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The Special Counsel

February 11, 2014

The President
The White House
Washington, D.C. 20510

Re: OSC File No. DI-12-1783

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), enclosed please find agency reports based on disclosures made by a whistleblower at the Department of Veterans Affairs (VA), Ralph H. Johnson VA Medical Center (Charleston VAMC), Charleston, South Carolina. The whistleblower, Ms. Christine Bethea, a former psychiatric-mental health nurse practitioner at the Charleston VAMC, alleged that employees engaged in conduct that constituted a violation of law, rule, or regulation, gross mismanagement, and a substantial and specific danger to public health and safety by assigning at least three nurse practitioners who are not certified in psychiatric-mental health care to positions within the Mental Health Service Line. Ms. Bethea consented to the release of her name.

The agency investigation substantiated that two of the nurse practitioners, Mary Coish and Naomi Ryan, were practicing in the Mental Health Service Line without the required qualifications or certification. The agency found that these nurse practitioners were assigned a scope of practice beyond their level of formal education, training, and certification, which may have resulted in less than optimal patient outcomes. However, the agency's investigation did not reveal any evidence to substantiate that patient care was negatively impacted by these nurse practitioners. Among corrective actions taken, the Charleston VAMC took immediate action to modify the scope of practice for Ms. Coish and Ms. Ryan, removing all mental health clinical practice elements for which they were not certified. I have determined that the agency reports contain all of the information required by statute and that the findings appear to be reasonable.

On June 20, 2012, OSC referred Ms. Bethea's allegations to Secretary of Veterans Affairs Eric Shinseki, to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d).[1]

[1]The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c) and (g).

Secretary Shinseki asked the Under Secretary for Health to conduct the investigation, who in turn requested the assistance of the Office of Nursing Services. On October 19, 2012, Secretary Shinseki submitted the agency's report to OSC. In response to OSC's request for additional information, the agency submitted a supplemental report on May 8, 2013. Pursuant to 5 U.S.C. § 1213(e)(1), Ms. Bethea submitted comments on the agency's report and supplemental report on January 23, 2013 and July 2, 2013. As required by 5 U.S.C. § 1213(e)(3), I am now transmitting the reports and the whistleblower's comments to you.

The Whistleblower's Allegations, Agency's Reports, and Whistleblower's Comments

The Whistleblower's Allegations

Ms. Bethea alleged that there were three nurse practitioners assigned to positions within the Charleston VAMC Mental Health Service Line who were practicing outside the scope of their certification. She stated that all three of these nurse practitioners performed the duties of psychiatric-mental health nurse practitioners, but none was certified in psychiatric-mental health care as required by the VA Nurse Qualification Standard. Their duties included evaluating, diagnosing, and prescribing psychotropic medications to veterans with a wide range of mental health issues, including patients with serious and persistent mental illness.

Specifically, Ms. Bethea stated that Naomi Ryan, a nurse practitioner licensed in Georgia and certified in adult health care, worked in a Mental Health Intensive Case Management Program in an outpatient clinic in Savannah, Georgia, which is part of the Charleston VAMC Mental Health Service Line. Ms. Ryan was responsible for providing care to veterans with a wide range of mental health diagnoses, such as post-traumatic stress disorder, schizophrenia, bipolar disorder, major depression, and schizoaffective disorder. Mary Coish, a nurse practitioner licensed in South Carolina and certified in family health care, served as a case manager in the Mental Health Intensive Case Management Program at the Charleston VAMC. As such, Ms. Coish worked with seriously and persistently mentally ill veterans who had acute psychiatric disorders and required intensive treatment and monitoring of psychotropic medications. Deborah Davis, a nurse practitioner licensed in South Carolina and certified in family health care, was assigned to the Substance Abuse Treatment Program, working with veterans with substance abuse and a wide range of other mental health issues.

