic) in Jacksonville, Florida. The whistleblower, **Whistleblower** Licensed Clinical Social Worker (LCSW), who consented to the release of her name, alleged that employees are engaging in conduct that may constitute violations of laws, rules or regulations, and gross mismanagement, which may lead to a substantial and specific danger to public health. The VA team conducted a site visit to the Medical Center on May 11–14, 2015.

Specific Allegations of Ms. Charette

1. **Employee #1** dispensed medications to VA patients in violation of Veterans Health Administration (VHA) policy;
2. **Employee #1** failed to properly document a VA patient's mental state in agency treatment records, which endangered the safety of VA employees who visited the individual at his residence; and
3. **Employee #1** has received gifts from owners of private assisted living facilities, which appears to violate ethics regulations.

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

After careful review of findings, VA makes the following conclusions and recommendations.

Conclusions for Allegation 1

- VA **did not substantiate** that **Employee #1** dispensed medications, as defined by applicable Federal and state law, when she on occasion delivered medications to VA patients or merely filled a Mental Health Intensive Case Management (MHICM) patient's pill box with drugs already in the Veteran's possession. To determine whether these activities triggered other Federal or state laws on the proper handling of medications, including any controlled substances, additional investigation is warranted into the types of drugs involved.
- Although Social Workers (SW) in the MHICM are clinical SWs, there is no VHA policy or protocol that clearly specifies whether MHICM SWs are or are not expected to deliver medications or medication refills to their patients and/or fill pill boxes for

patients as part of their role in providing medication assistance. **Employee #1**
Scope of Practice did not address or include responsibilities related to patient medications.

- VA **did not substantiate** that MHICM SWs are charged with performing medication reconciliation with their patients in violation of VHA policy.
- The Medical Center started operating the Clinic's MHICM program without adequate staffing.
- The MHICM program currently has two SW vacancies, and therefore does not meet the MHICM team requirements.
- VA is concerned that transporting MHICM Veterans to the Clinic (out of their community environment) to obtain assistance with filling their pill boxes from the MHICM pharmacist may not be Veteran-centric, compliant with MHICM goals, or an efficient use of resources.

Recommendations to the Clinic

1. Prioritize recruitment efforts to fill current vacancies in the Clinic's MHICM program. Consider detailing additional staff to the Clinic's MHICM program until the vacancies can be filled.
2. Evaluate the decision to initiate the MHICM program at the Clinic without the full complement of employees required by directive, and take appropriate action.
3. Conduct an investigation to identify what drugs were transported and delivered to patients by **Employee #1** (and any other MHICM SWs) and placed, with the SWs' assistance, into the patients' pill boxes, focusing especially on whether any controlled substances were included. Confer with District Counsel or General Counsel, to determine whether, under the specific facts, those activities triggered and violated Federal law on the proper handling of controlled substances. If so, consider what, if any, action is warranted.
4. Evaluate the current practice of transporting MHICM Veterans to the Clinic for pill box refills. Determine if this practice is Veteran-centric, meets MHICM goals, and is cost and time efficient.

Recommendation to VHA

5. Provide clear guidance about the role of the MHICM SWs in terms of medication management assistance and define such term. This should include not only policy guidance but also clarification in their VA Scope of Practice.

Conclusions for Allegation 2

- VA **substantiates** that **Employee #1** did not properly document a VA patient's encounter in agency treatment records. This employee did not make a timely and accurate entry.
- VA **did not substantiate** that **Employee #1** delay in documentation endangered the safety of VA employees who visited Veteran 2 at his residence. Based on information documented in Veteran 2's electronic health record (EHR), there was no indication that the patient was an immediate danger to himself or others. Consequently, entering a patient record flag (PRF) in this patient's EHR on this basis was not indicated, required, or ethically appropriate.
- Several case managers and Peer Support Specialist (PSS) in the MHICM program are not compliant with timeliness of documentation requirements.
- Difficulties in writing timely notes may be related to the need to complete documentation on desktop computers in the Clinic, after a long day of providing service in the community.
- The Clinic's MHICM program is not compliant with Medical Center policy MSH 116-5, which requires monthly chart reviews.

Recommendations to the Clinic

6. Provide additional training to staff about compliance with documentation accuracy and timeliness requirements. Assess for compliance and take appropriate educational, administrative, and disciplinary action to address any identified cases of non-compliance.
7. Provide training to the Clinic's MHICM staff about document review requirements. Provide any needed assistance in setting up a process for employees to complete periodic reviews on a monthly basis. Once training is completed and the process established, monitor for compliance and take appropriate educational, administrative, and disciplinary action to address any identified cases of non-compliance.
8. Consider technology solutions to facilitate more timely documentation by the MHICM SWs and PSSs, e.g. laptops or tablets that they could carry with them on home visits.
9. Conduct a review of prior MHICM records and record review reports. If multiple additional examples of non-compliance with the timeliness of entries are found and were not reported in quality reviews, take appropriate educational, administrative, or disciplinary actions.

10. Consider providing additional onsite supervisory support for the Clinic's MHICM program.
11. Consider providing **Employee #1** the MHICM team leader, a mentor and additional leadership training.

Conclusions for Allegation 3

- VA was not able to substantiate that **Employee #1** accepted a gift card from a non-VA facility representative.
- VA did not substantiate that the lunches provided by the representative violated the Standards of Ethical Conduct for Employees of the Executive Branch as they were de minimis. However, the acceptance of such otherwise permissible gifts on a frequent basis could lead a reasonable person to believe that employees are using their public office for private gain.
- Modest items of refreshment not offered as part of a meal, such as brownies, would be excluded from the definition of a "gift" for the purposes of the gift prohibitions of the Standards of Ethical Conduct. Items of nominal monetary value such as pens fall within the de minimis exception to these gifts.
- The MHICM program lacks policy and procedures on how the field should make referrals to non-VA facilities for medically necessary inpatient evaluations for possible admission/inpatient placement. By referring a consenting Veteran to a single particular inpatient facility for a voluntary inpatient mental health evaluation where that particular facility was not the only one which could clinically treat the Veteran and this fact was not explained to the Veteran, the MHICM team, including **Employee #1** would have endorsed that commercial enterprise in violation of 5 C.F.R. § 2635.702(c).
- **Employee #1** exercise of discretion and professional judgment in making referrals to River Point Behavioral Health while also being employed there potentially results in violation of the criminal conflict of interest law at 18 U.S.C § 208. Specifically, her recommended referral to River Point would directly and predictably positively impact the financial interests of her outside employer. Conversely, her referrals to River Point's competitors would negatively impact her outside employer's financial interest, which would still ostensibly constitute a technical violation of the financial conflict of interest law.

Recommendations to the Clinic

12. Provide additional training about the Standards of Ethical Conduct, with special emphasis on principals related to accepting gifts and avoiding the appearance of violating ethical standards. Monitor compliance and address non-compliance with appropriate educational, administrative, or disciplinary action.

13. Consider a written standard policy notifying all vendors who do business with the Clinic to refrain from distributing items of nominal monetary value. This notification should be in writing and provided to all employees.
14. Conduct a random but statistically significant review of referrals made under the MHICM program to see if, under the individual facts of each case, any of the referrals constituted an endorsement of the particular commercial enterprise in violation of 5 C.F.R. § 2635.702(c). (We recognize that in some cases only one entity may have been available, appropriate, and/or capable of providing the needed services).
15. Determine what, if any, administrative or disciplinary action is warranted in view of **Employee #1** referrals to River Point Behavioral Health while also being employed there, which potentially violated 18 U.S.C. § 208.

