

John U. Young  
Attorney Disclosure Unit  
U.S. Office of Special Counsel  
1730 M Street, NW, Suite 218  
Washington, DC 20036-4505

December 21, 2015

RE: Whistleblower Response to OSC File No. DI-15-1544

Dear Mr. Young:

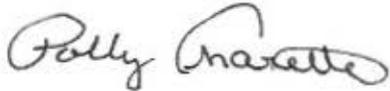
I am responding to the Report provided by the Office of Special Counsel ("OSC File Number DI-15-1544"), and generated by the team assembled by the Office of the Medical Inspector ("OMI") as directed by the Interim Under Secretary for Health. The report is very detailed and provides your office with much needed information to improve the care and safety of patients being treated by the Jacksonville Department of Veterans Affairs ("VA") MHICM Program, in Jacksonville, Florida. Although the report is detailed there is critical information that is either incomplete, misinterpreted, or completely excluded from the report. I appreciate the complexity of the allegations and that collecting and sorting through the information is not easy. I do believe that some of the inaccuracies within the report do not necessarily ensure accountability or full acknowledgment of the serious patient safety issues, ethical issues, and blatant violations of policies.

Since 2001, I have been working intimately with the military population both with the Department of Defense and Veteran's Administration. During this time of over 10 years with the government, I have been mentored by some of the most caring, compassionate managers and employees that have held the highest integrity, professional training, and patient centric thinking. Upon my arrival to the Jacksonville MHICM Program in 2012, it was disheartening to witness a pervasive and astonishing lack of accountability and oversight by the MHICM Program leadership. The concerns I raise regarding the Jacksonville, FL MHICM Program and its oversight problems by the Gainesville, FL VA Medical Center are based on my years of knowledge and training within the VA/Government, the importance of policies and procedures, the rules restricting a Licensed Clinical Social Worker ("LCSW") from certain practices, the humanistic behaviors that encourage a great place to work, and most importantly the knowledge to provide the safest, most quality, and ethical practices to care for our veterans.

Within the Jacksonville MHICM program, I observed and reported problems with management neglecting safety issues, ethical standards, and blatantly violating practices. Despite acknowledgment of my November 2012 disclosures reporting concern to the Chief of the MHICM Program, no accountability or changes were implemented nor enforced to correct these violations. The investigatory report indicates that my complaint regarding the mishandling of medication sparked a change in procedure, which is simply not true. All witnesses that report concerns with medication dispensation were hired and observed these violations after 2012, and continuing well into mid 2014. If the identified change of procedure indicated within the report occurred, it simply was not enforced and patient safety issues continued despite program management's full knowledge of the violation and risk.

I will detail where the report is incomplete so that your office will be able to make a fair, accurate, and fully informed decision to follow up on what is in the best interest for our veterans' care. The Mental Health Intensive Case Management (MHICM) is a valuable program and it deserves leadership and commitment that will cultivate an open and caring environment with safe practices both for the staff and the veterans impacted by this department. I trust that there will be adequate implementation of the recommendations generated within this investigation to both gather more accurate information and hold the respective parties accountable.

With Much Respect,

A handwritten signature in cursive script that reads "Polly A. Charette". The signature is written in black ink and is positioned above the typed name.

Polly A. Charette, LCSW

## Response to the Report

The report acknowledges three of my identified concerns where the patient, the social workers, or both could be potentially harmed due to the actions of Ms. Benjamin. I greatly appreciate the time and effort that was put into investigating the allegations.

**Allegation 1:** Ms. Benjamin dispensed medications to VA patients in violation of Veterans Health Administration (VHA) policy

## Conclusions

- VA **did not substantiate** that Ms. Benjamin 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.

## My Response

- The Gainesville, FL Medical Center is the supervisory facility for the Jacksonville Department of Veterans Affairs (VA) Outpatient Clinic, in Jacksonville, Florida. Prior to November 2012, The Medical Center's procedure was to have a pharmacist dispense the medications into the pill boxes. Medical Center Memorandum (MGM) No. 119-28, *Preparation and Dispensing of Medication*, states that a Pharmacist is the only professional who may dispense medication to patients."
- The Report indicates that only the act of delivery occurred. This is incorrect. At least three direct reports of Ms. Benjamin witnessed her filling medication trays WITHOUT the client's assistance or at times even without the client's presence. This DID include controlled substances that are easily noted on the reported patient's medication lists. This also DID include medications in which she was delivering on that same visit.
- By filling the medication trays without the patient's assistance is "dispensing" medications as defined in the Report, especially when those medications placed independently by Ms. Benjamin in the pill tray were personally delivered by her during the same visit.
- In December 2012, the Medical Center changed the pill box filling procedure for the Jacksonville, FL location. According to the report, the revised procedure stated 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.
- Ms. Benjamin continued to fill the medication trays far into 2014, after she was instructed to discontinue this activity in 2012. In these cases she continued to "dispense" medications to the patients.