The VA's Nurse Qualification Standard, set forth in VA Handbook 5005/27, Part II, Appendix G6, Section B, paragraph a(6), provides that, in addition to meeting the basic requirements for a registered nurse, a nurse practitioner must be licensed or otherwise

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Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

recognized as a nurse practitioner in a state, possess a master's degree from an accredited program, and maintain full and current certification as a nurse practitioner from the American Nurses Association or another nationally recognized certifying body. Paragraph a(6)(A) requires that the certification must be in the specialty to which the nurse practitioner is appointed. This requirement that nurse practitioners must be certified in the specialty they are working in is consistent with the scope-of-practice provisions found in state licensing statutes, such as the South Carolina Nurse Practice Act, S.C. Code Ann. §§ 40-33-30 and 40-33-34.

Ms. Bethea contended that allowing nurse practitioners who are not certified in psychiatric mental health care to perform the duties of mental health nurse practitioners not only violates VA rules and potentially state licensure laws, but also compromises patient care. She explained that these nurse practitioners demonstrated their lack of training, knowledge, and experience in evaluating and treating patients with psychiatric and mental health issues. Ms. Bethea raised her concerns regarding the lack of proper certification. She stated, however, that management failed to address the problem.

The Agency's Reports

The agency investigation substantiated a violation of VA Handbook 5005/27, Part II, Appendix G6 (Nurse Qualification Standard), with respect to Ms. Coish and Ms. Ryan. The report summarizes the requirements for nurse practitioners under the Nurse Qualification Standard, including certification within the specialty to which the nurse practitioner is appointed. The investigation revealed that Ms. Coish and Ms. Ryan were assigned to Mental Health Service positions with a scope of practice beyond their level of formal education, training, and certification. Specifically, the scope of practice for their positions included the performance of mental health examinations, psychiatric therapy and counseling, and substance abuse treatment in collaboration with the Substance Abuse Treatment Team. However, neither Ms. Coish nor Ms. Ryan met the nurse practitioner qualifications or certification requirements for psychiatric-mental health nursing in accordance with the Nurse Qualification Standard. The investigation revealed that Ms. Davis, who was assigned to her position prior to the March 17, 2009, enactment of the current Nurse Qualification Standard, is exempt from the nurse practitioner specialty certification requirement and, thus, there was no violation with respect to her scope of practice.

The report explains that VA has statutory authority to establish the qualifications of its health care practitioners and regulate their professional conduct. While VA nurses must be licensed by a state or territory of the United States, VA determines their scope of practice, without regard to state laws, for clinical nursing practice other than the prescription of controlled substances. Where state licensure and scope of practice rules conflict with federal law or VA rules, regulations or policy, VA employees must comply with the federal and VA provisions, even if their state practice act is more restrictive.

Under the Federal Controlled Substances Act, its implementing regulations, and VA policy, a health care practitioner may prescribe controlled substances only if the

practitioner's state license authorizes her to do so. Based on a review of the Georgia and South Carolina Nurse Practice Acts, the agency found that Ms. Coish, Ms. Ryan, and Ms. Davis are authorized by their advanced practice registered nurse licenses to prescribe controlled substances under their collaborative agreement with their physician supervisors. The investigation revealed there were no violations of the state acts with respect to the three nurse practitioners' collaborative practice agreements and requirements for physician supervision.

However, the investigation did substantiate a violation of the South Carolina Nurse Practice Act with respect to Ms. Coish's certification. The report confirms that the certification requirements for specialty areas of practice set forth in section 40-33-34(5) of the South Carolina Nurse Practice Act are consistent with the requirements of the current VA Nurse Qualification Standard. Thus, the agency found that section 40-33-34(5) was violated when Ms. Coish, who is licensed in South Carolina, was assigned to the VA Mental Health Service Line without the required Psychiatric-Mental Health Nursing Certification. With respect to Ms. Davis, who is also licensed in South Carolina, the agency determined there was no state law violation. As noted, state scope and practice standards do not apply to VA nurse practitioners to the extent that they are inconsistent with VA standards. Although the South Carolina certification requirements are consistent with the current VA Nurse Qualification Standard, Ms. Davis was hired prior to the enactment of the current Nurse Qualification Standard and is exempt from the specialty certification requirement therein. Thus, because Ms. Davis' assignment to the Mental Health Service Line is permitted under VA rules, the state standards do not apply.