Recommendation to VHA:

16. Consider establishing a policy or procedures to guide the MHICM staff in the field when making patient referrals to community hospitals or resources. See e.g., VHA Handbook 1140.5, Community Hospice Care: Referral and Purchase Procedures; VHA Directive 2011-034, Homeless Veterans Legal Referral Process, etc.

Summary Statement

VA has developed this report in consultation with other VHA and VA offices to address OSC's concerns that the Clinic may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, the Office of General Counsel (OGC) has provided a legal review, and the Office of Accountability Review (OAR) has examined the issues from a human resources (HR) perspective to establish accountability, when appropriate, for improper personnel practices. VA did find a violation of the criminal conflict of interest law, 18 U.S.C. § 208, which allegations the IG declined to prosecute, and VA also found violations of VA and VHA policy.

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I. Introduction

The I/USH requested that OMI assemble and lead a VA team to investigate allegations lodged with OSC concerning the Clinic. Whistleblower alleged that employees are engaging in conduct that may constitute violations of laws, rules or regulations, and gross mismanagement, which may lead to a substantial and specific danger to public health. The VA team conducted a site visit to the Medical Center on May 11–14, 2015.

II. Facility Profile

The Clinic provides a broad range of general and specialized medical, dental, surgical, psychiatric, nursing, and ancillary services with state-of-the-art technology and specialty services including diagnostic radiology, computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), and nuclear medicine, laboratory facilities, women's health services including mammography, mental health, telehealth, and audiology. The Clinic also provides pharmacy services. In the future, the ambulatory surgery center will be operational in this clinic. During fiscal year (FY) 2013, the clinic saw 32,007 unique patients for a total of 266,350 visits, and in FY 2014, 38,190 unique patients for a total of 309,194 visits.

The Clinic's parent facility is the North Florida/South Georgia Veterans Health System (hereafter, the Medical Center), part of Veterans Integrated Service Network (VISN) 8. Procedures or specialty care not provided by the Clinic or Veterans requiring hospitalization are assessed, stabilized, and transferred to either local facilities or to the Gainesville or Lake City VA Medical Centers, according to the urgency of their needs.

III. Specific Allegations of the Whistleblower

1. Employee #1 dispensed medications to VA patients in violation of Veterans Health Administration (VHA) policy;
2. Employee #1 failed to properly document a VA patient's mental state in agency treatment records, which endangered the safety of VA employees who visited the individual at his residence; and
3. Employee #1 has received gifts from owners of private assisted living facilities, which appears to violate ethics regulations.

IV. Conduct of Investigation

The VA team conducting the investigation included Team Member #1 Deputy Medical Inspector, and Team Member #2 Registered Nurse (RN), Clinical Program Manager, both of OMI; Team Member #3 LCSW, Fisher House & Family Hospitality Program Manager, representing the Social Work National Program Office, Team Member #4 RN, MBA, Health Care Ethicist, National Center for Ethics in Health Care, and Team Member #5 HR Specialist, representing OAR. VA reviewed relevant

policies, procedures, professional standards, reports, memorandums, and other documents listed in Attachment A. We toured the Clinic's MHICM clinic area, and held entrance and exit briefings with Medical Center leadership.

VA initially interviewed the whistleblower via teleconference on May 8, 2015, and again during the site visit. We also interviewed the following Medical Center employees:

- **Associate Chief** MD, Associate Chief, Geriatric Evaluation Center; Chair, Biomedical Ethics
- **Acting Chief** SW, Acting Chief Mental Health Service Line and Chief, Social Work Service
- **Service Chief** SW, Chief MHICM and Chief, Psychosocial Rehabilitation and Recovery Program (oversight service for the PSS) for the Medical Center
- **Service Chief** PharmD, Chief Pharmacy
- **Employee #2** Compliance Business Integrity
- **Employee #3** RN, Non-VA Care Coordination Supervisor
- **Employee #4** RN Non-VA Care Coordination
- **Employee #5** HUD-VASH Program Manager
- **Employee** Mental Health Clinic Clerk
- **Employee #7** Mental Health Clinic Clerk
- **Employee #1** Lead SW, MHICM Coordinator
- **Employee #8** ARNP, MHICM
- **Employee #9** PharmD, Clinical Pharmacist
- **Employee #10** SW, formerly assigned to the Jacksonville MHICM
- **Employee #11** PSS, MHICM
- **Employee #12** PSS, MHICM
- **Company #1** Wekiva Springs and River Point Behavioral Health representative (interacts with the Clinic)
- **Company #2** owner Autumn Village Assisted Living Facility

V. Findings, Conclusions, and Recommendations

SW and MHICM Background

According to the National Association for Social Workers, "SWs help individuals, families, and groups restore or enhance their capacity for social functioning, and work to create societal conditions that support communities in need."¹ Clinical SWs also diagnose and treat mental, behavioral, and emotional issues. Some clinical SWs are directly involved in mental health care and recovery of their assigned patients. According to the National Consensus Statement on Mental Health Recovery, "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of the person's choice

¹ National Association of Social Workers.
(<https://www.socialworkers.org/pressroom/features/general/profession.asp>)

while striving to achieve full potential.”² However, those with severe mental illness require more intensive treatment and care management to remain in the community.

Severe mental illness, primarily psychosis, is a major problem among VHA’s patient population.³ The clinical literature suggests that approximately 20 percent of people with severe mental illness are in need of intensive community case management services.⁴ State managed agencies provide Assertive Community Treatment (ACT), a case management approach for severely mentally ill patients that includes a multidisciplinary approach to ambulatory in-home care. VHA offers the VHA Mental Health Intensive Case Management (MHICM) program, which is comparable to state managed ACT programs.

The mission of the MHICM program is to improve the level of functioning and quality of life for Veterans with serious and persistent mental illness, helping them develop the skills and support necessary to live successful and personally satisfying lives in the community. Enrollment in the MHICM program is voluntary and the patient can decline further treatment from the program at any time. MHICM programs are intended to provide necessary treatment and support for Veterans who meet all of the following five criteria:

- **Diagnosis of Severe and Persistent Mental Illness.** Diagnosis of severe and persistent mental illness includes, but is not limited to: schizophrenia, bipolar disorder, major affective disorder, or severe PTSD. Mild to moderate organicity may coexist.⁵ Although the Veteran may have a co-occurring alcohol or substance abuse diagnosis, this is not the primary problem for which treatment is required.
- **Severe Functional Impairment.** Severe functional impairment is such that the Veteran is neither currently capable of successful and stable self-maintenance in a community living situation (e.g., hospitalized or homeless), nor able to participate in necessary treatments without intensive support.
- **Inadequately Served.** The Veteran is inadequately served by conventional clinic-based outpatient treatment or day treatment.
- **High Hospital Use.** High hospital use as evidenced during the past year by over 30 days of psychiatric hospital care, or three or more episodes of psychiatric hospitalization.
- **Clinically Appropriate for Outpatient Status.** Patients who are more appropriately managed clinically as inpatients need to remain in the inpatient setting.⁶

² The National Consensus Statement on Mental Health Recovery. <http://mentalhealth.samhsa.gov>

³ VHA Directive 2006-004, VHA Mental Health Case Management (MHICM). January 30, 2006.