- In addition to dispensing medications, she also was knowingly violating the "revised procedure".
- 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. Ms. Benjamin's individual Scope of Practice does not address medication assistance.

**My Response**

- Agreed. Since Ms. Benjamin's Scope of Practice "did not address or include responsibilities related to patient medications", then she should not have been participating in the dispensation of medications.
- VA did not substantiate that MHICM SWs are charged with performing medication reconciliation with their patients in violation of VHA policy.

**My Response**

- Agreed. We are not charged with medication reconciliation.
- The Report misinterpreted the information I provided.
- This is a patient safety issue. The fact is that, Ms. Benjamin is filling medication trays (dispensing). It is true that on multiple occasions Ms. Benjamin filled the medication WITHOUT a current medication list.
- She is "Communicating with and providing education to the patient, caregiver, or family members regarding updated medication information", which only "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" can perform.
- The Medical Center started operating the Clinic's MHICM program without adequate staffing.

**My Response**

- Agreed.
- The MHICM program currently has two SW vacancies, and therefore does not meet the MHICM team requirements.

**My Response**

- Unsure about current status of MHICM program vacancies.
- 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.

**My Response**

- Patients are frequently transported to the VA facility and out of their community environment.
- I believe the Veteran-centric MHICM goals of patient safety and quality of care would be met by having a licensed practitioner dispense the medications, when a patient is unsafe or unable to do so for him or herself.
- In addition, the licensed practitioner can communicate with and provide education to the patient. Which can only be performed by "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.”

**Allegation 2:** Ms. Benjamin 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

### Conclusions

- VA **substantiates** that Ms. Benjamin 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.

#### My Response

- Agreed.
- VA **did not substantiate** that Ms. Benjamin's 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

#### My Response

- The concern I raised was not in relation to a PRF. This was not necessary as the MHICM team communicates daily regarding our patients. I did not request nor expect a PRF to be entered.
- A telephone encounter was entered into the EHR on May 27, 2014 about a conversation Ms. Benjamin had with a patient on April 28, 2014.
- On April 28, 2014 the patient told Ms. Benjamin that he believed the mafia and VA staff had intentions to hurt him.
- On April 28, 2014 the patient specifically demanded, to Ms. Benjamin, that he wanted the VA staff to leave him alone and NOT come to his residence.
- Ms. Benjamin does mention she erroneously documented the date of the conversation in the patient's chart. She mentions that she talked to him on either May 1 or May 2, 2014.
- The actual date of of the conversation entered into the chart does not make a difference. Ms. Benjamin neglected to tell the MHICM staff about the “delusional content” which included fear of VA Staff and that she assessed him as “bizarre, agitated, and paranoid” nor that he adamantly told her not to send VA Staff to his residence. He did not want any more in-person contact from the VA staff.
- For well over a week after May 2, Ms. Benjamin led a daily morning meeting specifically to discuss the mental status of patients in the program. She did not verbally convey information regarding the phone conversation to the staff assigned to the veteran.
- Around mid May she instructed staff to cease contacting the patient, however even at this time I was still not provided with the content of the telephone conversation. I learned of the content over a month later within her late note.
- At any point the VA staff could have visited the home of an agitated and delusional patient who believed that the VA staff were going to hurt him. Ms. Benjamin did not let her direct reports know about these delusional thoughts, THEREFORE she put the VA staff in danger.

- Several case managers and PSS in the MHICM program are not compliant with timeliness of documentation requirements.

**My Response**

- I trust the accuracy of the Report.

- 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.

**My Response**

- All MHICM staff already use laptops. There are NO desktop computers in use for entering patient charts.
- Not only does each staff member have a laptop, they are also capable of connecting back the EHR from anywhere there is mobile phone coverage using an air card or other wireless connections.
- We frequently spent our personal time including staying late or doing work at home off hours to complete documentation and notes in the EHR. This work was done from our laptops, using our air card or other wireless services.
- The time we spent after hours to do our best to meet the documentation requirements was supposed to be credited back to Ms. Benjamin's direct reports as "Comp Time", yet this was not authorized by her.
- Ms. Benjamin told the staff "If you can't do your job in the allotted time, that's your problem. Also, there's no reason you shouldn't be able to get your job done - you have laptop computers."
- I'm not sure what the investigation team was told, but it was obviously inaccurate.
- We have laptop computers. We have the ability to get our notes in within a reasonable timeframe. Ms. Benjamin was regularly and grossly late on entering notes into the patients' chart. This is a patient care and safety issue.
- In addition, the negligent behavior of Ms. Benjamin also endangered her direct reports (see previous conclusion).
- This is a systemic issue, where accountability is nonexistent.