In addition, the investigation substantiated that Charleston VAMC management hired Ms. Coish and Ms. Ryan for Mental Health Service positions for which they were not qualified, and that their appointment to positions with a scope of practice beyond their level of formal education, training and certification "may have resulted in less than optimal patient outcomes." The report states that, at the time of Ms. Coish's and Ms. Ryan's selection, the functional statement template used by the Charleston VAMC had not been updated to reflect the current Nurse Qualification Standard requiring nurse practitioners to be certified in the specialty to which they are appointed. Dr. Donald (Hugh) Myrick, Chief of Mental Health Services, when Ms. Coish, Ms. Ryan and Ms. Davis were hired, stated that he based his selection of these three applicants on their multiple years of mental health experience and references.

The report states that during the selection process for Ms. Coish, Ms. Bethea raised her concerns regarding Ms. Coish's lack of proper certification to Linda Hood, mental health program specialist, who indicated that she would look into the issue. Although Ms. Hood recalled being asked to serve as a substitute member of the interview panel for Ms. Coish, she did not recall the details of the process or a conversation with Ms. Bethea or anyone else regarding Ms. Coish's qualifications. The report stated that Ms. Bethea also raised her concerns regarding Ms. Coish's certification with Colette Rhue, mental health nurse manager. Ms. Rhue stated that she believed Ms. Bethea was concerned about Ms. Coish's general credentials. She stated that she verified that Ms. Coish was credentialed pursuant to

facility policy, but did not relay the information back to Ms. Bethea in order to safeguard Ms. Coish's privacy.

Although the agency concluded that Ms. Coish and Ms. Ryan were given a scope of practice beyond their education, training, and certification, which may have resulted in less than optimal patient outcomes, the investigation did not reveal any evidence to substantiate that patient care was negatively impacted by these nurse practitioners. The investigation included a review of Vet Pro, the electronic databank used by VA facilities for the credentialing of licensed, registered, and/or certified health care providers, as well as the Ongoing Professional Practice Evaluations that include supervisory review of the nurse practitioners' clinical practice. In addition, VAMC Quality Manager Shirley Cooper confirmed that there were no complaints related to the delivery of care by these three nurse practitioners.

The report notes that all nurse practitioners work on teams of care providers led by physicians, and they have access to their lead physicians throughout their tours of duty. Thus, there is direct oversight by a physician to monitor the quality of care delivered to veterans. The report also explains how the Charleston VAMC assesses the quality of the clinical performance of Ms. Davis and other practitioners who are exempt from the specialty certification requirement of VA Handbook 5005/27. The report states that Ms. Davis is scrutinized using the same credentialing and privileging process used for every staff member who delivers care via a set of credentials, privileges, or scope of practice. In addition, Ms. Davis works closely and collaboratively with her specialty physician supervisor and is never without supervision.

The report also includes a summary of some of the procedures followed by Charleston VAMC Quality Management relating to the review and dissemination of new VA directives and handbook provisions. Quality Management reviews new directives and provisions to ensure consistency with local policy and then forwards them to the appropriate service chiefs. Beginning in fiscal year 2012, Quality Management follows up with the various services to ensure that any necessary action has been taken to update their policies.

In response to the findings, the report recommended that: 1) Ms. Coish and Ms. Ryan be immediately reassigned or their duties modified to roles with a scope of practice that aligns with their current qualifications; 2) Ms. Coish and Ms. Ryan should be encouraged to complete a formal education program that prepares them to become eligible to take the Adult Psychiatric-Mental Health Nursing Certification Examination; 3) the functional statement for nurse practitioners should be revised to reflect the qualification standards and dimensions of practice applicable to nurse practitioners pursuant to VA Handbook 5005/27; 4) the Charleston VAMC must complete a clinical care review of a random sample of patient care records for at least 10% of the patients for Ms. Coish and Ms. Ryan dating back to their date of hire. If any clinical care issues are identified, the facility should consider expanding the review up to a 100% review; and 5) the VAMC Quality Manager must review all advanced practice nurse practitioner scopes of practice for relevancy, accuracy, and appropriate alignment with current qualifications pursuant to VA Handbook 5005/27.