⁴ Ibid

⁵ Organicity in Reference to psychology/psychiatry Means that a mental disorder May likely have a Known biological cause

⁶ VHA Directive 2006-004, VHA Mental Health Intensive Case Management (MHICM). January 30, 2006.

The MHICM program provides case management for patients in need of intensive mental health care. Case management is a specialized and highly-skilled component of care management, and emphasizes a collaborative process that assesses, advocates, plans, implements, coordinates, monitors, and evaluates health care options and services so that they meet the needs of the individual patient. These services are provided to individuals who require a higher level of care management services, intensive support, and monitoring due to complex medical, mental health, or psychosocial factors beyond the services offered by the care management team. Case management may be short-term or long-term and is based on the patient's clinical needs, with interventions occurring at the Veteran, family, or caregiver levels. It is intended to maximize resource utilization and promote quality Veteran-centric care while producing cost effective outcomes.⁷

According to the Uniform Mental Health Services in VA Medical Centers and Clinics, MHICM programs must be available in all facilities with more than 1,500 patients on the Serious Mental Illness Research and Evaluation Center psychosis registry. These MHICM teams must provide the majority of their services in a community setting, frequently in the Veteran's home, with an average of two to three contacts per patient per week.⁸ The MHICM SW's role is to provide case management to patients and their families who are experiencing emotional, social, or economic problems of a serious or complex nature. These patients are seen for management of mental health care due to de-compensation of their mental status, psychosis, suicidal ideation, homicidal ideation, noncompliance with medication/treatment plan, and medication side effects.⁹ MHICM team members deliver medication refills to MHICM Veterans during their home visit; they also transport Veterans to and from their health care appointments, grocery shopping, planned outings, and to visit potential residences and assisted living facilities (ALF).

Allegation 1: Employee #1 dispensed medications to VA patients in violation of Veterans Health Administration (VHA) policy.

The whistleblower alleged that by filling a MHICM patient's (Veteran 1) pill box, Employee #1 was dispensing medications to a VA patient in violation of VHA policy. She also alleged that SWs are charged with performing medication reconciliation with their patients in violation of VHA policy.

Additional Background

VHA Handbook 1108.05 *Outpatient Pharmacy Services*, states in paragraph 3 that VA must follow all applicable Federal and state laws (where adopted) and regulations concerning the dispensing of medications to outpatients. Medical Center Memorandum (MCM) No. 119-28, *Preparation and Dispensing of Medication*, states that a pharmacist

⁷ VHA Handbook 1110.04, *Case Management Standards of Practice*. May 20, 2013.

⁸ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*. September 11, 2008.

⁹ Ibid

is the only professional who may dispense medication to patients.¹⁰ In addition, MCM No. 119-28 provides that dispensing also involves the appropriate labeling of medications by a pharmacist in a standardized format with a computer-generated label that includes patient, drug and clinic information.

Under the Food, Drug and Cosmetic Act (FDCA), 21 U.S.C. 301, et seq., the term "dispense to patients" means the act of delivering a prescription drug product to a patient or an agent of the patient either: (1) by a licensed practitioner or an agent of a licensed practitioner, either directly or indirectly, for self-administration by the patient or the patient's agent; or (2) by an authorized dispenser or an agent of an authorized dispenser under a lawful prescription of a licensed practitioner. See 21 C.F.R. 208.3(b)(1) and (2). Under this definition, an individual serving as an agent of a pharmacist dispenser may deliver medications, either directly or indirectly, to the patient for self-administration.

The Controlled Substances Act also defines the term "dispense" in 21 U.S.C. 802(10), which states:

(10) The term "dispense" means to deliver a controlled substance to an ultimate user or research subject by, or pursuant to the lawful order of, a practitioner, including the prescribing and administering of a controlled substance and the packaging, labeling or compounding necessary to prepare the substance for such delivery. The term "dispenser" means a practitioner who so delivers a controlled substance to an ultimate user or research subject.

The act of dispensing, therefore, concludes when possession of the controlled substance is delivered to the patient. Per VA policy, additional restrictions are imposed on the dispensing of controlled substances on an outpatient basis. See VHA Handbook 1108.01, Controlled Substances (Pharmacy Stock), at paragraph 15.m. and n., which provides:

m. Pharmacy Service must verify the identity of the person picking up the outpatient controlled substance prescription for outpatients or patients leaving the medical facility, and must require the signature of such person or their agent.

n. All outpatient prescriptions for controlled substances not picked up at the outpatient window must be returned to stock or mailed to the patient ensuring strict accountability. Pharmacy Service must maintain documentation to identify the disposition (whether mailed, dispensed at the pharmacy window, or returned to stock) of these prescriptions.

According to current Florida law governing the pharmacy profession, the term "dispense" means:

¹⁰ North Florida/South Georgia Memorandum No. 119-28, Change 3, Preparation and Dispensing of Medication. February 1, 2013.

the transfer of possession of one or more doses of medicinal drug by a pharmacist to the ultimate consumer or her or his agent. As an element of dispensing, the pharmacist shall, prior to the actual physical transfer, interpret and assess the prescription order for potential adverse reactions, interactions and dosage regimen she or he deems appropriate in the exercise of her or his professional judgment, and the pharmacist shall certify that the medicinal drug called for by the prescription is ready for transfer. The pharmacist shall also provide counseling on proper drug usage, either orally or in writing, if in the exercise of her or his professional judgment, counseling is necessary. The actual sales transaction and delivery of such drug shall not be considered dispensing.¹¹

Under the Florida definition, "dispensing" and "delivery" are distinct acts, with the actual physical transfer of the medication into the patient's possession constituting "delivery" of medication, not "dispensing."

The investigation found that the SW on occasion delivered medications or medication refills to the Veteran, as well as assisted with putting medications previously delivered to the Veteran into the Veteran's reminder pill box. Provided it was within her VA scope of practice as part of the MHICM team, the physical delivery of medications to the Veteran would be permissible under the above Federal and state laws, since the SW would have functioned as an agent of the pharmacist dispenser. Further, the activities involved with dispensing necessarily were completed upon physical delivery of the medications to the Veteran. In instances where **Employee #1** assisted the Veteran in filling the pill box with medications previously delivered to and in the Veteran's possession, there was no "dispensing" as defined under the FDCA, CSA or Florida law. The issue with both activities is more properly framed in terms of whether such an activity is sanctioned under the MHICM program and within her VA scope of practice.

Without knowing what medications, including any controlled substances, the SW delivered to Veteran 1, we cannot say whether other Federal law on the handling of controlled substances may have been triggered, when applied to specific facts.

On the other subject of medication reconciliation, per *paragraph 2.d.(8) of VHA Directive 2011-012, Medication Reconciliation*, medication reconciliation is defined as:

a process to ensure maintenance of accurate, safe, effective, and patient centered medication information by:

- a) Obtaining medication information from the patient, caregiver, or family members.
- b) Comparing the information obtained from the patient, caregiver, or family member to the medication information available in the VA electronic medical record, including active medications, recently expired medications,

¹¹ F.S.A. § 465.003(6).