- The Clinic's MHICM program is not compliant with Medical Center policy MSH 116-5, which requires monthly chart reviews.

**My Response**

- Agreed.

**Allegation 3:** Ms. Benjamin has received gifts from owners of private assisted living facilities, which appears to violate ethics regulations.

**Conclusions**

- VA was not able to substantiate that Ms. Benjamin accepted a gift card from a non-VA facility representative.

**My Response**

- The investigator states, "During our interview, Ms. Charette clarified that while Ms. Benjamin 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." I specifically mentioned to the investigators that the gift card I saw was in the amount of \$50.00.

- Regardless, there was lunch that was paid for by a gift card for \$50.00 that was given to Ms. Benjamin. Ms. Benjamin did take her staff to lunch, which is a kind gesture.
  - Although, Ms. Benjamin accepted a gift of \$50.00. This is clearly a policy violation.
- 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.

**My Response**

- I spoke with the MHCIM Chief and expressed my concerns.
  - I trust that Ms. Benjamin was informed by the Chief that the meals are inappropriate.
- 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.

**My Response**

- Agreed.
- 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 Ms. Benjamin, would have endorsed that commercial enterprise in violation of 5 C.F.R. § 2635.702(c).

**My Response**

- Agreed.
- Ms. Benjamin's 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.

**My Response**

- Agreed.

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May 09, 2016

RE: Second Whistleblower Response to OSC File No. DI-15-1544

Dear Mr. Young:

In reflecting upon this entire process of this VA OIG investigation of wrongdoings, I struggle to summarize the disappointment over the lack of an accurate, complete, and objective assessment along with total absence of accountability even when substantiated violations are identified. The latest answers from the North Florida/South Georgia Veterans Health System, Gainesville, Florida ("Medical Center") release all responsibility for violations reporting that "no corrective action is warranted". The VA Medical Center management actively disregarded valid concerns I brought forth for them to address, which ultimately led to my need to raise those issues along with others to the Office of Special Counsel ("OSC") for further examination.

As NF/SG VA Management continued to ignore reports and violations allowing reported behaviors to continue putting patients at risk, contacting the OSC was my only remaining option. The OSC's acceptance and acknowledgement that the situation warranted an investigation was a relief. I was optimistic that an independent and objective investigation by the VA Office of Inspector General ("OIG") would be a catalyst for policy enforcement and procedural changes necessary to maintain patient safety and policy within the NF/SG Medical Center, Jacksonville MHCIM program.

To my disappointment from the beginning of my interactions with the VA OIG Team, it was obvious that the process would neither be fair nor objective. At my initial interview there was no apparent unbiased gathering of facts and information. The interview was clearly not focused on improvement, but more so on justification of violations. This investigation conducted by the VA OIG is flawed and failed to fully address the serious issues within the MHCIM department concerning the health and safety of our veterans and staff along with serious misconduct. In candor, this is a clear example of a Department of Veterans Affairs (VA) investigations concerning whistleblower disclosures being deficient and unreasonable.

During my interview, the lead investigator treated me with a lack of professionalism and as though I was the party under investigation. She used mockery as a form of communication, altered facts, reworded my answers, and immediately came to conclusions to without listening to or gathering all the information. On several occasions, I had to correct her inaccurate reiteration of my words and defend myself, as she made attempts to alter facts and discredit my statements. It concerned me that this interview was only recorded by a person taking notes on a pad of paper and I had no way of reviewing the accuracy of the documentation. Additionally, in several instances the lead investigator was already openly verbalizing justifications and offering

potential excuses for the inappropriate actions of MHICM management. As a response to some of my serious allegations, she posed challenging defensive questions in an unprofessional manner, such as “Well do you even know the gift policy?”, “How would you even know the gift card was for \$50?” and “Where have you seen in writing a social worker cannot manage medications?” Instead of gathering facts in an unbiased manner, she cut off my statements and queried me with an intent to discredit and minimize my allegations.