The report confirms that the Charleston VAMC is now aware of the correct advanced practice nurse practitioner qualifications required by VA Handbook 5005/27 and, at the time of submission of the report, was conducting a review of all scopes of practice to ensure alignment with VA policy. Further, VAMC management eliminated from the scopes of practice for Ms. Coish and Ms. Ryan those elements that are inappropriate for nurse practitioners who do not have psychiatric-mental health certification. VAMC management further stated its intention to review of Ms. Coish's and Ms. Ryan's patient care records as recommended. Finally, the report confirms that the functional statement for nurse practitioners had been revised in accordance with the recommendation.

As noted, in response to OSC's request for additional and updated information on the corrective actions taken, the agency provided a supplemental report on May 8, 2013. The supplemental report confirms that the Charleston VAMC took immediate action to modify the scopes of practice for Ms. Coish and Ms. Ryan. The report explains that Ms. Coish now functions as a family nurse practitioner in the Medical Service for Hepatitis B patient care delivery. Ms. Ryan now functions as an adult nurse practitioner case manager in the Mental Health Service Line, and is responsible only for general medical practice not related to the delivery of mental health specialty care. Copies of the functional statements and scopes of practice for Ms. Coish and Ms. Ryan are included with the supplemental report.

In addition, the supplemental report states that Charleston VAMC management made the decision to conduct a case review of significantly greater than 20% of the patient records available for Ms. Coish and Ms. Ryan dating back to their dates of hire. The review, which was conducted by Dr. Jeffery Culver, Acting Chief, Mental Health Service Line, included more than 20% of Ms. Coish's and Ms. Ryan's patient charts and 100% of their notes for the period of time they treated those patients. Based on this review, Dr. Culver concluded that, in all cases, the care provided by both practitioners was appropriate, safe, and evidence-based, and there were no negative findings.

The supplemental report further confirmed that Charleston VAMC management conducted a review of the scopes of practice for all advanced practice nurse practitioners to ensure alignment with the nurse practitioner qualification standards in VA Handbook 5005/27. As a result, all functional statements for nurse practitioners have been modified to reflect the appropriate licensure, education, certification, and dimensions of practice for their grades.

The Whistleblower's Comments

Ms. Bethea provided comments on the report and supplemental report pursuant to § 1213(e)(1). She initially raised her concerns regarding the evidence presented and the recommendation to modify the nurse practitioners' duties to roles with a scope of practice that aligned with their current qualifications. Following her review of the supplemental report, Ms. Bethea expressed that she was pleased that the Charleston VAMC has taken steps to correct the clinical practice issues relating to Ms. Ryan and Ms. Coish. She noted, "Veterans of this nation who are affected by serious mental illness are a precious population

and the safety of the care provided to them must be maintained." She further noted that, despite her raising concerns regarding Ms. Coish's certification when she was hired and subsequently during evaluations, no action was taken to correct this problem until the recommendations resulting from this investigation were made. She also questioned the validity of the clinical care review that was conducted by the Acting Chief of the Mental Health Service Line, noting that she believes this internal review could represent a conflict of interest.

The Special Counsel's Findings

I have reviewed the original disclosure, the agency reports, and the whistleblower's comments. Based on that review, I have determined that the reports contain all of the information required by statute and that the findings appear to be reasonable.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the unredacted agency reports and the whistleblower's comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted agency reports and whistleblower's comments in OSC's public file, which is available online at www.osc.gov.[2] This matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosures

[2] The VA provided OSC with reports containing employee names (enclosed), and redacted reports in which employees' names were removed. The VA has cited Exemption 6 of the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) as the basis for its redactions to the reports produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the reports in our public file. OSC objects to the VA's use of FOIA to remove these names because under FOIA, such withholding of information is discretionary, not mandatory, and therefore does not fit within the exceptions to disclosure under 5 U.S.C. § 1219(b), but has agreed to post the redacted version of the reports as an accommodation.