- medications given at other VA facilities (via remote data view), and non-VA medications, in order to identify and address discrepancies.
- c) Assembling and documenting the medication information in the VA electronic medical record.
 - d) Communicating with and providing education to the patient, caregiver, or family members regarding updated medication information.
 - e) Communicating relevant medication information to and between the appropriate members of the VA and non-VA health care team.”¹²

This Directive states that VA providers are to conduct this clinical task. For purposes of the Directive, VA providers are defined at paragraph 2.d.(16) as:

physicians, medical trainees, advanced practice nurses, physician assistants, and other health care professionals who provide primary care or specialty care within the limitations of their individual VA privileges or scopes of practice.

Findings

The Jacksonville, Florida, MHICM team is allotted a 0.2 Full Time Equivalent Employee (FTEE) psychiatrist, one FTEE for a lead SW, two FTEEs for non-lead SW case managers, one FTEE for an advanced practice nurse case manager (APRN), two FTEEs for peer support specialist, and the availability of a pharmacist as needed.¹³ In 2010, the Clinic initiated the MHICM program at the Clinic, Employee #1 was hired as the team lead SW for the program. Due to issues with resource limitations from 2010 through July 2012, no other MHICM staff members were hired, and Employee #1 performed most of the functions of the program alone. Employee #1 stated that during this time she helped her MHICM patients’ fill their pill boxes, including those for Veteran 1. She also indicated that she sometimes picked up the medications or refills at the facility and delivered them to the patient. Thus, her assistance with the pill box would at times involve medications she had delivered personally to the patient.

At the time, Veteran 1 was a 54-year-old male with a history of PTSD, schizoaffective disorder, hypertension, diabetes, obstructive sleep apnea disorder with severe decompensation requiring continuous positive airway pressure while asleep, and severe day time somnolence. He had been hospitalized (voluntarily and involuntarily) on numerous occasions since 2001 for evaluation and treatment of psychiatric issues. Employee #1 began managing Veteran 1’s case in November 2010. The Veteran previously was not compliant with his medication regimen and was having difficulty filling his pill box because of impaired coordination. He also fell asleep frequently while

¹² VHA Directive 2011-012, *Medication Reconciliation*. March 9, 2011. (http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2390)

¹³ Peer Support Specialist (PSS): A PSS is a person with a mental health and/or co-occurring condition, who has been trained and certified to help others with these conditions, identify and achieve specific life and recovery goals. See VHA Handbook 1163.05, *Psychological Rehabilitation and Recovery Services Peer Support* (July 1, 2011) and <http://www.gpo.gov/fdsys/pkg/PLAW-110publ387/content-detail.html>. A PSS is a current or previous consumer of mental health and/or substance use disorder services who is hired to provide peer support services to others engaged in mental health treatment. (<http://www.vacareers.va.gov/peer-to-peer/>).

attempting to fill his pill box. She documented that on some occasions she assisted the Veteran with pill box filling by taking them from a larger box in which he stored his previously obtained medications and placing them in his smaller reminder pill box. She stated that in her previous non-VA position as a SW in the Florida ACT program she frequently filled her patients' pill boxes using drugs already in their possession in this same manner. VA contacted the State of Florida Surgeon General's Office to inquire if they had a written policy describing this function, and they were unable to provide anything in writing. On other occasions, she assisted in filling the Veteran's pill box with medications or refills that she picked up and delivered to him.

The whistleblower was hired as SW case manager in the Clinic's MHICM program in July 2012. As part of her orientation, she conducted home visits with Employee #1 to the home of Veteran 1. During the visit the whistleblower alleges she witnessed Employee #1 filling the Veteran's pill boxes without referring to a current list of medications to verify which medications dosages and frequencies he had been prescribed. Employee #1 stated that she did bring the most recent list of the patient's prescribed medications and referred to that list when filling the patient's pill box. We interviewed other staff members who also witnessed Employee #1 filling pill boxes, but none could recollect with certainty if Employee #1 did or did not refer to a list of medications while doing so. Some of them did indicate that Employee #1 appeared to "know what she was doing," and voiced concern about performing this function if they had to cover for Employee #1.

On November 7, 2012, the whistleblower voiced her concern about SWs filling pill boxes to Employee #1 supervisor, who instructed Employee #1 to stop the practice immediately. In December 2012, the Medical Center changed the pill box filling procedure. The revised procedure states that if an APRN is not available to perform a home visit and the patient is unable to fill his or her own pill boxes in the community environment, as the ability to function successfully in the community is a goal of the MHICM program, the MHICM program staff will transport the Veteran to and from the MHICM pharmacist at the Clinic who would review the medications with the patient and fill the pill boxes.¹⁴

By early 2013, the MHICM program team staff vacancies were filled and the APRN was assigned to patients who needed assistance with their pill boxes. The APRN position again became vacant in December 2013, at which time interviewees reported they assumed that Employee #1 began filling pill boxes again based on the rapidity with which she conducted her visits. Currently, the Clinic's MHICM program has two SW vacancies; the current APRN was hired in February 2015.

Neither VHA Handbook 1110.04, *Case Management Standards of Practice*, nor VHA Handbook 1110.02, *Social Work Professional Practice*, specifically addresses whether MHICM SWs are authorized or expected to fill pill boxes for patients having difficulty performing that task. We were unable to find a policy or protocol that provides guidance

¹⁴ See VHA Directive 2008-020, Patient Transportation Program (where this type of activity by certain staff is authorized as an incidental duty).

on whether MHICM SWs are authorized to assist Veterans in filling their reminder pill boxes with medications already in their possession. Nor does the policy address whether such SWs are to deliver medications to their MHICM patients. With respect to **Employee #1** her VA Scope of Practice is silent on whether her role includes medication assistance (and how that term would be defined).

With regards to the allegation that MHICM SWs are charged with performing medication reconciliation with patients, the whistleblower and the other SWs who were interviewed told the investigation team that they do not assemble and document information about a Veteran's medications in the EHR, provide updated medication information to the Veteran or caregiver, or communicate medication information to and between members of the VA and non-VA health care teams.

Conclusions

- **VA did not substantiate** that **Employee #1** engaged in "dispensing" medications, as defined by applicable Federal and state laws, when she delivered medications to VA patients or assisted with filling the patient's pill box with medications already in the Veteran's possession. These activities could fairly be considered to be in furtherance of VA program goals (in the areas of patient education, particularly on the need for patient compliance with his drug regimen). However, to determine whether these activities, as performed by **Employee #1** may have triggered and violated other Federal law on the proper handling of controlled substances, additional investigation is warranted into the types of medications she delivered or put into the patient's pill box.
- Although SWs in the MHICM are clinical SWs, there is no VHA policy or protocol that clearly specifies whether MHICM SWs are or are not expected to deliver medications to their MHICM patients or to assist such patients with filling their pill boxes as part of their role in providing medication assistance. MHICM SWs must act only within their VA Scope of Practice. **Employee #1** individual Scope of Practice does not address medication assistance.
- **VA did not substantiate** that MHICM SWs are charged with performing medication reconciliation (as that term is defined by VHA policy) with their patients.
- The Medical Center started operating the Clinic's MHICM program without adequate staffing.
- The MHICM program currently has two SW vacancies, and therefore does not meet the MHICM team requirements.
- VA is concerned that transporting MHICM Veterans to the Clinic (out of their community environment) to obtain assistance with filling their pill boxes from the MHICM pharmacist may not be Veteran-centric, compliant with MHICM goals, or an efficient use of resources.