Upon receipt and review of the initial formulated report, it was now undeniably clear that the OIG was failing to conduct a fair, comprehensive, and unbiased analysis. Many violations that I witnessed and reported to the OIG investigatory team could have been easily verified with a minimal amount of effort to review accessible information. Some disclosures during the interview were completely excluded from the Report to the Office of Special Counsel OSC File Number DI-15-1544 (“The Report”). A few of the examples of missing information are my reports of recording false information in patients’ medical record regarding medication management, concrete evidence of policy and procedure violations, EEO case information and sworn testimony, and specific further details about medication management violations and gifts from outside facilities. The OIG interview team did not even record or investigate all of the violations that were occurring within the MHICM program.

Even when the OIG substantiated violations, the Medical Center was allowed to and found themselves free and clear of any wrongdoing. For example, the original findings of the OIG Report state the “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 violations of 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.” The Medical Center disturbingly responded that they “determined that no disciplinary or administrative action is warranted.”

The Report also “directs the facility to conduct an investigation to identify which drugs were transported, delivered, and placed into patients' pill boxes by Ms. Benjamin, to determine if any controlled substances were involved, and to determine if federal law was violated.” The OIG had complete access to the patient medical records, which has the full medication lists. They could have easily and independently identified which medications were involved in the patient’s care. It appears that they prematurely ceased viewing this information or simply chose not to provide their findings in the report. Bottom line is that it lacks full disclosure and transparency.

The OIG ultimately left the Medical Center to investigate its own violations. The facility’s response was “the Medical Center conducted an investigation and consulted the General Counsel on its findings. The local Controlled Substance Coordinator also reviewed the information and found no evidence of any violation of law.” Violations of law are different than violations of policy, from what I understand there is evidence that both were violated. The response is unclear if they are stating that there were no controlled substances involved or that the procedures followed with the controlled substances were not a violation of law and does not address policy in this statement. There is no transparent way to determine if they are operating on facts or overlooking information based on the internal review that has no oversight for accuracy. The statement is vague and not transparent to the public as to what information they are basing their

findings. As I state in my original response to the report, controlled substances were involved in the violations. One identified patient's medical record containing clear information regarding controlled substances was completely excluded from the reported findings and not mentioned.

Directly contradicting the OIG reported findings, MHICM senior leadership stated in a sworn deposition taken shortly before the OIG Investigation that it's VA policy and state law that social workers should not be filling med boxes and she has addressed that issue. She additionally states that social workers can only observe the medications and clarifies that they can take the medication to the home, watch the veteran fill the med box, put them in the lock box and can do everything except dispense the meds. She further acknowledges an affirmative to the statement that social workers can't actually physically put medicines in the box themselves. The OIG Team declined review of these documents when offered to them. They further enabled and supported management to express "confusion" and "lack of policy" within the MHICM Program when explaining away the gross misconduct with medication in the program. When a staff member receives no training on medication handling, it is quite clear it is not authorized nor sanctioned behavior.

I have already submitted a thorough and detailed response to The Report. I defer to the statements and facts in my previous responses as additional indicators regarding the flaws in the OIG investigation process. The overall process and outcome of this investigation is disturbing and quite clearly shows a flawed, biased, distorted and incomplete investigation. There is no indication of administrative actions nor evidence of corrective actions that would be performed by any reasonable person. Despite the OIG report substantiating some undeniable violations of both VA and VHA policies and laws, there is an apparent outright absence of accountability.

In closing, I openly stepped forward hoping for transparent and honest repair within this system. Instead I was met with significant harassment, retaliation and personal damages for doing what I know is the right thing and in the best interest of our Veterans. As many Whistleblowers, I paid a high price for reporting concerns both internally and externally. In retrospect, I would still make the same decision to represent the truth despite the personal cost it has had for me. As a person who holds our Veterans in high regard, I have for over 15 years and will continue to serve them with the Core "I CARE" standards that I swore by at the Veteran's Administration: Integrity, Commitment, Advocacy, Respect, and Excellence. We are in a time in which Veteran Affairs' Secretary Robert McDonald states that VA staff must focus to "Rebuild trust with Veterans and stakeholders." This is certainly not an example that holds up to that commitment. I look forward to the response of the Office of Special Counsel's assessment of this investigation, as they strive to analyze and report validity of OIG findings. Furthermore, I challenge General Michael Missal to review his own team for Highest Quality Investigations in which he is promising Veteran's and The American People.

With Much Respect,

A handwritten signature in black ink that reads "Polly Charette". The signature is written in a cursive, flowing style with a long horizontal stroke at the end.

Polly Charette, LCSW