Recommendations to the Clinic

1. Prioritize recruitment efforts to fill current vacancies in the Clinic's MHICM program. Consider detailing additional staff to the Clinic's MHICM program until the vacancies can be filled.
2. Evaluate the decision to initiate the MHICM program at the Clinic without the full complement of employees required by directive, and take appropriate action.
3. Conduct an investigation to identify what drugs were transported and delivered personally to patients by **Employee #1** (and any other MHICM SW who did the same). Particular focus should be on whether those activities included delivery or possible repackaging of any controlled substances. Confer with District Counsel or General Counsel, to determine whether these activities, as performed by **Employee #1** triggered and violated Federal law on the proper handling of controlled substances. If so, consider what, if any, action is warranted.
4. Evaluate the current practice of transporting MHICM Veterans to the Clinic for pill box refills. Determine if this practice is Veteran-centric, meets MHICM goals, and is cost and time efficient.

Recommendation to VHA

5. Provide clear guidance about the role of the MHICM SWs in terms of medication management assistance and define such term. This should include not only policy guidance but also clarification in their VA Scope of Practice.

Allegation 2: **Employee #1 failed to properly document a VA patient's mental state in agency treatment records, which endangered the safety of VA employees who visited the individual at his residence.**

Whistleblower raised a concern that **Employee #1** failed to properly document a change in Veteran 2's condition, thereby endangering the safety of other members of the health care team. According to the whistleblower, Veteran 2 scheduled a medical appointment on April 25, 2014. Per the local protocols, patients must be contacted prior to a visit from the MHICM team members, and must give their permission for the MHICM team to conduct a visit. The whistleblower stated the PSS contacted Veteran 2 on Thursday, April 24, 2014, via telephone, to remind him of his upcoming appointment and scheduled pick-up by the MICHM team for the following day. On April 25, the whistleblower and a PSS arrived at the home of Veteran 2 to transport him to his scheduled appointment, but the patient was not at home and was not reachable by phone. **Whistleblower** reported that on April 30, she and a PSS notified **Employee #1** that they had not been able to reach Veteran 2 and **Employee #1** stated she had no contact with the Veteran and suggested that the whistleblower and the PSS go to the Veteran's home to check on him.

The whistleblower reported being upset a month later, when she saw a late entry note for April 28, in which Employee #1 assessed Veteran 2's thoughts as disorganized with delusional content and his behavior as agitated and paranoid. The whistleblower reported she felt that a patient record flag (PRF) should have been placed on the Veteran's record and she and the PSS had been placed at risk when they visited Veteran 2's home for the wellness check on April 30.

Additional Background

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history, including past and present illnesses, examinations, tests, treatments, and outcomes.¹⁵ As explained in paragraph 13 of VHA Handbook 1110.04, Case Management Standards of Practice:

Documentation is a key means of communication among interdisciplinary team members. Documentation contributes to a better understanding of a Veteran and his or her family/caregiver's unique needs and allows for interdisciplinary service delivery to address those needs while reflecting the accountability and involvement of the [Case Manager] in Veteran care.¹⁶

As described in para. 13.a. and b. of this same Handbook, information about any significant interactions with patients, care provided, changes to the treatment plan and its effect, as well as changes in the patient's condition must also be documented in the EHR. This must be done within the timeframes delineated by facility policy.

Consistent with the requirements of section 3102(1) of title 44, U.S.C. to provide for effective controls over the creation and over the maintenance and use of records in the conduct of current business, VHA Handbook 1907.01, para. 2, requires the field to:

maintain complete, accurate, timely, clinically-pertinent, and readily-accessible patient health records, which contain sufficient recorded information to serve as a basis to plan patient care, support diagnoses, warrant treatment, measure outcomes, support education, research, and facilitate performance improvement processes and legal requirements.¹⁷

Case management documentation should include a comprehensive baseline case management assessment, periodic reassessments, plan of care, and information about any significant interactions with Veterans (whether by telephone or in person). If a Veteran's condition warrants a change in the level of case management intensity, that documentation must occur in the EHR.

According to VHA Handbook 1907.01, *Health Information Management and Health Records*, para. 16.a.(2): "Health record completion and delinquency policies must be

¹⁵ VHA Handbook 1907.01, *Health Information Management and Health Records*. March 19, 2015.

¹⁶ VHA Handbook 1110.04, *Case Management Standards of Practice*. May 20, 2013.

¹⁷ VHA Handbook 1907.01, *Health Information Management and Health Records*. March 19, 2015.

developed and must be consistent with accreditation standards, regulatory requirements, and medical staff guidelines".¹⁸ According to the Medical Center's local policy, MHS 116-4, *Documentation by Mental Health Professionals*, documentation of ongoing MHICM care, including progress notes, telephone notes and no-show notes, must be completed within 24 hours of the encounter.¹⁹

Pursuant to VHA Directive 2010-053, *Patient Record Flags* (PRF), PRFs are to be used to alert VHA medical staff and employees to patients whose behavior, medical status, or characteristics may pose an immediate threat either to their own safety, the safety of other patients or employees, or compromise the delivery of safe health care in the initial moments of patient encounter. PRFs are displayed during the patient look-up process. The Directive limits their use to immediate clinical safety issues and further defines the proper and prohibited uses of PRFs.

PRF software provides users with the ability to create, assign, deactivate, edit, produce reports, and view patient record flag alerts. VHA has designated two categories of PRFs, Category I (national) and Category II (local) flags. Category I PRFs are nationally approved and distributed for implementation by all facilities. Individual Veterans Integrated Service Networks (VISN) or facilities approve Category II PRFs; they are not shared between facilities.

Each PRF includes a narrative that describes the reason for the flag and may include some suggested actions for users to take when they encounter the patient. Other information displayed to the user includes the Flag Type, Flag Category, Assignment Status, Initial Assignment Date, Approved by, Next Review Date, Owner Site, and Originating Site. When assigning a flag, authorized users must write a progress note that clinically justifies each flag assignment action. For ethical reasons, it is inappropriate to use a PRF in the absence of a clear risk to safety.²⁰

The Medical Center's MHS 116-4, *Documentation by Mental Health Professionals*, October 1, 2014, requires record reviews to assess compliance with documentation standards. Mental Health direct care staff members are responsible for reviewing and complying with documentation requirements and assisting in record review activities. Supervisors are responsible for ensuring adherence with documentation requirements and providing feedback to staff. The Mental Health Service Line Section Chiefs are responsible for monitoring compliance with documentation requirements, and disseminating results of record reviews with supervisory staff. The Mental Health Service Line Quality Improvement Committee is responsible for review of records to assess compliance with mandates and dissemination of results to the Section Chiefs.²¹ This policy describes the procedures for monitoring documentation compliance; these procedures include a monthly chart review, and a report of findings to the Mental Health Executive Committee through the Mental Health Quality Improvement committee.

¹⁸ Ibid

¹⁹ North Florida/South Georgia MHS 116-4, *Documentation by Mental Health Professionals*. October 1, 2014.

²⁰ VHA Directive 2010-053, *Patient Record Flags*. December 3, 2010.

²¹ Ibid

These findings are also given to the Service Chiefs or Program Manager for appropriate action within 2 weeks.

Findings

At the time of the cited event, Veteran 2 was a 57-year-old male with a long history of paranoid schizophrenia with baseline intermittent delusional periods, and both cocaine and cannabis abuse. Our review of the EHR revealed that on January 27, 2014, the Veteran's fiduciary contacted Employee #1 following the Veteran's most recent hospitalization in a non-VA psychiatric facility and expressed concerns about his mental status, including increased delusional thinking, increased mood liability/agitation, repeated calls to 911, and conflicts with neighbors. Employee #1 contacted the Veteran's assigned psychiatrist, who agreed that the Veteran should be assessed for possible assignment to the MHICM program. On February 5, 2014, upon completion of Veteran 2's assessment, he agreed to participate in the MHICM program. Employee #1 and both PSSs visited and followed up with Veteran 2 until April 11, 2014, at which time Employee #1 informed the Veteran that he would be assigned a different case manager. During this 2-month period, both Employee #1 and the PSS documented the Veteran as delusional on multiple occasions.

On April 18, the whistleblower visited the Veteran at his home, and assessed him as oriented, with a normal mood and responding and behaving appropriately. During this visit, the Veteran acknowledged his upcoming appointments at the Clinic on April 25, and agreed to being transported to and from these appointments by the case manager and PSS. On Friday, April 25, as scheduled, the PSS arrived at the Veteran's home to transport him to his appointments, but the Veteran did not answer the door or telephone calls. On Monday, April 28, and Tuesday, April 29, the PSS attempted to contact the Veteran without success. On April 30, the whistleblower and the PSS attempted to reach the Veteran without success; the whistleblower documented this information in a note in the Veteran's medical record 2 days later on May 2. The PSS notified Employee #1 that they had been unable to reach the Veteran and Employee #1 gave her approval for the whistleblower and the PSS to conduct a wellness check; there is no indication in this note that Employee #1 had spoken with the Veteran recently. During the wellness check, they were unable to locate the Veteran, whose landlord informed them that he sees the Veteran every day and did not notice anything unusual. He agreed to pass on to the Veteran that VA staff members were looking for him. On April 30, Employee #1 entered a late entry "admission note" describing the MHICM program plan. The whistleblower continued to attempt to reach the Veteran without success. On May 9, she documented that she was aware that the Veteran had "phoned Employee #1 last week and spoke for a prolonged period of time." This note does not identify the exact date during the week of Monday, April 28 through Friday, May 2 that Employee #1 spoke with the Veteran.

On May 27, 2014, Employee #1 documented that she spoke with the Veteran on April 28, at which time he informed her that he no longer wanted any services from the MHICM program. According to the note, the Veteran's thoughts appeared disorganized

with delusional content and he appeared paranoid and agitated. Employee #1 reported that this encounter was very similar to the multiple prior encounters she had with him. The note does not indicate any concern that the Veteran was an immediate threat to himself or others, and a PRF was not indicated. Later the same day, Employee #1 added an addendum to the May 27 note, restating that she "spoke with the Veteran by phone on 4/28/15." During interview, Employee #1 stated that she did not speak with the Veteran prior to giving the whistleblower and the PSS approval to do a wellness check on April 30, but that she spoke to the Veteran on either May 1 or 2, and the date of the April 28 was erroneous. Her work calendar indicates that on May 2, 2014, she spoke with the Veteran, at which time the Veteran refused any further services from MHICM. The Medical Center's landline phone records do not reflect a call to or from the Veteran's phone number from April 28 through May 2, 2014. The Case Managers also use facility-issued mobile phones, and at times, their personal mobile phones, to speak with patients. Because the Medical Center was unable to access the mobile phone records for Employee #1 phone, we were unable to verify when the call between Employee #1 and Veteran 2 had occurred. The MHICM program discharged the Veteran on June 2, 2014, based on his request to disengage and his refusal to return calls by MHICM staff.

While reviewing the Veteran's medical record, VA noted numerous notes that other case managers and PSSs in the MHICM program had entered more than 24 hours after the encounter with the patient. None of the interviewed MHICM employees were able to articulate the requirement for document reviews, and did not recall being involved in any record review activities, or receiving any feedback about record reviews done for the MHICM program.

The Chief, MHICM, who is the supervisor for both the Medical Center's and the Clinic's MHICM employees, is located in Gainesville at the Medical Center. She informed the VA team that she conducts periodic chart reviews of MHICM notes for the Clinic but does not record her findings in writing. She did not recall uncovering any significant documentation issues while reviewing records. She also stated that on a biannual basis, at the time of reporting to the Medical Center, she assigns staff to conduct chart reviews and compiles a report describing the findings of these reviews. She also reported that the Clinic's MHICM staff employees have not conducted chart reviews for over 4 years.

Conclusions

- VA **substantiates** that Employee #1 did not properly document a VA patient's encounter in agency treatment records. This employee did not make a timely and accurate entry as identified above.
- VA **did not substantiate** that Employee #1 delay in documentation endangered the safety of VA employees who visited Veteran 2 at his residence. Based on information documented in Veteran 2's EHR, there was no indication that the patient

was an immediate danger to himself or others. Consequently, entering a PRF in this patient's EHR was not indicated, required, or ethically appropriate.

- Several case managers and PSS in the MHICM program are not compliant with timeliness of documentation requirements.
- Difficulties in writing timely notes may be related to the need to complete documentation on desktop computers in the Clinic, after a long day of providing service in the community.
- The Clinic's MHICM program is not compliant with Medical Center policy MSH 116-5, which requires monthly chart reviews.

Recommendations to the Clinic

6. Provide additional training to staff about compliance with documentation accuracy and timeliness requirements. Assess for compliance and take appropriate educational, administrative, and disciplinary action to address any identified cases of non-compliance.
7. Provide training to the Clinic's MHICM staff about document review requirements. Provide any needed assistance in setting up a process for employees to complete periodic reviews on a monthly basis. Once training is completed and the process established, monitor for compliance and take appropriate educational, administrative, and disciplinary action to address any identified cases of non-compliance.
8. Consider technology solutions to facilitate more timely documentation by the MHICM SWs and PSSs, e.g. laptops or tablets that they could carry with them on home visits.
9. Conduct a review of prior MHICM records and record review reports. If multiple additional examples of non-compliance with the timeliness of entries are found and were not reported in quality reviews, take appropriate educational, administrative, or disciplinary actions.
10. Consider providing additional onsite supervisory support for the Clinic's MHICM program.
11. Consider providing **Employee #1** the MHICM team leader, a mentor and additional leadership training.

Allegation 3: **Employee #1 has received gifts from owners of private assisted living facilities, and made referrals to one of them, which appear to violate ethics regulations.**

The whistleblower alleged that **Employee #1** accepted gifts and meals from representatives of health care facilities who conduct business with VA, including Autumn Village ALF and the Wekiva Springs behavioral health treatment center (inpatient and outpatient). In addition, **Whistleblower** initially alleged that **Employee #1** received a \$50 gift card from a representative of a local ALF for the Outback Steakhouse®, and that **Employee #1** had shown it to her. She stated that **Employee #1** received the gift card around the 2012 Christmas or New Year's holidays, and used it to purchase lunch for her and four other MHICM staff at the restaurant.

The whistleblower also alleges that **Employee #1** employment as an intake coordinator and mental health evaluator at River Point Behavioral Health, a private health care facility that offers a full continuum of specialized inpatient and outpatient services for behavioral health and substance abuse, is a violation of VA ethics policy as **Employee #1** selects and advises the other MHICM team members regarding the community inpatient facility to which Veterans will be taken for needed evaluation and possible admission.

Additional Background

A. Criminal Conflict of Interest Laws and Standards of Ethical Conduct

The criminal conflict of interest laws prohibit employees from participating personally and substantially in any official particular matters that would directly and predictably affect their own financial interests or those of their spouse, minor child, general partner, any person/entity they serve as an officer, Director, Trustee, general partner or employee, or any person/entity with whom they are negotiating for employment or with whom they have an arrangement for future employment. 18 U.S.C. § 208(a); see 5 C.F.R. § 2635.402.

The Standards of Ethical Conduct generally prohibit employees from accepting gifts given by a prohibited source or because of official position. 5 C.F.R. § 2635.202(a): A prohibited source is any person or entity seeking official action from, doing business with, or conducting activities regulated by the employee's agency, or whose interests may be substantially affected by the performance or nonperformance of the employee's duties. 5 C.F.R. § 2635.203(d). Modest items of food and refreshment not offered as part of a meal are excluded from the definition of a "gift" for the purposes of the gift prohibitions. 5 C.F.R. § 2635.203(b)(1). Relevant exceptions to the gift prohibitions include a de minimis exception for unsolicited gifts with a market value of \$20 or less per occasion, aggregating no more than \$50 in a calendar year from any single source.²² However, there are limitations on use of exceptions, where accepting gifts from the same or different sources on a basis so frequent that a reasonable person would lead to believe that the employee is using public office for private gain. 5 C.F.R. § 2635.202(c).

²² Office of Government Ethics: 5 C.F.R. Part 2635: Standards of ethical conduct for employees of the executive branch. (<http://www.oge.gov/Laws-and-Regulations/OGE-Regulations/5-C-F-R--Part-2635---Standards-of-ethical-conduct-for-employees-of-the-executive-branch/>)

The Standards of Ethical Conduct also generally prohibit employees from using their official title, position or authority to endorse any private product, service or enterprise. 5 C.F.R. § 2635.702(c).

All VA employees are required to abide by the criminal conflict of interest laws and Standards of Ethical Conduct. VA provides mandatory annual ethics training on the criminal conflict of interest laws and Standards of Conduct in the Learning Management System.

B. Involuntary and Involuntary Inpatient Placements

If a Veteran's condition deteriorates or changes to the point that the MHICM clinical SW treating the Veteran determines, for instance, that there is a substantial likelihood that without care or treatment the Veteran will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior, then the Veteran is to be taken to the nearest receiving facility by local law enforcement for examination, and if appropriate, involuntary placement. See F.S.A. § 394.463. For cases that do not warrant the required procedures above and where a patient voluntarily seeks and consents to evaluation at an inpatient facility, Florida law generally permits a facility to receive for observation, diagnosis, or treatment any person 18 years of age or older making application by express and informed consent for admission. See F.S.A. § 394.4625. In the case at hand involving VA social workers who are acting within the course of their employment and the scope of their Federal practice, VA's MHICM clinical SWs will initially assess the capacity of their Veteran-patients to understand and provide express and informed consent to seek and obtain a voluntary inpatient mental health evaluation at an inpatient facility in the community.²³ Where such patients consent to seek such an evaluation, VA notes that national MHICM policy, VHA Handbook 2006-004, VHA Mental Health Intensive Case Management (MHICM) (2006), does not address how referrals to community resources are to be made. This is particularly noteworthy because Federal employees are prohibited from endorsing a private commercial enterprise. 5 C.F.R § 2635.702(c).

Findings

Criminal Conflict of Interest Laws and Standards of Ethical Conduct

During our interview, Whistleblower clarified that while Employee #1 had shown her a gift card for the Outback Steakhouse® that she did not know how much it was worth because it did not have a monetary value printed on it. No other staff members indicated that they had seen the gift card, but some had "heard" that an ALF representative had given one to Employee #1. During interviews, all but one of the

²³ The investigative team understands that no sharing agreement (contract) exists between VA and any of the local inpatient providers to furnish needed services to MHICM patients (at VA expense) under the described circumstances. Were there one, the patients could properly be referred to that contractor. (As an aside, these patients typically file claims for reimbursement or payment of unauthorized private medical costs they personally incur for emergency treatment provided them by a non-VA provider, pursuant to VA's reimbursement authority or other available legal authority).

other MHICM staff (who was not available to be interviewed) confirmed participating in the lunch. None of them reported paying for their lunch, and no one was sure what method of payment Employee #1 had used. Employee #1 denied receiving a gift card from a representative of an ALF, but did confirm that she and her staff went to lunch at the steakhouse. We asked the ALF representative who allegedly gave Employee #1 the gift card if she had given a VA employee a gift card around the holidays. She stated "I don't remember, I don't think so." When asked specifically if she had ever given Employee #1 a \$50 gift card for Outback Steakhouse®, she said "never."

In addition, Employee #1 and other MHICM staff stated that a Wekiva Springs ALF and River Point Behavioral Health representative had taken the team out to lunch 2–3 times. We interviewed the community partner representative, and she reported that she did take MCHIM team members to lunch when she had a new program at her facilities to discuss with them, e.g. the opening of a new unit or program. She reported that she usually spends between 5-10 dollars per person. She said that she recalled taking the MCHIM staff out 2 or 3 times in a year. She was able to articulate the ethics rules and understood she was not to spend more than 20 dollars a person or more than 50 dollars in a year.

The MHICM team interviewees also stated that at times, this same community partner representative brought brownies and pens to the Clinic for the staff. The items are placed in the break room and available to all staff. The individual who supplied these items reported that she had been told by VA (but she could not remember by whom) that she was allowed to provide items as long as they are intended for everyone and of nominal cost. She reported she never gave items to a specific individual, and that each package of multiple brownie bites cost \$4.00 and each pen cost \$0.80.

Although they were aware that ethical standards exist, none of the MHICM staff employees were able to accurately articulate the tenets of the Standards of Ethical Conduct, especially those pertaining to accepting gifts.

MHICM Social Worker Referrals for Non-VA Hospital Admissions

As discussed above, in cases where involuntary placement may be warranted, Veterans will be transported to the nearest local hospital by local law enforcement in accordance with applicable Florida law.

In other cases (i.e. where a MHICM team determines a Veteran-patient's clinical situation warrants an inpatient evaluation and the team makes an initial determination that the Veteran is capable of voluntarily consenting to such an evaluation), all of the Clinic MHICM case managers, the licensed clinic SWs, and the advanced practice nurse stated they then contact Employee #1 to find out where the patient should be taken.²⁴ Employee #1 stated that the case managers can determine where to take

²⁴ The nearest VA medical center with inpatient mental health capabilities is in Gainesville, Florida, approximately 2 hours away. If a MHICM patient is stable and a bed is available at the VA facility in Gainesville, then the patient

patients based on their condition and bed availability but “for some reason” they always contact her. No MHICM staff members, including **Employee #1** and the MHICM supervisor, were able to identify a written policy or procedure describing the referral process, including the decision-making factors that determine which mental health facility a Veteran is referred to for inpatient admission.

Employee #1 stated that once notified that a Veteran needs to be admitted, she determines the receiving facility based on the diagnosis, bed availability, and the rapport their program has established with the facility. The template note used for this referral notes that the patient agrees to the final placement. She stated the MHICM team has developed an excellent professional rapport with River Point Behavior Health and Wekiva Springs. River Point provides psychiatric treatment and addiction treatment to patients, as well as involuntary evaluations and admissions. Wekiva Springs offers residential treatment for addictions, trauma recovery, PTSD, depression, anxiety and other mood disorders, and recently began accepting involuntary admissions. She stated too that bed availability is rarely an issue with these two facilities. She reported that these two facilities routinely provide updates to the Clinic on each patient's progress (with the patient's consent) whereas other nearby facilities would not readily provide patient updates and did not notify MHICM of the pending discharge of a Veteran, which complicated the MHICM team's management of their Veterans. Those interviewed also stated that if a Veteran does not wish to go to the recommended facility, then the team will instead take the Veteran to the facility preferred/identified by the Veteran if there is an available bed.

In situations where there was more than one available facility that had the capacity to evaluate the patient and this was not explained to the Veteran (so that the Veteran could make his/her selection), to the extent that MHICM SWs recommended that the Veteran go to River Point Behavioral Health or Wekiva Springs, they would have violated the prohibition against officially endorsing private entities.

5 C.F.R. § 2635.702(c).

Employee #1 stated that she has been employed at River Point Behavioral Health since 2001, where she is regularly scheduled to work one weekend shift per week performing mental health intake assessments. Her employment is not contingent on patient volume or unexpected staffing needs on an “as needed” basis; she works her shift regardless of the number of occupied facility beds or anticipated intakes. We were unable to find evidence that **Employee #1** employment at River Point Behavioral Health resulted in personal gain, however, as she recommended that patients be referred to River Point or Wekiva Springs she ostensibly participated in matters affecting the interests of her outside employer. In addition to the MHICM program, other services at the Clinic, (e.g. primary care providers, referred 384 Veterans) to River Point Behavioral Health and Wekiva Springs from January 2013 through May 2015.

can be transported there. Most cases; however, require more urgent medical attention; hence, the need to access available community resources.

VA OIG's Criminal Investigation Division investigated the allegations against **Employee #1** and declined referral to the Department of Justice for prosecution.

Conclusions

- VA was not able to substantiate that **Employee #1** accepted a gift card from a non-VA facility representative.
- VA did not substantiate that the lunches provided by the representative violated the Standards of Ethical Conduct for Employees of the Executive Branch as they were de minimis. However, the acceptance of such otherwise permissible gifts on a frequent basis could lead a reasonable person to believe that employees are using their public office for private gain.
- Modest items of refreshment not offered as part of a meal, such as brownies, would be excluded from the definition of a "gift" for the purposes of the gift prohibitions of the Standards of Ethical Conduct. Items of nominal monetary value such as pens fall within the de minimis exception to these gifts.
- The MHICM program lacks policy and procedures on how the field should make referrals to non-VA facilities for medically necessary inpatient evaluations for possible admission/inpatient placement. By referring a consenting Veteran to a single particular inpatient facility for a voluntary inpatient mental health evaluation where that particular facility was not the only one which could clinically treat the Veteran and this fact was not explained to the Veteran, the MHICM team, including **Employee #1** would have endorsed that commercial enterprise in violation of 5 C.F.R. § 2635.702(c).
- **Employee #1** exercise of discretion and professional judgment in making referrals to River Point Behavioral Health while also being employed there potentially results in violation of the criminal conflict of interest law at 18 U.S.C § 208. Specifically, her recommended referral to River Point would directly and predictably positively impact the financial interests of her outside employer. Conversely, her referrals to River Point's competitors would negatively impact her outside employer's financial interest, which would still ostensibly constitute a technical violation of the financial conflict of interest law.

Recommendations to the Clinic

12. Provide additional training about the Standards of Ethical Conduct, with special emphasis on principals related to accepting gifts and avoiding the appearance of violating ethical standards. Monitor compliance and address non-compliance with appropriate educational, administrative, or disciplinary action.

13. Consider a written standard policy notifying all vendors who do business with the Clinic to refrain from distributing items of nominal monetary value. This notification should be in writing and provided to all employees.
14. Conduct a random but statistically significant review of referrals made under the MHICM program to see if, under the individual facts of each case, any of the referrals constituted an endorsement of the particular commercial enterprise in violation of 5 C.F.R. § 2635.702(c). (We recognize that in some cases only one entity may have been available, appropriate, and/or capable of providing the needed services).
15. Determine what, if any, administrative or disciplinary action is warranted in view of **Employee #1** referrals to River Point Behavioral Health while also being employed there, which potentially violated 18 U.S.C. § 208.

Recommendation to VHA:

16. Consider establishing a policy or procedures to guide the MHICM staff in the field when making patient referrals to community hospitals or resources (not under contract with VA).

VI. Summary Statement

VA has developed this report in consultation with other VHA and VA offices to address OSC's concerns that the Clinic may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, OGC has provided a legal review, and OAR has examined the issues from an HR perspective to establish accountability, when appropriate, for improper personnel practices. VA did find a violations criminal conflict of interest law, 18 U.S.C. § 208, which criminal allegations the IG declined to prosecute, and did find violations of VA and VHA policy.

Attachment A
Documents Reviewed in Addition to the EHR

National Association of Social Workers.

(<https://www.socialworkers.org/pressroom/features/general/profession.asp>)

The National Consensus Statement on Mental Health Recovery.

(<http://mentalhealth.samhsa.gov>)

VHA Directive 2006-004, *VHA Mental Health Case Management (MHICM)*. January 30, 2006. (http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1375)

VHA Handbook 1110.04, *Case Management Standards of Practice*. May 20, 2013.

(http://www.va.gov/optometry/docs/VHA_Handbook_1110-04_Case_Management_Standards_of_Practice.pdf)

VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*. September 11, 2008.

(http://www.mirecc.va.gov/VISN16/docs/UMHS_Handbook_1160.pdf)

VHA Handbook 1163.05, *Psychological Rehabilitation and Recovery Services Peer Support*. July 1, 2011.

(http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2430)

VHA Directive 2011-012, *Medication Reconciliation*. March 9, 2011.

(http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2390)

VHA Handbook 1907.01. *Health Information Management and Health Records*. March 19, 2015. (http://www1.va.gov/VHAPublications/ViewPublication.asp?pub_ID=3088)

VHA Directive 2010-053, *Patient Record Flags*. December 3, 2010.

(http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2341)

VHA Handbook 5025/4, *Legal*. October 12, 2007.

(http://www1.va.gov/vapubs/viewpublication.asp?pub_id=242&ftype=2)

VHA Directive 2013-006, *The Use of Unlicensed Assistive Personnel (UAP) in Administering Medications*. March 5, 2013.

(http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2872)

North Florida/South Georgia Memorandum No.119-28, Change 3. *Preparation and Dispensing of Medication*. February 1, 2013.

North Florida/South Georgia Memorandum No. 119-29, *Drug Administration and Documentation*. August 1, 2014.

North Florida/South Georgia Veterans Health System Mental Health Intensive Case Management Gainesville Program Manual.

North Florida/South Georgia Veterans Health System Patient Education Information Veteran's Handbook Psychiatry Service.

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